

GHI Health Plan

<http://www.ghi.com>

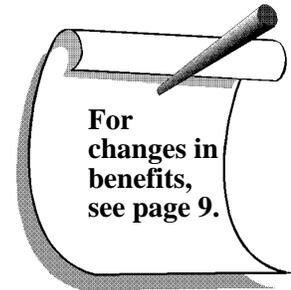
2007

A Prepaid Comprehensive Medical Plan with a High Option Point of Service Product

High Option Plan Serving: All of New York and Northern New Jersey

Standard Option Plan Serving: New York City (the Boroughs of Manhattan, Brooklyn, Bronx, Queens, and Staten Island), all of Nassau, Suffolk, Rockland, Westchester Counties, and Northern New Jersey

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Enrollment code for this Plan:

801 High Self Only

802 High Self and Family

804 Standard Self Only

805 Standard Self and Family



*This Plan has full accreditation from URAC
See the 2007 Guide for more information on accreditation.*

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



Important Notice from GHI Health Plan About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) 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.

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Introduction

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

Group Health Incorporated
441 Ninth Avenue
New York, NY 10001

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means GHI Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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 fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & 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 Program premium.

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

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

- 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 888/456-3728 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- 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); o
 - 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 tests 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. 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 Prepaid Plan with a High Option Point-of-Service product

This Plan offers two benefit packages. A High Option and a Standard Option. Within the Plan's network you are encouraged to select a personal doctor who will provide or arrange your care and you will pay minimal amounts for comprehensive benefits. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

Because the Plan emphasizes care through participating providers and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a more comprehensive range of benefits than many insurance plans.

In addition to providing comprehensive health services and care for accidents, illness and injury, the Plan emphasizes preventive benefits such as routine office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network. Under the High Option benefit package, you may go outside the network for treatment. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges, and the benefits available may be less comprehensive.

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

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

Our High Option benefit package offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

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

When you use a participating hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not all be participating providers. If they are not, you will be reimbursed at 50% of the Plan's fee schedule under the High Option benefits package and nothing under the Standard Option benefits package.

Your Rights

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

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

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

Service area

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

To enroll with us in the Standard Option you must live or work in our service area. Our service area is: New York City (the Boroughs of Manhattan, Brooklyn, Bronx, Queens, and Staten Island) all of Nassau, Suffolk, Rockland and Westchester Counties, New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

Section 2 How we change for 2007

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

Benefit changes to the High Option Plan Only

- Your share of the non-postal premium will increase by 10.4% for Self Only or 9.4% for Self and Family

Benefit changes to the Standard Option Plan Only

- Your share of the non-postal premium will increase by 2.0% for Self Only or 2.0% for Self and Family

Changes to this Plan for both options:

1. Immunizations

Adult Immunizations– add from the 2005-2006 Adult Immunization Schedule (ACIP):

- Varicella (Chickenpox) – for all persons aged 19-49
- Tetnus, Diptheria and Pertussis (TDAP) – for person’s aged 19-64, with a booster every ten years

Child Immunizations – add/follow ACIP’s recommendation for the vaccine to prevent Rotavirus for infants between eight and thirty-two weeks of age.

2. Acupuncture

Unlimited visits; no utilization management.

3. Nutritional Counseling:

Expand benefit to 4 sessions per year for any member.

4. Cardiac Rehabilitation:

Expansion of the current benefit to include those members diagnosed with CAD with significant cardiac impairment, but without a history of MI, CBG or not awaiting a heart transplant. Criteria would include a requirement of active participation in either disease management (PATH) or complex care management.

