



Group Health Cooperative

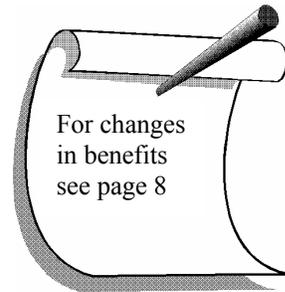
2006

<http://www.ghc.org>

A Health Maintenance Organization

Serving: Most of Washington State and Northern Idaho

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



This Plan has an Excellent Accreditation from the National Committee for Quality Assurance (NCQA), an independent, non-profit organization dedicated to improving health care quality and service. See the 2005 guide for more information on accreditation.

Western Washington

Enrollment codes for this Plan:

- 541 High Option Self Only**
- 542 High Option Self and Family**
- 544 Standard Option Self Only**
- 545 Standard Option Self and Family**

Eastern & Central Washington and Northern Idaho

Enrollment codes for this Plan:

- VR1 High Option Self Only**
- VR2 High Option Self and Family**
- VR4 Standard Option Self Only**
- VR5 Standard Option Self and Family**



Authorized for distribution by the:



United States Office of Personnel Management

Center for Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-012

Notice of the Office of Personnel Management's Privacy Practices

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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202/606-0745 and ask for OPM’s FEHB Program privacy official for this purpose.

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

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707

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

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

Important Notice from Group Health Cooperative About Our Prescription Drug Coverage and Medicare Part D

OPM has determined that the Group Health Cooperative Federal plan prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 Group Health Cooperative will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Table of Contents

Table of Contents	1
Introduction	3
Plain Language	3
Stop Health Care Fraud!	3
Preventing Medical Mistakes	4
Section 1. Facts about this HMO plan	6
General features of our High and Standard Options	6
How we pay providers	6
Who provides my health care?	6
Your Rights	6
Service Area	7
Section 2. How we change for 2006	8
Changes to this Plan	8
Section 3. How you get care	9
Identification cards	9
Where you get covered care	9
• Plan Providers	9
• Plan Facilities	9
What you must do to get covered care	9
• Primary care	9
• Specialty care	9
• Hospital care	10
Circumstances beyond our control	11
Services requiring our prior approval	11
Section 4. Your costs for covered services	12
Copayments	12
Deductible	12
Coinsurance	12
Your catastrophic protection out-of-pocket maximum	12
High and Standard Option Benefits	13
Section 5. High and Standard Option Benefits Overview	15
Section 5 (a) Medical services and supplies provided by physicians and other health care professionals	16
Section 5 (b) Surgical and anesthesia services provided by physicians and other health care professionals	27
Section 5 (c) Services provided by a hospital or other facility, and ambulance services	32
Section 5(d) Emergency services/accidents	35
Section 5 (e) Mental health and substance abuse benefits	37
Section 5 (f) Prescription drug benefits	40
Section 5 (g) Special features	43
• Flexible benefits option	43
• Consulting Nurse Service	43
• Services for deaf and hearing impaired	43
• Reciprocity benefit	43
• Travel benefit	43
Section 5 (h) Dental benefits	44
Non-FEHB benefits available to Plan members	46

Section 6 General exclusions - Things we don't cover	47
Section 7 Filing a claim for covered services.....	48
Section 8 The disputed claims process.....	49
Section 9 Coordinating benefits with other coverage.....	52
When you have other health coverage.....	52
What is Medicare?.....	52
• Should I enroll in Medicare?	52
• The Original Medicare Plan (Part A or Part B)	53
• Medicare Advantage (Part C).....	53
• Medicare prescription drug coverage (Part D).....	54
TRICARE and CHAMPVA	56
Workers' Compensation.....	56
Medicaid.....	56
When other Government agencies are responsible for your care	56
When others are responsible for injuries	56
Section 10 Definitions of terms we use in this brochure	57
Section 11 FEHB facts	58
Coverage information.....	58
• No pre-existing condition limitation.....	58
• Where you can get information about enrolling in the FEHB Program.....	58
• Types of coverage available for you and your family	58
• Children's Equity Act.....	58
• When benefits and premiums start	59
• When you retire	59
When you lose benefits	59
• When FEHB coverage ends.....	59
• Spouse equity coverage	59
• Temporary Continuation of Coverage (TCC).....	60
• Converting to Individual Coverage.....	60
• Getting a Certificate of Group Health Plan Coverage.....	60
Section 12. Two Federal Programs complement FEHB benefits	61
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	61
The Federal Long Term Care Insurance Program	64
Index.....	65
Summary of Benefits for Group Health Cooperative– Standard Option – 2006	66
Summary of Benefits for Group Health Cooperative – High Option – 2006	68
2006 Rate Information for Group Health Cooperative.....	70

Introduction

This brochure describes the benefits provided by Group Health Cooperative under our contract (CS 1043) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Group Health Cooperative's administrative office is:

Group Health Cooperative
521 Wall Street
Seattle, WA 98121

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-888/901-4636 and explain the situation.

If we do not resolve the issue:

**CALL – THE HEALTH CARE FRAUD HOTLINE
202/418-3300**

OR 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); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine 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 medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of test or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital 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.

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 reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- ▶ www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- ▶ www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- ▶ www.talkaboutrx.org/index.jsp. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- ▶ 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 health care professionals working to improve patient safety.
- ▶ www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option or Standard Option plan.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive covered services from Plan providers, you generally will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

General features of our High and Standard Options

Our High Option plan is a copayment plan, with most services subject to a copayment. This plan also includes dental coverage.

Our Standard Option is an annual deductible plan. Most services are subject to the annual deductible, coinsurance and copayments. There is no dental coverage on this plan.

How we pay providers

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

Who provides my health care?

Group Health Cooperative is a Mixed Model Prepayment (MMP) Plan. The Plan provides medical care by doctors, nurse practitioners, and other skilled Medical personnel working as medical teams. Specialists are available as part of the medical teams for consultation and treatment.

In some of the Group Health Cooperative Service areas, participating providers are practitioners who provide routine care within their private office settings in the community.

The first and most important decision each member must make is the selection of a primary care provider. The decision is important since it is usually through this provider that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care provider to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a Plan approved written referral by the member's primary care provider, with the following exception: a woman may see a participating General and Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Doctor of Osteopathy, Obstetrician or Advanced Registered Nurse Practitioner who provide women's health care services directly, without a referral from her primary care provider, for medically appropriate maternity care, reproductive health services, preventive care and general examination, gynecological care and medically appropriate follow-up visits for the above services. If your chosen provider diagnoses a condition that requires referral to other specialists or hospitalization, you or your chosen provider must obtain preauthorization and care coordination in accordance with applicable Plan requirements.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You can also find out about Care Management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you would like more information about us, call 1-888/901-4636, or write to Group Health Cooperative, Customer Service, P.O. Box 34590, Seattle WA 98124-1590. You may also contact us by fax at 1-206/901-4612 or visit our Web site at www.ghc.org. You may get information about us, our networks, providers and facilities.

Service Area

To enroll in this Plan, you must live or work in our Service Area. Group Health Cooperative providers practice in the following areas. Our service area is:

Western Washington (entire counties):

- Island
- King
- Kitsap
- Lewis
- Mason
- Pierce
- San Juan
- Skagit
- Snohomish
- Thurston
- Whatcom

In Grays Harbor County, the following cities, by Zip Code:

- Elma (98541)
- Malone (98559)
- McCleary (98557)
- Oakville (98568)
- Porter (98573)

In Jefferson County, the following cities, by Zip Code:

- Brinnon (98320)
- Chimacum (98325)
- Gardner (98334)
- Hadlock (98339)
- Nordland (98358)
- Port Ludlow (98365)
- Port Townsend (98368)
- Quilcene (98376)

Central and Eastern Washington (entire counties):

- Benton
- Columbia
- Franklin
- Kittitas
- Spokane
- Walla Walla
- Whitman
- Yakima

Northern Idaho (entire counties):

- Kootenai
- Latah

If you receive care outside our service area, we will pay only for emergency services as described on pages 35 and 36, or those services covered under the “Travel Benefit” described on page 43. We will not pay for any other health care services.