5. Rx:

- Step Therapy - addition of four rules
 1. Generic ACE inhibitor first rule (before the use of brand ACE inhibitors or ARBs)
 2. Generic cholesterol medication rule (before the use of brand cholesterol drugs)
 3. Generic Antidepressant first rule
 4. Diabetic Second Line medications: Byetta and Symlin

Please note: Step Therapy looks back into the member’s claim history to see if the member meets the rules to allow coverage of the pre-selected medications. If the rule is met, the claim processes and the member/pharmacy are not aware of the step therapy rule. Existing users of the medication are not impacted

- Prior Authorization - addition of 10 drugs requiring proof of medical necessity and a diagnosis from physician for the prescription to be covered

1. Myobloc / botulinum toxin

2. Penlac / ciclopirox solution
3. Tazorac / tazarotene
4. Lidoderm / lidocaine patch
5. Orenzia / abatacept
6. IVIG / immune globulins
7. Novantrone / mitoxantrone
8. Sutent / sunitinib malate
9. Nexavar / sorafenib tosylate
10. Xeloda / capecitabine

Section 3. How you get care

Identification cards	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 212/501-4GHI (4444). You may also request replacement cards through the GHI website, www.ghi.com</p>
Where you get covered care	<p>You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you have the High Option Plan with our point-of-service program, you can also get care from non-Plan providers, but it will cost you more.</p>
<ul style="list-style-type: none">• Plan providers	<p>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.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
<ul style="list-style-type: none">• Plan facilities	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.</p>
What you must do to get covered care	<p>Within the Plan’s network, you are encouraged to select a personal doctor who will provide or arrange your care, in which case you will pay minimal amounts for comprehensive benefits under the High Option Plan. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges, and the benefits available may be less comprehensive.</p>
<ul style="list-style-type: none">• Primary care	<p>You may seek care from a doctor, dentist, podiatrist, qualified clinical psychologist, optometrists, chiropractor, nurse, certified midwife, nurse practitioner/clinical specialist, or qualified clinical social worker and any other duly-licensed, registered or certified practitioner or privately-operated facility permitted to perform or render care or service described in this brochure.</p>
<ul style="list-style-type: none">• Specialty care	<p>You may see the specialist whenever you and your family feel you need care.</p> <p>Here are other things you should know about specialty care:</p> <ul style="list-style-type: none">• 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 <p>You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.</p> <p>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</p>

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

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

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

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

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

How to get approval for...

- **Your hospital stay** Pre admission review for non emergency hospitalization and plan notification following emergency admissions. Review of proposed hospital confinement will be made to determine projected length of stay. In addition to confirming the medical necessity of such hospitalization.
- **How to precertify an admission** To precertify an admission call GHI at 212-615-4662.
- **Maternity care** Precertification is waived for Maternity Care

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

Failure to comply with pre - admission review or the concurrent review will result in the following reductions in health benefit reimbursement: \$125 per day to a maximum of \$250 per confinement.

Circumstances beyond our control

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

Services Requiring our prior approval

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

- High –tech radiology
- High-tech nursing
- Infusion therapy
- Mental Health and Substance Abuse
- Infertility Services
- Bariatric Surgery

If no one contacted us, we will not pay for those services. For certain services, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, is medically necessary, and follows generally – accepted medical practice. Your physician must obtain prior precertification for the following services:

- Skilled Nursing
- Non-emergency hospital admissions

You do not need precertification in these cases

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

Section 4 Your costs for covered services

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

Copayments

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

Example: When you see a participating provider you pay a copayment of \$15 per office visit under the High Option and a \$25 per office visit under the Standard Option and when you go in the hospital, you pay nothing.

Deductible

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

The calendar year deductible for certain services is:

- For nursing service, you pay an annual deductible of \$150 per individual or family.
- For appliances, oxygen or equipment, you pay an annual deductible of \$100 per individual or family.
- For referred ambulatory, laboratory tests and diagnostic x-rays, which is only available under the High Option Plan, you pay a \$25 deductible per referral.
- The Standard Option coverage has a \$50 prescription drug deductible that you must meet each calendar year and a \$250 per day maximum \$750 per admission hospital deductible. The hospital deductible is waived for maternity care.

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

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

Coinsurance

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

Your catastrophic protection out-of-pocket maximum

Under the High Option Plan, after your out-of-pocket expenses total \$10,000 per person in any calendar year for covered services provided by a non-participating provider, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services.

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

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

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

High and Standard Option Benefits

See page 9 for how our benefits changed this year. Page 67 and page 69 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.