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

Plan members who are temporarily outside the service area of this Plan have access to care with Kaiser Permanente Plans. If you need services when out of the area, and are in the service area of a Kaiser Permanente Plan, you may obtain care from any Kaiser Permanente Provider, medical office, or medical center. If you plan to travel and wish to obtain more information about the benefits available to you, please call Customer Service at 1-888/901-4636.

Section 2. How we change for 2006

Do not rely 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 to this Plan

High Option only:

- Your share of the non-Postal premium for Enrollment Code 54 will increase by 3.8% for Self Only or 4.3% for Self and Family. Your share of the non-Postal premium for Enrollment Code VR will increase by 31.4% for Self Only or 7.6% for Self and Family.
- In Section 5(a), under Alternative Treatments, Acupuncture, your self-referred visit limit has increased from 5 to 8 visits per diagnosis per calendar year (see page 25).
- In Section 5(a), under Alternative Treatments, Naturopathic services, your self-referred visit limit has increased from 2 to 3 visits per diagnosis per calendar year (see page 25).
- In Section 5(h) Dental Benefits, a PPO network is now available for your dental care. If you choose a PPO Provider, you will pay (see pages 44-45):

	<u>Non PPO Providers</u>	<u>PPO Providers</u>
• Preventive Care	Nothing	Nothing
• Basic Dental Care	50%	50%
• Major Dental Care	70%	50%

- In Section 5(h), Dental benefits, we have added fissure sealants for children through age fourteen (14) to the list of covered preventive care services. These services will be paid at 100% after the annual deductible is met (see page 45).
- In Section 5(h), Dental benefits, we have changed the preventive care visit schedule to two (2) procedures per calendar year (see page 43).

Standard Option only:

- Your share of the non-Postal premium for Enrollment Code 54 will increase by 5.3% for Self Only or 5.3% for Self and Family. Your share of the non-Postal premium for Enrollment Code VR will increase by 7.3% for Self Only or 7.3% for Self and Family.
- In Section 5(a), under Alternative Treatments, Acupuncture, your self-referred visit limit has increased from 5 to 8 visits per diagnosis per calendar year (see page 25).
- In Section 5(a), under Alternative Treatments, Naturopathic services, your self-referred visit limit has increased from 2 to 3 visits per diagnosis per calendar year (see page 25).

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (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, please call our Customer Service at 1-888/901-4636 or write to us at Group Health Cooperative, Customer Service, P.O. Box 34590, Seattle WA 98124-1590.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles and/or coinsurance, and you will not have to file claims.

- **Plan Providers**

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

We list Plan providers in the provider directory, which we update periodically. You may call Customer Service at 1-888/901-4636. The list is also on our website.

- **Plan Facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directories. The list is also on our Web site.

What you must do to get covered care

You and each family member should choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. There are several ways to select a physician; you may contact Customer Service 1-888/901-4636 or your chosen plan facility for assistance.

- **Primary care**

Your primary care physician (such as family practitioner or pediatrician), will arrange for most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call Customer Service at 1-888/901-4636 or contact your chosen plan facility. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care, but you may also self-refer to many specialists at Group Health Cooperative facilities. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. However, you may see a woman’s health care specialist or a mental health provider without a referral. A woman may see a participating General or Family Practitioner, Physician’s Assistant, Gynecologist, Certified Nurse Midwife, Doctor of Osteopathy, Obstetrician or Advanced Registered Nurse Practitioner who provide women’s health care services directly, without a referral from her primary care provider, for medically appropriate maternity care, reproductive health services, preventive care and general examination, gynecological care, and medically appropriate follow-up visits for the above services. If the chosen provider diagnoses a condition that requires a referral to other specialists or hospitalization, you or your chosen provider must obtain preauthorization and care coordination in accordance with applicable Plan requirements.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
 - Reduce our service area and you enroll in another FEHB plan.

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact our Customer Service Department at 1-888/901-4636 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 required.

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at 1-888/901-4636. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person. 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process "prior approval." Your physician must obtain "prior approval" for the following services: Hospitalization, Specialty Care and orders for Durable Medical Equipment. Upon obtaining "prior approval," all of the above are subject to the applicable deductibles, copays or coinsurance.

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see your primary care physician, you pay a copayment of \$15 per office visit if you are on the High Option Plan. On the Standard Option Plan you pay a copayment of \$20 as well as the plan coinsurance per office visit.

Example: When you are admitted to the hospital, you pay \$200 per day up to a \$600 per person per hospitalization under the High Option Plan; under the Standard Option Plan you pay \$200 per day up to \$600 per person per hospitalization after the annual deductible is met.

Deductible

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

The calendar year deductible is \$500 per person under the Standard Option. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1500 under the Standard Option. There is no calendar year deductible for the High Option Plan.

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

Coinsurance

Coinsurance on the High Option plan is the percentage of our allowed charges for specific benefits that you must pay for your care. The Standard Option plan has both a plan coinsurance as well as a coinsurance for specific benefits. Services subject to the benefit specific coinsurance are not subject to the plan coinsurance.

Example: On both the High Option Plan and the Standard Option Plan, you would pay 50% of our allowed charges for infertility services; 20% of our allowed charges for durable medical equipment; and 20% for ambulance services. On the Standard Option Plan, the plan coinsurance would apply to other benefits such as office visits, lab and x-rays, etc.

Your catastrophic protection out-of-pocket maximum

After your copayments, coinsurance and deductibles total \$2,000 per person or \$4,000 per family enrollment in any calendar year for either the High Option or Standard Option plans, you do not have to pay any more for covered services. However, copayments, coinsurance and deductibles for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments, coinsurance, and deductibles for these services under both the High Option and Standard Option Plans:

- Infertility services
- Medical devices, equipment and supplies
- Dental care
- \$125 non-Plan emergency care copayment
- Ambulance services
- Pharmacy copays

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

High and Standard Option Benefits

See page 8 for how our benefits changed this year. Page 65 and page 66 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5 High and Standard Option Benefits Overview	15
Section 5 (a) Medical services and supplies provided by physicians and other health care professionals	16
Diagnostic and treatment services	16
Lab, X-ray, and other diagnostic tests	17
Preventive care, adult	17
Preventive care, children	18
Maternity care	18
Family planning	19
Infertility services	19
Allergy care	20
Treatment therapies	20
Physical and occupational therapies	21
Speech therapy	21
Hearing services (testing, treatment, and supplies)	22
Vision services (testing, treatment, and supplies)	22
Foot care	22
Orthopedic and prosthetic devices	23
Durable medical equipment (DME)	24
Home health services	24
Chiropractic	25
Alternative treatments	25
Education classes and programs	26
Section 5 (b) Surgical and anesthesia services provided by physicians and other health care professionals	27
Surgical procedures	27
Reconstructive surgery	29
Oral and maxillofacial surgery	30
Organ/tissue transplants	31
Anesthesia	31
Section 5 © Services provided by a hospital or other facility, and ambulance services	32
Inpatient hospital	32
Outpatient hospital or ambulatory surgical center	33
Rehabilitative therapies	33
Extended care benefits/skilled nursing care facility benefits	34
Hospice care	34
Ambulance	34
Section 5(d) Emergency services/accidents	35
Emergency within our service area	36
Emergency outside our service area	36
Ambulance	36
Section 5 (e) Mental health and substance abuse benefits	37
Mental health and substance abuse benefits	37
Section 5 (f) Prescription drug benefits	40
Covered medications and supplies	41
Section 5 (g) Special features	43
Flexible benefits option	43
Consulting Nurse Service	43
Services for deaf and hearing impaired	43
Reciprocity benefit	43
Travel benefit	43

Section 5 (h) Dental benefits44
Non-FEHB benefits available to Plan members46
Summary of Benefits for Group Health Cooperative– Standard Option – 200666
Summary of Benefits for Group Health Cooperative – High Option – 200668
2006 Rate Information for Group Health Cooperative70

Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-888/901-4636 or at our Web site at www.ghc.org.

Each option offers unique features.

High Option Plan:

The High Option Plan covers most services subject to a copayment. Select services are covered subject to a coinsurance and some services are covered in full. This plan also covers Preventive, Basic and Major dental care. See Section 5 for plan specifics.

Standard Option Plan:

The Standard Option Plan is an annual deductible plan, with most services covered subject to the annual deductible, plan coinsurance and a copayment. See Section 5 for plan specifics. Dental care is not covered on this plan.

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Under Standard Option –The calendar year Deductible is \$500 per person (\$1500 per family). The calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We added “(No Deductible, No Coinsurance)” to show when they do not apply.
- Under High Option –We have no calendar year Deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
<p>Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.</p>		
Diagnostic and treatment services	You pay - Standard Option	You pay - High Option
Professional services of physicians <ul style="list-style-type: none"> • In provider’s office 	\$20 per office visit The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	\$15 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • Office medical consultations • Second surgical opinion 	\$20 per office visit The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	\$15 per office visit
At home	Nothing	Nothing

Lab, X-ray, and other diagnostic tests	You pay - Standard Option	You pay - High Option
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound • Electrocardiogram and EEG 	<p>Nothing for the first \$500 of covered services per calendar year then 20% plan Coinsurance after the deductible is satisfied.</p>	<p>Nothing</p>
Preventive care, adult		
<p>Routine screenings according to the Plan's well adult schedule, such as but not limited to:</p> <ul style="list-style-type: none"> • Total blood cholesterol—once every five years • Colorectal cancer screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 • Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older • Routine Pap test 	<p>\$20 per office visit (No Deductible or plan Coinsurance)</p>	<p>Nothing</p>
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every one to two years according to risk 	<p>\$20 per office visit (No Deductible or plan Coinsurance)</p>	<p>Nothing</p>
<p>Routine immunizations limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (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 	<p>Nothing</p>	<p>Nothing</p>

Preventive care, adult - continued on next page

Preventive care, adult (<i>continued</i>)	You pay - Standard Option	You pay - High Option
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, or travel.</i>	<i>All charges</i>	<i>All charges</i>
Preventive care, children		
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations, immunization updates and care according to the Plan's well child schedule (up to age 22) 	\$20 per office visit (No Deductible or plan Coinsurance)	Nothing
<ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> – Eye exams to determine the need for vision correction once every 12 months – Ear exams to determine the need for hearing correction 	\$20 per office visit (No Deductible or plan Coinsurance)	\$15 per office visit
Maternity care		
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to have “prior approval” for your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care, including circumcision of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See “Hospital benefits” Section 5(c) and “Surgery benefits” Section 5(b). 	Copays, Deductible and plan Coinsurance are waived for routine prenatal and postnatal care	Copays are waived for routine prenatal and postnatal care
<i>Not covered: Routine sonograms to determine fetal age, size, or sex</i>	<i>All charges</i>	<i>All charges</i>

Family planning	You pay - Standard Option	You pay - High Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization See Surgical procedures Section 5(b) • Intrauterine devices (IUD's)-insertion • Injectable contraceptive drugs • Diaphragms-fitting <p>Note: We cover oral contraceptives and implantable contraceptives under the prescription drug benefits Section 5(f).</p>	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>	<p>\$15 per office visit</p>
<p><i>Not covered: Reversal of voluntary or involuntary surgical sterilization</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Infertility services		
<p>Nonexperimental infertility services limited to general diagnostic services. Specific diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterine insemination (IUI) 	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>50% of all charges</p>	<p>\$15 per office visit</p> <p>50% of all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>In vitro fertilization</i> – <i>Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Fertility drugs</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Allergy care	You pay - Standard Option	You pay - High Option
Testing and treatment	\$20 per office visit The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	\$15 per office visit
<ul style="list-style-type: none"> • Allergy injections • Allergy serum 	Nothing	Nothing
<i>Not covered: any testing or treatment that does not meet Plan protocols</i>	<i>All charges</i>	<i>All charges</i>
Treatment therapies		
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under “Organ/Tissue Transplants” on page 31.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis 	\$20 per office visit The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	\$15 per office visit
<ul style="list-style-type: none"> • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	Nothing when administered at home	Nothing when administered at home
<ul style="list-style-type: none"> • Growth hormone therapy (GHT) 	Covered under prescription drug benefit	Covered under prescription drug benefit
<ul style="list-style-type: none"> • Dietary formula for the treatment of Phenylketonuria (PKU) 	Nothing	Nothing
<ul style="list-style-type: none"> • Enteral nutritional therapy when necessary due to malabsorption, including equipment and supplies 	20% of charges for enteral nutritional therapy. Equipment and supplies are covered under Durable medical equipment (DME) (No Deductible)	20% of charges for enteral nutritional therapy. Equipment and supplies are covered under Durable medical equipment (DME)
<ul style="list-style-type: none"> • Total parenteral nutritional therapy and supplies necessary for its administration 	Nothing for formula. Equipment and supplies are covered under Durable medical equipment (DME) (No Deductible or plan Coinsurance)	Nothing for formula. Equipment and supplies are covered under Durable medical equipment (DME)

Treatment therapies – continued on next page

Hearing services (testing, treatment, and supplies)	You pay - Standard Option	You pay - High Option
Hearing testing to determine hearing loss	\$20 per office visit The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	\$15 per office visit
<i>Not covered: hearing aids, testing and examinations for them</i>	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • When dispensed through a Plan facility one contact lens per diseased eye following cataract surgery provided by a Plan doctor in lieu of an intraocular lens. Replacement will be provided only when needed due to change in your medical condition and will be replaced only one time within any 12 month period. • Eye exam to determine the need for vision correction • Annual eye exams or refractions <p>Note: See “Preventive care, children,” for eye exams for children.</p>	\$20 per office visit The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses</i> • <i>Contacts lenses and related supplies including examinations and fittings for them, except as provided above</i> • <i>Eye exercises and orthoptics</i> • <i>Evaluations and surgical procedures to correct refractions which are not related to eye pathology including complications</i> 	<i>All charges</i>	<i>All charges</i>
Foot care		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	\$20 per office visit The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	\$15 per office visit