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Summary of benefits for the High Option of the GHI Health Plan- 200773

Section 5 High and Standard Option Benefits Overview

This Plan offers a High and Standard Option. Both benefit packages are described in Section 5. Make sure that 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 the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High Option benefits, contact us at 212/501-4GHI (4444) or at our Web site at www.ghi.com.

Both Options offers the following unique features:

- **Flexiable benefit options**
- **Large Case Management**
- **Customer Service Answer Line**
- **Services for deaf and hearing impaired**
- **High risk pregnancies**
- **Centers of excellence fior transplants/heart surgery etc.**
- **Travel benefir/services overseas**

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$15 per visit for participating providers. POS: 50% of the Plan’s fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.	\$25 per visit for participating providers. Waived for Pediatric visits All charges for non-participating providers
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • Office medical consultations • Second surgical opinion 	\$15 per visit for participating providers. POS: 50% of the Plan’s fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.	\$25 per visit for participating providers. Waived for Pediatric visits All charges for non-participating providers
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment 	Nothing for participating providers. POS: 50% of the Plan’s fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.	Nothing for participating providers. All charges for non-participating providers
At home	\$15 per visit for participating providers. POS: 50% of the Plan’s fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.	\$25 per visit for participating providers. All charges for non-participating providers

Benefit Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests	High Option	Standard 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>\$15 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service.</p> <p>POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.</p>	<p>\$25 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service.</p> <p>All charges for non-participating providers.</p>
Preventive care, adult	High Option	Standard Option
<p>Routine Physical Every Year</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test • Osteoporosis screening 	<p>\$15 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service</p> <p>POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount</p>	<p>\$25 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service</p> <p>All charges for non-participating providers.</p>
<p>Sigmoidoscopy, screening – every five years starting at age 50</p>	<p>\$15 per visit for participating providers.</p> <p>POS: 50% of the Plan’s fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating providers.</p> <p>All charges for non-participating providers.</p>
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	<p>\$15 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service</p> <p>POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount</p>	<p>\$25 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service</p> <p>All charges for non-participating providers.</p>
<p>Routine Pap test</p>	<p>\$15 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service</p>	<p>\$25 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service</p>

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Preventive care, adult (cont.)		
	POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.	All charges for non-participating providers
Routine mammogram – covered for women age 35 and older, as follows: <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 two consecutive calendar years 	\$15 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.	\$15 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges</i>
Routine immunizations, limited to: <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 older Varicella (Chickenpox) – for all persons aged 19-49 Tetnus, Diphtheria and Pertussis (TDAP) – for persons aged 19-64, with a booster every 10 years 	\$15 per visit for participating providers. POS: 50% of the Plan’s fee schedule for non-participating providers, and any difference between our fee schedule	\$25 per visit for participating providers. All charges for non-participating providers.
Preventive care, children	High Option	Standard Option
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics ACIP’s recommendation for the vaccine to prevent Rotavirus for infants between 8 and 32 weeks of age. 	Nothing for participating providers. POS: 50% of the Plan’s fee schedule for non participating providers, and any difference between our fee schedule and the billed amount	Nothing for participating providers. All charges for non-participating providers.
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) 	Nothing for participating providers. 50% of the Plan’s fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.	Nothing for participating providers. All charges for non-participating providers
Examinations, such as: <ul style="list-style-type: none"> Eye exams to determine the need for vision correction 	\$15 per visit for participating providers.	\$25 per visit for participating providers.