Foot care – continued on next page

Foot care (<i>continued</i>)	You pay - Standard Option	You pay - High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails and similar routine treatment of conditions of the foot, excepted as stated above</i> • <i>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)</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Orthopedic and prosthetic devices</p>		
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Ostomy supplies necessary for the removal of bodily secretions or waste through an artificial opening • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, intraocular lenses, and surgically implanted breast implant following mastectomy. <p>Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device.</p> <ul style="list-style-type: none"> • Occlusal splints (including fittings) for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Therapeutic shoe inserts for severe diabetic foot disease • Braces, such as back, knee, and leg braces, but not dental braces 	<p>20% of all charges (No Deductible)</p>	<p>20% of all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>foot orthotics</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>cost of artificial or mechanical hearts</i> • <i>cost of penile implanted device</i> • <i>orthopedic and prosthetic replacements provided except when medically necessary</i> • <i>replacement of devices, equipment and supplies due to loss, breakage or damage</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay - Standard Option	You pay - High Option
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Under this benefit, we cover:</p> <ul style="list-style-type: none"> • hospital beds; • standard wheelchairs; • crutches; • walkers; • canes; • oxygen and oxygen equipment for home use; • nasal CPAP device; • blood glucose monitors; • external insulin pumps; and medically necessary replacement of supplies. 	<p>20% of our allowance (No Deductible)</p>	<p>20% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs except when approved by the medical director as medically necessary</i> • <i>Replacement of devices, equipment and supplies due to loss, breakage or damage</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Home health services		
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy, and medications 	<p>\$20 Copay and 20% plan Coinsurance per visit</p> <p>20% for oxygen therapy</p> <p>\$20 Copay per prescription for generic formulary oral medications or a \$30 Copay per prescription for brand name formulary oral medications</p> <p>A \$60 Copay for non-formulary oral medications when prescribed by a Plan doctor.</p>	<p>Nothing per visit by provider</p> <p>20% for oxygen therapy</p> <p>\$15 Copay per prescription for generic formulary oral medications or a \$25 Copay per prescription for brand name formulary oral medications.</p> <p>A \$50 Copay for non-formulary oral medications when prescribed by a Plan doctor.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Chiropractic	You pay - Standard Option	You pay - High Option
<p>Manipulative therapy services—for manipulation of the spine and extremities when treatment is received from a Plan provider and meets Plan protocols.</p>	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>	<p>\$15 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Maintenance therapy</i> • <i>Care given on a non-acute asymptomatic basis</i> • <i>Services provided for the convenience of the member</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Alternative treatments		
<p>Acupuncture services – Self referral to a plan provider for up to eight (8) visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan.</p>	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>	<p>\$15 per office visit</p>
<p>Naturopathic services – Self referral to a plan provider for up to three (3) visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan.</p>	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>	<p>\$15 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Maintenance therapy</i> • <i>Vitamins</i> • <i>Food supplements</i> • <i>Care given on a non-acute asymptomatic basics</i> • <i>Services provided for the convenience of the member</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> • <i>Botanical and herbal medicines</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Education classes and programs	You pay - Standard Option	You pay - High Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Tobacco Cessation—Participation in the Plan’s “Free and Clear (tobacco cessation) Program” is required in order to receive coverage for one course of nicotine replacement or other approved pharmacy product therapy per year. • Diabetes self-management 	<p>Nothing for the Program; See Section 5(f) for pharmacy charges for nicotine replacement therapy</p> <p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>	<p>Nothing for the Program; See Section 5(f) for pharmacy charges for nicotine replacement therapy</p> <p>\$15 per office visit</p>

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> • <i>Cost of penile implanted device</i> • <i>Cost of an artificial or mechanical heart</i> • <i>Weight loss programs</i> • <i>Adjustable gastric banding Laparoscopic or Open</i> • <i>Bilio-pancreatic bypass</i> • <i>Distal gastric bypass</i> • <i>Duodenal Switch</i> • <i>Mini-gastric bypass</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Reconstructive surgery</p>		
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – 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, birthmarks, webbed fingers, and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance of breasts; – treatment of any physical complications, such as lymphedemas; – compression garments to treat lymphedemas (see Durable Medical Equipment) – breast prostheses and surgical bras and replacements (see Prosthetic devices). <p>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.</p>	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$15 per office visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Oral and maxillofacial surgery		
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip or cleft palate • Removal of stones from salivary ducts • Excision of malignancies • Excision of non-dental cysts and incision of non-dental abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures • TMJ related services (non-dental) 	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$15 per office visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants including preparation for implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Surgical correction of malocclusion done solely to improve appearance</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Under Standard Option –The calendar year Deductible is \$500 per person (\$1500 per family). The calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We added “(No Deductible, No Coinsurance)” to show when they do not apply.
- Under High Option –We have no calendar year Deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).

Benefit Description	You pay	
<p>Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.</p>		
Inpatient hospital	You pay – Standard Option	You pay - High Option
<p>Room and board, such as:</p> <ul style="list-style-type: none"> • Semiprivate room accommodations; • Special care units such as intensive care or cardiac units • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization</p> <p>(No plan Coinsurance, Deductible applies)</p>	<p>A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood and blood derivatives • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services 	<p>A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization</p> <p>(No plan Coinsurance, Deductible applies)</p>	<p>A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization</p>

Inpatient hospital – continued on next page

Inpatient hospital (<i>continued</i>)	You pay – Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care, rest cures, domiciliary or convalescent care</i> • <i>Non-covered facilities, such as nursing home, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care, except when medically necessary</i> 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center		
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines administered at the facility • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood derivatives • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p>	<p>\$20 per procedure or visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>	Outpatient surgery is subject to a \$75 Copayment per procedure or visit
Rehabilitative therapies		
<p>Physical therapy, occupational therapy, speech therapy- Two months per condition per calendar year for the services of each of the following in a certified rehabilitation facility:</p> <ul style="list-style-type: none"> • Qualified physical therapist • Qualified speech therapists; and • Qualified occupational therapists 	<p>A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization</p> <p>(No plan Coinsurance, Deductible applies)</p>	A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization
<i>Not covered: Long-term rehabilitative therapy</i>	<i>All charges</i>	<i>All charges</i>

Extended care benefits/skilled nursing care facility benefits	You pay – Standard Option	You pay - High Option
Skilled nursing facility (SNF) benefit: When full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and authorized by the Plan you will receive up to 60 days per calendar year.	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Rest cures • Domiciliary or convalescent care • Personal comfort items such as telephone or television 	<i>All charges</i>	<i>All charges</i>
Hospice care		
<p>Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services could include:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care • Drugs • Biologicals • Medical appliances and supplies that are used primarily for the relief of pain and symptom management • Family counseling <p>These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>	<i>All charges</i>
Ambulance		
Ground and air ambulance transportation to a Plan facility, Plan designated facility, or non-Plan designated facility, when medically appropriate and ordered or authorized by a Plan doctor.	20% of charges (No Deductible)	20% of charges

Section 5(d) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under Standard Option –The calendar year Deductible is \$500 per person (\$1500 per family). The calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We added “(No Deductible, No Coinsurance)” to show when they do not apply.
- Under High Option –We have no calendar year Deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care physician. 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. Remember, it is your responsibility to notify the Plan.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 24 hours by calling the Plan notification line at 1-888/457-9516, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full. If you have questions about acute illnesses other than emergencies, you should call your primary care physician.

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

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

If you are admitted to an in-Plan hospital or designated facility directly from the emergency room, we will waive the Emergency Room copayment.

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

If you need to be hospitalized, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full.

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

Emergency services/accidents – continued on next page

Benefit Description	You pay	
<p>Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.</p>		
Emergency within our service area	You pay – Standard Option	You pay - High Option
<ul style="list-style-type: none"> Emergency or urgent care at a Plan doctor's office Emergency or urgent care at a Plan urgent care center 	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>	<p>\$15 per office visit</p>
<ul style="list-style-type: none"> Emergency care at a plan or plan designated emergency department Emergency care at a non-plan facility, including doctors' services 	<p>\$75 Copay per member per visit</p> <p>\$125 Copay per member per visit</p>	<p>\$75 Copay per member per visit</p> <p>\$125 Copay per member per visit</p>
<p><i>Not covered: Elective care or non-emergency care</i></p>	<p><i>All charges except at Plan doctor's office or Plan urgent care center</i></p>	<p><i>All charges except at Plan doctor's office or Plan urgent care center</i></p>
Emergency outside our service area		
<ul style="list-style-type: none"> Emergency or urgent care at a doctor's office Emergency or urgent care at an urgent care center Emergency care at a hospital, including doctors' services 	<p>\$125 Copay per member per visit</p>	<p>\$125 Copay per member per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Ambulance		
<p>Professional ambulance service which include both ground and air ambulance transportation, when medically appropriate and approved by the plan.</p> <p>See Section 5(c) for non-emergency service.</p>	<p>20% of charges (No Deductible)</p>	<p>20% of charges</p>
<p><i>Not covered: Cabulance</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5 (e) Mental health and substance abuse benefits

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are clinically appropriate to treat your condition.
- Plan doctors must provide or arrange your care.
- Under Standard Option –The calendar year Deductible is \$500 per person (\$1500 per family). The calendar year Deductible and plan Coinsurance applies to almost all benefits in this Section. We added “(No Deductible, No Coinsurance)” to show when they do not apply.
- Under High Option –We have no calendar year Deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
<p>Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.</p>		
Mental health and substance abuse benefits	You pay – Standard Option	You pay - High Option
<p>We will cover all diagnostic and treatment services for the treatment of mental health and substance abuse conditions that are clinically necessary and recommended by the member’s primary physician and approved by the Plan Medical Director or designee.</p>	<p>Cost sharing and limitations for benefits that we cover (for example, visit/day limits, copayments, and out-of-pocket maximums) for mental health and substance abuse are based on the cost sharing and limits for similar benefits under our Plan medical, hospital, prescription drug, diagnostic testing, and surgical benefits.</p>	<p>Cost sharing and limitations for benefits that we cover (for example, visit/day limits, copayments, and out-of-pocket maximums) for mental health and substance abuse are based on the cost sharing and limits for similar benefits under our Plan medical, hospital, prescription drug, diagnostic testing, and surgical benefits.</p>

Mental health and substance abuse benefits - continued on next page

Mental health and substance abuse benefits (continued)	You pay – Standard Option	You pay - High Option
<p>Mental health inpatient and outpatient treatment can include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Diagnostic tests • Consultation services • Psychiatric treatment (individual, family and group therapy) by providers such as psychiatrists, psychologists, or clinical social workers • Hospitalization (including professional services) • Services in approved alternative care settings such as partial hospitalization • Medication management visits <p>Substance abuse inpatient and outpatient treatment can include:</p> <ul style="list-style-type: none"> • Diagnosis, treatment and counseling for alcoholism and drug addiction • Diagnostic tests • Detoxification • Hospitalization (including inpatient professional services) • Medication management visits • Alcohol and drug education • Services in approved alternative care settings such as intensive outpatient treatment 	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization.</p> <p>(No plan Coinsurance for inpatient facility charges)</p> <p>\$20 Copay for generic formulary drugs or a \$30 Copay for brand name formulary drugs and a \$60 Copay for non formulary drugs when prescribed by a Plan Doctor, to treat a mental health or substance abuse condition.</p> <p>(No Deductible or plan Coinsurance on pharmacy)</p> <p>A \$25 Copayment per day for partial hospitalization and 20% plan Coinsurance; no day limit.</p> <p>Nothing for the first \$500 per calendar year, then covered at the 20% plan Coinsurance for diagnostic tests.</p>	<p>\$15 per office visit</p> <p>A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization.</p> <p>\$15 Copay for generic formulary drugs or a \$25 Copay for brand name formulary drugs and a \$50 Copay for non formulary drugs when prescribed by a Plan Doctor, to treat a mental health or substance abuse condition.</p> <p>A \$25 Copayment per day for partial hospitalization; no day limit.</p> <p>Nothing for diagnostic tests</p>

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits (continued)	You pay – Standard Option	You pay - High Option
<p><i>Not covered:</i></p> <p><i>Mental health inpatient and outpatient treatment that the Plan excludes are:</i></p> <ul style="list-style-type: none"> • <i>Psychiatric evaluation or therapy that is court ordered as a condition of parole or probation unless determined by a Plan provider to be necessary and appropriate</i> • <i>Psychological testing that is not medically necessary</i> • <i>Services that are custodial in nature</i> • <i>Assessment and treatment services that are primarily vocational and academic in nature (i.e., educational testing)</i> • <i>Services provided under a Federal, state, or local government</i> • <i>Services rendered or billed by a school or a member of its staff</i> • <i>Continued services if you do not substantially follow your treatment plan</i> • <i>Treatment not authorized by a Plan provider, provided by the Plan, or specifically contracted for by the Plan</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plans' clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5 (f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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 Option –We have no calendar year Deductible or Coinsurance under the prescription drug benefits.
- Under High Option –We have no calendar year Deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A Plan physician or referral doctor must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy.
- **We use a formulary.** Prescriptions written by Plan physicians are dispensed in accordance with the Plan's drug formulary. A drug formulary is a list of preferred pharmaceutical products that our pharmacists and physicians, have developed to assure that you receive quality prescription drugs at a reasonable price. Non-formulary drugs will be covered only if based on medical necessity and if prescribed by a plan doctor. For information about specific formulary drugs, please call Customer Service at 1-888/901-4636.
- A generic equivalent to a brand name drug will be dispensed if it is available. If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. You pay a higher copay when a brand name drug is prescribed.
- **These are the dispensing limitations.** Prescription drugs prescribed by Plan doctors and filled at Plan pharmacies will be dispensed for up to a 30-day supply. You will be required to pay a copay for each 30-day supply. If your prescription is written for more than a 30-day supply, such as a 90-day supply, you are responsible for three copays, one for each 30-day supply. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Customer Service at 1-888/901-4636.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells that drug. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a name-brand drug.

Prescription drug benefits begin on the next page.