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, children (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Ear exams to determine the need for hearing correction 	<p>\$15 per visit for participating providers.</p> <p>POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating providers.</p> <p>All charges for non-participating providers.</p>
<p>Examinations done on the day of immunizations (up to age 22)</p>	<p>Nothing for participating providers.</p> <p>POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>Nothing for participating providers.</p> <p>All charges for non-participating providers</p>
Maternity care	High Option	Standard Option
<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 must precertify your normal delivery. Maternity admissions should be precertified no later than the second trimester. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical Benefits, not maternity benefits, apply to circumcision if this is the case. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>A single \$15 copay for all pre- and post-natal care from a participating provider.</p> <p>POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>A single \$25 copay for all pre- and post-natal care from a participating provider.</p> <p>All charges for non-participating providers.</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...	
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <p>Voluntary sterilization (See Surgical procedures Section 5b)</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per visit for participating providers.</p> <p>POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating providers.</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic counseling 	<i>All charges.</i>	<i>All charges.</i>
Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • In vitro fertilization (limited to three transfers per lifetime) • Embryo transfer • Artificial insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>\$15 per visit for participating providers.</p> <p>POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating providers.</p> <p>All charges for non-participating providers.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cost of donor sperm 	<i>All charges.</i>	<i>All charges.</i>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections • Treatment materials (such as allergy serum) 	<p>\$15 per visit for participating providers.</p> <p>POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating providers.</p> <p>All charges for non-participating providers.</p>
<p><i>Not covered:</i></p>	<i>All charges.</i>	<i>All charges.</i>