Benefit Description	You pay	
<p>Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.</p>		
Covered medications and supplies	You pay – Standard Option	You pay - High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy:</p> <ul style="list-style-type: none"> • Drugs (including injectibles) for which a prescription is required by Federal law • Insulin • Diabetic supplies, including needles, syringes, lancets, urine and blood glucose testing reagents; a copay charge applies per item per each 30-day supply • Oral, injectable, and implanted contraceptive drugs and devices • Compound dermatological preparations • Disposable needles and syringes for the administration of covered prescribed medications • Allergy serum <p>Intravenous fluids and medication for home use are covered under (Section 5(a) – “Treatment Therapies”)</p>	<p>A \$20 Copay for generic formulary drugs or a \$30 Copay for brand name formulary drugs, per prescription unit or refill for up to a 30- day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).</p> <p>A \$60 Copay for non-formulary drugs when prescribed by a Plan doctor.</p> <p>(No Deductible or plan Coinsurance for pharmacy)</p> <p>Nothing for Allergy serum</p>	<p>A \$15 Copay for generic formulary drugs or a \$25 Copay for brand name formulary drugs, per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).</p> <p>A \$50 Copay for non-formulary drugs when prescribed by a plan doctor.</p> <p>Nothing for allergy serum</p>
<p>Mail Order Drug Program</p> <ul style="list-style-type: none"> • Prescription medications mailed to your home by the Group Health mail order pharmacy. (Mail order issues up to a 90 day supply) 	<p>\$15 per 30 day supply; \$30 per 60 day supply; \$30 per 90 day supply for generic drugs</p> <p>\$25 per 30 day supply; \$50 per 60 day supply; \$60 per 90 day supply for brand formulary drugs.</p> <p>\$55 per 30 day supply; \$110 per 60 day supply; \$150 per 90 day supply for non-formulary drugs.</p> <p>(No Deductible or plan Coinsurance for pharmacy)</p>	<p>\$10 per 30 day supply; \$20 per 60 day supply; \$20 per 90 day supply for generic drugs</p> <p>\$20 per 30 day supply; \$40 per 60 day supply; \$50 per 90 day supply for brand formulary drugs.</p> <p>\$45 per 30 day supply; \$90 per 60 day supply; \$125 per 90 day supply for non-formulary drugs.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You pay – Standard Option	You pay - High Option
<p>Limited Benefits:</p> <ul style="list-style-type: none"> • Drugs to aid in tobacco cessation. Participation in the Plan’s Free and Clear Program is required in order to receive coverage for one course of nicotine replacement therapy per calendar year. • Sexual dysfunction drugs; dosage limits set by the Plan. Contact Customer Service at 1-888/901-4636 for details. 	<p>\$20 Copay for generic formulary drugs or a \$30 Copay for brand name formulary drugs for each 30-day supply.</p> <p>A \$60 Copay for non-formulary drugs when prescribed by a Plan doctor.</p> <p>(No Deductible or plan Coinsurance for pharmacy)</p> <p>50% Coinsurance</p>	<p>\$15 Copay for generic formulary drugs or a \$25 Copay for brand name formulary drugs, for each 30-day supply.</p> <p>A \$50 Copay for non-formulary drugs when prescribed by a Plan doctor.</p> <p>50% Coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> • <i>Drugs obtained at a non-Plan pharmacy except when due to an out-of-area emergency</i> • <i>Vitamins and nutritional substances, including dietary formulas and special diets, except for the treatment of phenylketonuria (PKU); total parenteral; and enteral nutrition therapy</i> • <i>Oral nutritional supplements</i> • <i>Medical supplies such as dressings, antiseptics, etc</i> • <i>Experimental drugs, devices and biological products</i> • <i>Drugs for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Replacement of lost or stolen drugs, medicines or devices</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5 (g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Consulting Nurse Service	<p>For urgent care information and after hours care between 5:30 PM and 8:30 AM call toll-free 1-800/297-6877 for Western WA or 1-800/497-2210 for Eastern WA and Idaho.</p>
Services for deaf and hearing impaired	<p>Members who are hearing or speech-impaired may use the following number to access a Group Health Facility, staff member, or Group Health provider.</p> <p>Washington: 711 or 1-800/833-6388</p> <p>Idaho: 711 or 1-800/377-3529</p>
Reciprocity benefit	<p>Plan members who temporarily reside or are traveling outside the service area of this Plan may have access to care with Kaiser Permanente Plans. If you need services when out of the area, and are in the service area of a Kaiser Permanente Plan, you may obtain care from any Kaiser Permanente provider, medical office, or medical center, applicable cost shares will apply. If you plan to travel and wish to obtain more information about the benefits available to you, please call our Customer Service Center at 1-888/901-4636.</p>
Travel benefit	<p>If you are traveling, and are outside the Plans' service area by more than 100 miles, certain health services, i.e., follow-up care and continuing care, are covered. You pay a \$25 copay per follow-up or continuing care visit, up to a maximum Plan copayment of \$1,200 per person per calendar year. You must pay the provider at the time you receive the services. If the services are covered under this benefit, you will be reimbursed the reasonable charges for the care, up to a maximum of \$1,200 per person per calendar year, and the \$25 copay per visit will be deducted from the payment you receive from the Plan.</p> <p>Submit a claim to the Plan for the services on a HCFA Form 1500, with necessary supporting documentation, i.e., itemized bills and receipts, along with an explanation of the services, and the identification information from your ID card. Send the claims to Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585.</p>

Section 5 (h) Dental benefits

	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> • 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. • You are not required to receive your care from specified dental providers, although your out-of-pocket costs will be less if you obtain services from providers in the PPO network. • 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. • Be sure to read Section 4, “<i>Your costs for covered services,</i>” for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • The following is a summary of the Plan’s dental benefits. Please call the Plan’s member Services Department at 1-206/522-2300 or 1-800/554-1907 or you may visit our website at www.deltadentalwa.com for a listing of preferred providers or more information on additional exclusions and limitations. 	
--	--	--

The Dental program will pay a percentage of the reasonable and customary charge for dental services listed below and will reimburse any dentist, dental hygienist (under the supervision of a dentist), or denturist, that you select. You pay an annual Deductible of \$50 per member and \$150 per family, per year up to \$1,000 maximum benefit, per member per year as well as any amounts over Plan payment. You are not required to receive your care from specified dental providers, although your out-of-pocket costs will be less if you obtain services from providers in the PPO network.

Important: Benefits are provided only for services included in the list of covered dental services and no charge will be paid in excess of the reasonable and customary charge. No dental benefit will be paid for any dental services or supply, which is incomplete or temporary.

Dental Benefits		
Dental Services	You pay – Standard Option	You pay - High Option
<p>Preventive Care services include:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning and polishing of teeth) not more than two (2) procedures in a calendar year • Routine oral examinations, except for orthodontics • Flouride treatment for children under age 16 • Fissure sealants for children through age 14 • Dental X-rays, except for orthodontics • Bacteriologic cultures and biopsies of tissue • Emergency palliative treatment for relief of dental pain • Space maintainers, except for orthodontics 	Not Covered	Nothing after the deductible

Dental Benefits – continued on next page

Dental Benefits (<i>continued</i>)	You pay – Standard Option	You pay - High Option
<p>Basic Dental Care includes:</p> <ul style="list-style-type: none"> • Fillings (restorations) using amalgam, silicate, acrylic synthetic porcelain and composite fill materials to restore teeth broken down by decay or injury; on posterior teeth, an allowance will only be made for an amalgam filling • Endodontic treatment as follows: root canal therapy, pulpotomy, apicoectomy, and retrograde fillings • Simple extractions • Oral surgery • Basic periodontal services, limited to occlusal adjustment when performed with a covered root scaling • Study models • Crown build-up on non-vital teeth • Pin retention of fillings • Recementing inlays, onlays, and crowns • Recementing bridges • Repairs to full and partial dentures and bridges • General anesthetics and analgesics • Injectable antibiotics 	<p>Not Covered</p>	<p>PPO Network - 50% of reasonable and customary charges after the deductible</p> <p>Non- PPO Network - 50% of reasonable and customary charges after the deductible</p>
<p>Major dental care includes:</p> <ul style="list-style-type: none"> • Major periodontal treatment of the gums and supporting structure of the teeth • Bridges and dentures • Crowns and gold restorations • Replacement of damaged appliances 	<p>Not Covered</p>	<p>PPO Network - 50% of reasonable and customary charges after the deductible</p> <p>Non PPO Network - 70% of reasonable and customary charges after the deductible</p>
<p><i>Not covered: other dental services not shown as covered.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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 maximum.

20% Vision Hardware *Discount*

Federal employees and their covered dependents are now eligible for a **20%** vision hardware discount at our GHC See Centers in Western Washington and Vision Centers East of the Cascades. The discount applies to the cost of one or more pairs of prescription eyeglasses/sunglasses or one purchase of contact lenses per year, when purchased at any of the GHC See or Vision Centers. Fitting and evaluation fees are not included in the discount. For more information, call Customer Service at 1-888-901-4636, or go online to www.seecenter.com

Take Care Stores – *Health care products*

Our GHC Take Care stores sell self-care and wellness products for knee, back, & neck care, blood pressure monitors, allergy-control bedding, weight management, sports therapy & exercise, and much more. There are four GHC Take Care Stores (located at Group Health Capitol Hill, Group Health Northgate Medical Center, Group Health Eastside Hospital, and Group Health Olympia Medical Center), or you can order directly online from the Take Care website www.take-care.com

Hear Centers – *Hearing visits & supplies*

Our GHC Hear Centers offer a full range of the latest hearing aid technology from the world's leading manufacturers, as well as custom noise plugs, swim molds, assistive listening devices, accessories, and batteries. There are five Hear Centers (located in Everett, Redmond/Bellevue, Seattle/Central, Tacoma, and Olympia). For more information, go online to www.thehearcenter.com