Allergy care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Allergy care (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges.</i>	<i>All charges.</i>
Treatment therapies	High Option	Standard Option
<p>Chemotherapy and radiation therapy</p> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 35.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis 	<p>In a doctor’s office, nothing for a participating provider.</p> <p>POS: In a doctors office, 50% of the Plan’s fee schedule, for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>In a doctor’s office, nothing for a participating provider.</p> <p>All charges for non-participating providers.</p>
<ul style="list-style-type: none"> • High-tech nursing and infusion therapy • IV infusion therapy • Parenteral and enteral therapy • Other home IV therapies <p>Note: Contact us at (212) 615-4662 prior to receiving services to ensure coverage.</p> <ul style="list-style-type: none"> • Intermittent home nursing service • Provided by a Registered Nurse or Licensed Practitioner • Authorized and supervised by a doctor • Intermittent visits less than 2 hours per day 	<p>Nothing for a participating provider.</p> <p>POS: All charges for non-participating providers.</p>	<p>Nothing for a participating provider.</p> <p>All charges for non-participating providers.</p>
<ul style="list-style-type: none"> • Growth hormone therapy (GHT). This benefit is provided under our Prescription Drug Benefits. You must fill the prescription at a pharmacy that participates under the program Express Scripts PERxCare Retail Pharmacy Program. 	<p>Generic drug: \$10 copay per prescription or refill</p> <p>Name brand drug, listed on formulary: \$20 copay per prescription or refill</p> <p>Name brand drug not on formulary: \$50 copay per prescription or refill</p>	<p>After a \$50 annual deductible per person</p> <p>Generic drug: \$10 copay per prescription or refill</p> <p>Name brand drug, listed on formulary: \$25 copay per prescription or refill</p> <p>Name brand drug not on formulary: \$50 copay per prescription or refill</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Treatment for experimental or investigational procedures.</i> • <i>Therapy necessary for transsexual surgery.</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
Physical and occupational therapies	High Option	Standard Option
<ul style="list-style-type: none"> · 60 visits per condition for the services of each of the following: <ul style="list-style-type: none"> - qualified physical therapist; - occupational therapist. <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other daily living activities.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.</p>	<p>\$15 per visit for participating providers.</p> <p>POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating providers.</p> <p>All charges for non-participating providers.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Speech therapy	High Option	Standard Option
<p>60 visits per condition</p>	<p>\$15 per visit for participating providers.</p> <p>POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating providers.</p> <p>All charges for non-participating providers.</p>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Hearing testing 	<p>\$15 per visit for participating providers.</p> <p>POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating providers.</p> <p>All charges for non-participating providers.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...	
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> Medical and surgical benefits for diagnosis and treatment of diseases of the eye. 	<p>\$15 per visit for participating provider.</p> <p>For non-participating providers, you pay 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating provider.</p> <p>All charges for non-participating providers.</p>
<ul style="list-style-type: none"> Examination of the eyes to determine if glasses are required: once each calendar year. One set of single vision or bifocal lenses (toric kryptok or flat top 22mm): once each calendar year. One pair of basic frames from available styles: one every two years. Contact lenses for certain unusual medical conditions (such as post cataract surgery or keratoconus treatment). Replacement of broken lenses with lenses of the same prescription and material originally supplied. 	<p>Nothing for services provided by participating opticians, optometrists and vision centers.</p> <p>POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.</p>	<p>Nothing for services provided by participating opticians, optometrists and vision centers.</p> <p>All charges for non-participating providers.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Frames at any time unless lenses are also provided.</i> <i>Replacement or repair of frames.</i> <i>Certain bifocals and trifocals, tinted, plastic and oversized lenses and sunglasses and frames other than basic frames; contact lenses for cosmetic purposes.</i> <i>Charges in excess of the maximum GHI allowance.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Foot care	High Option	Standard Option
<p>Podiatric services, including the routine treatment of corns, calluses, and bunions, and the partial removal of toenails, are limited to 4 visits per calendar year.</p>	<p>\$15 per visit for participating provider.</p> <p>For non-participating providers, you pay 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount.</p>	<p>\$25 per visit for participating provider.</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <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> <i>Orthotics devices for the feet.</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices	High Option	Standard Option
<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. • Orthopedic devices, such as braces. • Ostomy supplies. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. 	<p>20% of the Plan's fee schedule for a participating provider.</p> <p>POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider.</p> <p>Note: \$100 deductible applies per individual or family. There is a combined maximum of \$25,000 per year per person with these benefits and private duty nursing.</p>	<p>20% of the Plan's fee schedule for a participating provider.</p> <p>All charges for non-participating providers.</p> <p>Note: \$100 deductible applies per individual or family. There is a combined maximum of \$25,000 per year per person with these benefits and private duty nursing.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • orthopedic and corrective shoes • arch supports • foot orthotics • heel pads and heel cups • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>corrective appliances for treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Durable medical equipment (DME)	High Option	Standard Option
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. <p>Note: Call us at (212) 615-4662 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% of the Plan's fee scheduled for a participating provider.</p> <p>POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider.</p> <p>Note: \$100 deductible applies per individual or family. There is a combined maximum of \$25,000 per year per person with these benefits and private duty nursing.</p>	<p>20% of the Plan's fee scheduled for a participating provider.</p> <p>All charges for non-participating providers.</p> <p>Note: \$100 deductible applies per individual or family. There is a combined maximum of \$25,000 per year per person with these benefits and private duty nursing.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing aids and air purification devices</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Alarm and Alert Services</i> 	<i>All charges.</i>	<i>All charges.</i>
Home health services	High Option	Standard Option
<p>The following conditions must be met:</p> <ul style="list-style-type: none"> • Home health care must be provided and billed by a certified home health agency, which has an agreement with GHI to provide home health care services. • You must remain under the care of a medical doctor. • The services are provided according to a plan of treatment approved by the attending medical doctor. • Medical evidence substantiates that you would have required further inpatient care had the home health care not been available. • Part-time or intermittent nursing care by a registered professional nurse (R.N.) or a home health aide under the supervision of a registered professional nurse. • Physical therapy. • Respiration or inhalation therapy. • Prescription drugs. • Medical supplies which serve a specific therapeutic or diagnostic purpose. • Other medically necessary services or supplies that would have been provided by a hospital if the subscriber were still hospitalized. 	<p>Nothing for a participating provider.</p> <p>POS: All charges for a non-participating provider.</p>	<p>Nothing for a participating provider.</p> <p>All charges for a non-participating provider.</p>
<p>Private Duty Nursing services rendered at home or in the hospital by a registered nurse (R.N.) or when an R.N. is not available by a licensed practical nurse (L.P.N).</p>	<p>Nothing for a participating provider.</p> <p>POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider.</p> <p>Note: \$150 annual deductible applies per person or family. There is a combined maximum of \$25,000 per calendar year per person with these benefits and Durable Medical Equipment.</p>	<p>Nothing for a participating provider.</p> <p>All charges for non-participating providers.</p> <p>Note: \$150 annual deductible applies per person or family. There is a combined maximum of \$25,000 per calendar year per person with these benefits and Durable Medical Equipment.</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter.</i> 	<i>All charges.</i>	<i>All charges.</i>