Smoking Cessation

Any currently enrolled Group Health may participate in the nationally recognized Free & Clear program free of charge. Participants pay extra for any pharmaceuticals used. To learn more, call Group Health Customer Service at 1-800-901-4636 or go online to www.ghc.org/products/freeclr.jhtml

MySmile – *An online oral health website*

Now there's a personalized, online tool for tracking your dental benefits, tips for lowering out of pocket costs, and much more. Visit MySmile – a new addition to your plan brought to you by Washington Dental Service. Site available to GHC High Option members only.

www.deltadentalwa.com/MySmile

MyGroupHealth – *An online health center website*

MyGroupHealth is an online health center available to all members. MyGroupHealth provides access to valuable health risk assessment tools, doctor profiles and selection, medical center locations and programs, and 22,000 pages of reliable health care information, and you can:

- Send & receive messages with your doctor/nurse
- Request an appointment
- Refill pharmacy prescriptions and drug information
- Learn about and improve your health
- Manage your health care business
- View your brochure online

Visit MyGroupHealth at www.ghc.org

Medicare Advantage Plan

As a member of the FEHB Medicare Advantage Plan, your member ID card entitles you to participate in our popular SilverSneakers program. With over twenty health and fitness facilities to choose from throughout the Puget Sound area, and **now in Spokane County**, you choose what you want to do: relax in a sauna, improve your posture and flexibility in a SilverSneakers class, or tone your body with weight training, circuit training, or aerobics. Additional benefits include a hearing aid allowance of \$250 (once every 24 months) and an eye glass allowance for standard lenses covered in full and \$100 toward the purchase of frames (once every 24 months).

Weight Management Program

The Weight Management program offers Group Health members a total lifestyle plan. It teaches positive behaviors that promote health, and helps improve overall well-being through weight management. For more information, call 206-527-6920 in Seattle or 1-888-874-7783 or go online to www.ghc.org/products/weight_management.

For more information about these and other benefits available to Group Health members, please call Group Health Customer Service at 1-888-901-4636 toll free or go online to our web site at www.ghc.org

Section 6 General exclusions - Things we don't cover

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

We do not cover the following:

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

Section 7 Filing a claim for covered services

When you see Plan providers, receive services at Plan hospitals and facilities, or fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your applicable cost shares.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-888/901-4636.

When you must file a claim – such as for services you receive outside of the Plan's service area – submit it with the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585

Phone: 1-888/901-4636

Prescription drugs

Outpatient drugs and medicines obtained at non-Plan pharmacies are not covered; except when due to an out of area emergency.

Submit your claims to: Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585

Phone: 1-888/901-4636

Other supplies or services

Submit your claims to: Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585

Phone: 1-888/901-4636

Deadline for filing your claim

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

When we need more information

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

Section 8 The disputed claims process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"> a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Group Health Cooperative, Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"> a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial – go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>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.</p>

	<p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p>5</p>	<p>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.</p> <p>If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.</p> <p>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.</p> <p>You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.</p>

The disputed claims process (*continued*)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-888/901-4636 and we will expedite our review; or
- b) We denied your initial request for care or pre-authorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 1-202/606-0755 between 8 a.m. and 5 p.m. eastern standard time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payer, after the primary payer plan pays, we will apply benefits as described in this brochure to any balances left owing.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as

costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan provider or preauthorized as required.

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

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim 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 to file your claim, call us at 1-888/901-4636.

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

- **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) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. When you elect to become part of our Medicare Advantage plan, we will waive your outpatient copayment and your hospital emergency room copayment. We will also waive all coinsurances and deductibles. **You are responsible for your outpatient drug copayment.**

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not

contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D, and we are the secondary payer, 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 payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart

A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
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...		✓ for 30-month coordination period
• This Plan was the primary payer before eligibility due to ESRD		
• Medicare was the primary payer before eligibility due to ESRD	✓	
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

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 both 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 the program.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care, up to the benefit limits of this plan. You must use our providers.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in 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 program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact our Customer Service at 1-888/901-4636 for our subrogation procedures.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by the Medicare managed care plan, or Medicare, unless provided in conjunction with skilled nursing care and/or skilled rehabilitation services. Custodial care that lasts 90 days or longer is sometimes known as long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.
Experimental or investigational services	The Plan makes its determination of experimental or investigational treatment, including medical and surgical services, drugs, devices and biological products upon review of evidence provided by evaluations of national medical associations, consensus panels, and/or other technological evaluations, including the scientific quality of such supporting evidence and rationale. The information it reviews comes from the U.S. Food and Drug Administration, and from scientific evidence in published medical literature, as well as in published peer-reviewed medical literature.
Group health coverage	Coverage offered by your employer.
Medically necessary	<p>Medical services or hospital services which are determined by the Plan Medical Director or designee to be:</p> <ol style="list-style-type: none">Rendered for the treatment or diagnosis of an injury or illness; andAppropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; andNot furnished primarily for the convenience of the Member, the attending physician, or other Provider of service. <p>Whether there is “sufficient scientific evidence” shall be determined by the Plan based on the following: peer-reviewed medical literature; publications, reports, evaluations, and regulations issued by state and federal government agencies; Medicare local carriers, and intermediaries; and such other authoritative medical sources as deemed necessary by the Plan.</p>
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: the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies.
Us/We	Us and we refer to Group Health Cooperative.
You	You refers to the enrollee and each covered family member.

Section 11 FEHB facts

Coverage information

- **No pre-existing condition limitation**

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

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

See www.opm.gov/insure/health for enrollment as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who 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 a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

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

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

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

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

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. 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 paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2005 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.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the

Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

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

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

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

- **Converting to Individual Coverage**

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

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

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

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

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Section 12. Two Federal Programs complement FEHB benefits

Important information OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

- **What is an FSA?** It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:
- **Health Care Flexible Spending Account (HCFSAs)**
 - Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
 - Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
 - The maximum annual amount that can be allotted for the HCFSAs is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSAs up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSAs. The minimum annual amount is \$250.
- **Dependent Care Flexible Spending Account (DCFSAs)**
 - Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
 - Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return.
 - The maximum annual amount that can be allotted for the DCFSAs is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSAs. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.
- **Enroll during Open Season** You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2005, you must make a new election to continue participating in 2006. Enrollment is easy!
 - **Online:** visit www.fsafeds.com and click on **Enroll**.

Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.
- **What is FSA Feds Accounts?** FSA Feds Accounts is a third-party administrator hired by OPM to manage the FSAFEDS Program. FSA Feds Accounts is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

- **Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSAs. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 12 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this Plan, typical out-of-pocket expenses include: your office visit copay, inpatient hospital copay and your pharmacy copay.

Under the Standard Option of this Plan, typical out-of-pocket expenses include: your office visit copay, inpatient hospital copay, and your lab and x-rays. The plan would not cover the annual deductible or coinsurance amounts that you pay.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. ***Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.*** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at <https://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp>. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (1-877-372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

- Health care expenses**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

- Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the Dependent Care Tax Credit Worksheet

from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance during your period of coverage the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Allergy tests	20	Maternity benefits	18
Allogeneic (donor) bone marrow transplants	31	Medicaid.....	56
Alternative treatment.....	25	Medically necessary	57
Ambulance	34, 36	Medicare.....	52, 53, 55
Anesthesia	31, 33	Members	
Autologous bone marrow transplants.....	20, 31	Family	58
Blood and blood derivatives.....	32, 33	Mental conditions.....	37, 38, 39
Breast cancer screening.....	17	Newborn care	18
Casts	32, 33	Non-FEHB Benefits.....	46
Changes for 2005	8	Nurse (Anesthetist).....	32
Chemotherapy	20	Nurse (Midwife).....	6, 9
Cholesterol tests	17	Nurse (Practitioner).....	6, 9
Circumcision.....	18, 28	Occupational therapy	21
Claims	9, 15, 43, 48, 49, 51, 61	Office visits.....	16
Coinsurance.....	6, 9, 12, 57, 62	Oral and maxillofacial surgery	30
Colorectal cancer screening	17	Orthopedic devices.....	23
Congenital anomalies.....	27, 29	Ostomy and catheter supplies.....	23
Consulting Nurse	43	Out-of-pocket expenses.....	12
Contraceptive drugs and devices.....	19, 41	Outpatient surgery	33
Coordination of benefits.....	52	Oxygen	24, 32, 33
Covered charges.....	12, 53	Pap test.....	17
Covered providers.....	9	Physical therapy	21
Crutches	24	Prescription drugs.....	40, 41, 42
Deductible	6, 9, 12, 62	Preventive care, adult.....	17, 18
Definitions	57	Preventive care, children	18
Dental care	44, 45	Prior approval.....	11
Diagnostic	16, 17, 19, 32, 33, 37, 38	Prostate cancer screening	17
Disputed claims review	49, 51	Prosthetic devices.....	23
Donor expenses (transplants)	31	Provider	6, 9
Dressings.....	32, 33	Radiation therapy.....	20
Durable medical equipment (DME).....	24	Registered Nurse	24
Educational classes and programs.....	26	Room and board	32
Effective date of enrollment.....	59	Second surgical opinion	16
Emergency	35, 36	Skilled nursing facility	31, 34
Experimental or investigational	6, 42, 47, 57	Speech therapy	21
Eyeglasses	22	Spinal manipulation	25
Family planning.....	19	Splints	23, 32
Fecal occult blood test.....	17	Sterilization procedures.....	19, 28
General exclusions.....	47	Subrogation	56
Hearing services.....	22	Substance abuse	37, 38, 39
Home health services	24	Surgery	27, 28
Home nursing care	24	Syringes.....	41
Hospice care.....	34	Temporary continuation of coverage	60
Hospital.....	9, 10, 32, 33, 36, 48	Tobacco cessation	26, 42
Immunizations	17	Transplants.....	31
Infertility	19	Treatment therapies.....	20, 21
Insulin	24, 41	Vision services	22
Laboratory and pathological services.....	17, 33	Well child care	18
Licensed Practical Nurse.....	24	Wheelchairs.....	24
Mail order prescription drugs.....	41	Workers' compensation.....	56
Mammograms	17	X-rays.....	17, 32, 33, 44
Manipulative therapy	25		

Summary of Benefits for Group Health Cooperative– Standard Option – 2006

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan providers, except in emergencies.
- Below, an asterisk (*) means the item is subject to the \$500/individual, \$1500/family calendar year Deductible.

Benefits	You Pay	Page
* Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	\$20 per office visit. The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	16
• Diagnostic tests, lab and X-ray services	Nothing for the first \$500 per calendar year then covered at the 20% plan Coinsurance after the annual deductible.	17
* Services provided by a hospital:		
• Inpatient	\$200 per day for 3 days; maximum of \$600 per person per hospitalization	32-33
• Outpatient	\$20 per office visit. The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	33
* Emergency benefits:		
• In-area	\$75 Copay per visit	36
• Out-of-area	\$125 Copay per visit	36
* Mental health and substance abuse treatment:		
Prescription drugs	Regular cost sharing (No Deductible or plan Coinsurance for pharmacy)	37-39
• For a 30-day supply per prescription unit or refill	\$20 Copay for generic prescriptions	41-42
	\$30 Copay for brand name prescriptions	41-42
	\$60 Copay for non-formulary prescription	41-42
Mail order	(No Deductible or plan Coinsurance for pharmacy)	
• For a 30-day supply per prescription unit or refill (issued up to a 90-day supply)	\$15 per 30 day supply; \$30 per 60 day supply; \$30 per 90 day supply for generic drugs	41
	\$25 per 30 day supply; \$50 per 60 day supply; \$60 per 90 day supply for brand formulary drugs.	41
	\$55 per 30 day supply; \$110 per 60 day supply; \$150 per 90 day supply for non-formulary drugs.	41
Dental care		
• See Dental schedule for complete coverage	Not covered	44-45
* Vision care		
• Routine eye exam and refractions for eyeglasses	\$20 per office visit. The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit. (This is subject to any combination of covered office visits per calendar year.)	22
Special features: Flexible benefits option; Consulting Nurse service; Services for deaf and hearing impaired; Reciprocity benefit; and Travel benefit		43

Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$2000/Self Only or \$4000/Self and Family enrollment per year. Some costs do not count toward this protection.	12
--	---	----

Summary of Benefits for Group Health Cooperative – High Option – 2006

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	\$15 Copay for primary care or specialist	16
Services provided by a hospital:		
• Inpatient	\$200 per day for 3 days; maximum of \$600 per person per hospitalization	32-33
• Outpatient	\$75 Outpatient Surgery Copay	33
Emergency benefits:		
• In-area	\$75 Copay per visit	36
• Out-of-area	\$125 Copay per visit	36
Mental health and substance abuse treatment:	Regular cost sharing	37-39
Prescription drugs:		
• For a 30-day supply per prescription unit or refill	\$15 Copay for generic prescription	41-42
	\$25 Copay for brand name prescription	41-42
	\$50 Copay for non-formulary prescription	41-42
Mail order		
• For a 30-day supply per prescription unit or refill (issued up to a 90-day supply)	\$10 per 30 day supply; \$20 per 60 day supply; \$20 per 90 day supply for generic drugs	41
	\$20 per 30 day supply; \$40 per 60 day supply; \$50 per 90 day supply for brand formulary drugs.	41
	\$45 per 30 day supply; \$90 per 60 day supply; \$125 per 90 day supply for non-formulary drugs.	41
Dental care		44-45
• See Dental Schedule for complete coverage	\$50 Deductible per member (\$150 per family) variable copays for most care and any charges beyond the Plan payment	
Vision care		
• Routine eye exam and refractions for eyeglasses	\$15 Copay per office visit	22
Special features: Flexible benefits option; Consulting Nurse service; Services for deaf and hearing impaired; Reciprocity benefit; and Travel benefit		43
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$2000/Self Only or \$4000/Self and Family enrollment per year. Some costs do not count toward this protection.	12

Notes

2006 Rate Information for Group Health Cooperative

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

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

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

Type of Enrollment	Code	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Postal Premium</i>	<i>Postal Premium</i>
		<u>Biweekly</u>	<u>Biweekly</u>	<u>Monthly</u>	<u>Monthly</u>	<u>Biweekly</u>	<u>Biweekly</u>
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Western Washington							
High Option Self Only	541	\$139.18	\$49.34	\$301.56	\$106.90	\$164.31	\$24.21
High Option Self and Family	542	\$316.08	\$109.52	\$684.84	\$237.29	\$373.15	\$52.45
Standard Option Self-Only	544	\$111.71	\$37.23	\$242.03	\$80.67	\$132.18	\$16.76
Standard Option Self and Family	545	\$252.18	\$84.06	\$546.39	\$182.13	\$298.41	\$37.83
Eastern and Central Washington and Northern Idaho							
High Option Self Only	VR1	\$139.18	\$57.12	\$301.56	\$123.76	\$164.31	\$31.99
High Option Self and Family	VR2	\$316.08	\$135.40	\$684.84	\$293.37	\$373.15	\$78.33
Standard Option Self Only	VR4	\$118.42	\$39.47	\$256.58	\$85.52	\$140.13	\$17.76
Standard Option Self and Family	VR5	\$272.36	\$90.78	\$590.10	\$196.70	\$322.29	\$40.85