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Home health services (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Services and supplies related to normal maternity care.</i> • <i>Services and supplies provided following a noncovered hospital admission or admission to a facility that is not a participating facility.</i> • <i>Services and supplies provided when the subscriber would not have required continued inpatient care.</i> • <i>High-tech nursing and infusion therapy.</i> 	<i>All charges.</i>	<i>All charges.</i>
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjustment procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application. 	\$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.	\$25 per visit for participating providers. All charges for non-participating providers.
<i>Not covered:</i> <ul style="list-style-type: none"> • naturopathic services • hypnotherapy • biofeedback 	All charges	<i>All charges</i>
Alternative treatments	High Option	Standard Option
Acupuncture – unlimited visits; no utilization management	All charges	\$20 per visit for participating providers. All charges for non-participating providers.
Educational classes and programs	High Option	Standard Option
Coverage is limited to: <ul style="list-style-type: none"> • Diabetes self-management • Cholesterol Management • Arthritis • Asthma • Hepatitis C • Multiple Sclerosis • Depression • Osteoporosis • Nutritional Counseling 	Nothing For diabetes self management call Diabetes Health Solutions at (800) 881-4008 For arthritis and osteoporosis information call Arthritis Foundation NYC Chapter at (212) 984-8713 To enroll in our Asthma Cholesterol Management, Hepatitis C Multiple Sclerosis & Depression program call GHI Disease Management Line (212) 615-0363	Nothing For diabetes self management call Diabetes Health Solutions at (800) 881-4008 For arthritis and osteoporosis information call Arthritis Foundation NYC Chapter at (212) 984-8713 To enroll in our Asthma program call (212) 615-0363
Smoking Cessation	All charges in excess of \$100	All charges in excess of \$100

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Surgical procedures	High Option	Standard Option
A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery)– see Services requiring our prior approval on page 12. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns 	\$15 per office procedure for a participating provider. Nothing for a participating provider in a hospital or a participating ambulatory surgery center. POS: 50% of the Plan’s fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.	\$25 per office procedure for a participating provider. Nothing for a participating provider in a hospital or a participating ambulatory surgery center. All charges for non-participating providers.
Not covered: <ul style="list-style-type: none"> • Reversal of voluntary sterilization. • Stand-by services. 	All charges	All charges

Benefit Description	You pay After the calendar year deductible...	
Reconstructive surgery	High Option	Standard Option
<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. <p>Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</p>	<p>\$15 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.</p>	<p>\$25 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>All charges for non-participating providers.</p>
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: • surgery to produce a symmetrical appearance on the other breast • treatment of any physical complications, such as lymphedemas • breast prostheses and surgical bras and replacements (see Prosthetic devices). <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>\$15 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.</p>	<p>\$25 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>All charges for non-participating providers.</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> • Surgeries related to sex transformation 	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>
Oral and maxillofacial surgery	High Option	Standard Option
<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, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures, and • Removal of impacted teeth • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$15 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers..</p>	<p>\$25 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>All charges for non-participating providers.</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Oral and maxillofacial surgery (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) • All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to Other services in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure. Limited to:</p> <ul style="list-style-type: none"> • Cornea • Human Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. 	<p>\$15 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>POS: 50% of the Plan’s fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.</p>	<p>\$25 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>All charges for non-participating providers.</p>
<ul style="list-style-type: none"> • Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if patient meets the staging descriptions) <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> - Allogeneic transplants for - Infantile malignant osteoporosis - Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer 	<p>\$15 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>POS: 50% of the Plan’s fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.</p>	<p>\$25 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>All charges for non-participating providers.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p>NOTE:</p> <ul style="list-style-type: none"> We cover related medical and hospital expenses of the donor when we cover the recipient up to a maximum of \$10,000 per transplant. Travel expenses up to a maximum of \$150 per person per day and \$10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center. This includes food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place. <p>Note: The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery. There is a separate lifetime maximum benefit up to \$1,000,000 per recipient for each type of covered transplant.</p>		
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> Allogeneic transplants for Breast cancer Epithelial ovarian cancer <p>National Transplant Program (NTP)- We will cover transplants approved as safe and effective for a specific disease by the Federal Drug Administration (FDA) or National Institute of Health, or which our Medical Director determines is medically necessary, appropriate and advisable on a case-by-case basis. We will cover the medical and hospital services, and related organ acquisition costs. Eligibility for transplants will be determined and approved in advance solely by our Medical Director upon recommendation of your PCP. Additionally, all transplants must be performed at hospitals specifically approved and designated by us to perform these procedures. Specialty physician experts from our designated centers of excellence will provide clinical review and support to the Medical Director’s decision.</p>	<p>\$15 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>POS: 50% of the Plan’s fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.</p>	<p>\$25 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>All charges for non-participating providers.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note:</p> <ul style="list-style-type: none"> • We cover related medical and hospital expenses of the donor when we cover the recipient up to a maximum of \$10,000 per transplant. • Travel expenses up to a maximum of \$150 per person per day and \$10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center. This includes food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place. <p>Note: The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery. There is a separate lifetime maximum benefit up to \$1,000,000 per recipient for each type of covered transplant.</p>	<p>\$15 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>POS: 50% of the Plan’s fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.</p>	<p>\$25 per office procedure for participating providers.</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>All charges for non-participating providers.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<p><i>All Charges</i></p>	<p><i>All Charges</i></p>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>POS: Any difference between our fee schedule and the billed amount for non-participating providers.</p>	<p>Nothing for a participating provider in the hospital or a participating ambulatory surgery center.</p> <p>All charges for non-participating providers.</p>

Anesthesia - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Anesthesia (cont.)	High Option	Standard Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: Any difference between our fee schedule and the billed amount for non-participating providers.	Nothing for a participating provider in the hospital or a participating ambulatory surgery center. All charges for non-participating providers.
<i>Not covered:</i> Services administered by the same practitioner performing surgery	All charges	All charges

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
Note: The calendar year deductible applies only when we say below: “(calendar year deductible applies)”.		
Inpatient hospital	High Option	Standard Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$100 per inpatient admission up to a maximum of \$200	\$250 per day per inpatient admission up to a maximum of \$750 per inpatient admission
Other hospital services and supplies, such as: <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 or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	Nothing (included in the \$100.00 per inpatient admission for a Plan facility)	Nothing (included in \$250 per day per inpatient admission to a maximum of \$750 per inpatient admission)
Not covered: <ul style="list-style-type: none"> • Custodial care, rest cures, domiciliary or convalescent care • Non-covered facilities, such as nursing homes and schools 	<i>All Charges</i>	<i>All Charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital (cont.)		
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing car, except when medically necessary</i> • Long term rehabilitation 	<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 • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 	Nothing for a Plan facility.	Nothing for a Plan facility.
Diagnostic laboratory tests, X-rays, and pathology services	\$25 copayment	All Charges
Chemotherapy and radiation	Nothing for chemotherapy and radiation provided in a participating facility. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.	Nothing for chemotherapy and radiation provided in a participating facility. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition.		
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits		
Skilled nursing facility (SNF): Limited to 30 days: <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplied and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your doctor as governed by Medicare guidelines. 	Nothing for a participating provider. POS: All charges for a non-participating provider.	Nothing for a participating provider. All charges for a non-participating provider.
	<i>All Charges.</i>	<i>All Charges</i>

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <p>Custodial care</p>	<i>All Charges.</i>	<i>All Charges</i>
Hospice care	High Option	Standard Option
<p>Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include:</p> <ul style="list-style-type: none"> • inpatient/outpatient care; and • family counseling under the direction of a doctor. <p>Note: Your provider must certify that you are in the terminal stages of illness, with a life expectancy of approximately six months or less. The hospice must have an agreement with us or recognized by Medicare as a hospice.</p>	Nothing	Nothing
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<i>All Charges</i>	<i>All Charges</i>
Ambulance	High Option	Standard Option
<p>Ambulance services for each trip to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility.</p>	All charges in excess of \$100.	All charges in excess of \$100.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Air ambulance</i> • <i>Ambulette services</i> 	All charges	All charges

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. It is your responsibility to ensure that the Plan has been promptly notified.

Emergencies within our service area

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

Emergencies outside our service area

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

Note: If you were admitted to the hospital from the Emergency Room the applicable copay is waived.

A participating GHI provider must provide your follow-up care. We cover care provided by a non-participating provider at 100% of the Plan’s fee schedule.

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Emergency within our service area</p> <ul style="list-style-type: none"> • Emergency medical/surgical care at a doctor's office • Emergency medical/surgical care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors’ services <p>Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.</p>	<p>\$15 per office visit for a participating provider.</p> <p>\$75 copay and any charges that exceed the emergency fee schedule.</p> <p>POS: Any difference between our fee schedule and the billed amount for a non-participating provider.</p>	<p>\$25 per office visit for a participating provider.</p> <p>\$75 copay and any charges that exceed the emergency fee schedule.</p> <p>Any difference between our fee schedule and the billed amount for a non-participating provider.</p>
<p><i>Not covered: Elective care or non-emergency care</i></p>	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...	
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency medical/surgical care at a doctors' office • Emergency medical/surgical care at an urgent care center 	<p>\$15 per office visit for a participating provider.</p> <p>POS: Any difference between our fee schedule and the billed amount for a non-participating provider....</p>	<p>\$25 per office visit for a participating provider.</p> <p>Any difference between our fee schedule and the billed amount for a non-participating provider.</p>
<ul style="list-style-type: none"> • Emergency care as an outpatient or inpatient at a hospital, including doctors' services <p>Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.</p>	<p>POS: Any difference between our fee schedule and the billed amount for a non-participating provider.</p> <p>Note: For emergency services billed for by a doctor, you pay any difference between our fee schedule and the billed amount.</p>	<p>Any difference between our fee schedule and the billed amount for a non-participating provider.</p> <p>Note: For emergency services billed for by a doctor, you pay any difference between our fee schedule and the billed amount.</p>
Not covered: Elective care or non-emergency care	<i>All Charges.</i>	<i>All Charges.</i>
Ambulance	High Option	Standard Option
<p>Professional ambulance service to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility.</p> <p>See 5(c) for non-emergency service.</p>	All charges in excess of \$100.	All charges in excess of \$100.
Not covered: air ambulance and ambullette services	<i>All Charges.</i>	<i>All Charges.</i>

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.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Mental health and substance abuse benefits	High Option	Standard Option
All diagnostic and treatment services obtained from a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$15 per visit for outpatient mental health care.	\$25 per visit for outpatient mental health care.
<ul style="list-style-type: none"> • Diagnostic tests • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	Nothing Nothing	Nothing Nothing
Not covered: <ul style="list-style-type: none"> • Services we have not approved. • Facility charges of a non-participating general hospital or facility. • Treatment by a non-participating provider. 	<i>All Charges.</i>	<i>All Charges.</i>

Mental health and substance abuse benefits - continued on next page

High and Standard Option

Benefit Description	You pay After the calendar year deductible...	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	<i>All Charges.</i>	<i>All Charges.</i>
Preauthorization	To be eligible to receive these benefits you must follow your treatment plan and all of our network authorization processes on pages 12 and 35. Contact us at 1-(800) 692-7311	
Limitation	There are no benefits if you do not obtain a treatment plan.	

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$50 per person. The calendar year deductible applies to the Standard Option Only.

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 licensed doctor must write the prescription.
- Where you can obtain them.** You may fill the prescription at a pharmacy that participates under the program through Express Scripts PERxCare Retail Pharmacy Program. You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication.
- We use a formulary.** The formulary is a list of preferred, clinically effective prescription drugs that are also cost-effective. Express Scripts acts on behalf of GHI to provide affordable access to clinically sound, high quality pharmacy benefits for you. The formulary is developed using an evaluation process. The process begins with an assessment of the drug's clinical effectiveness by an independent panel of physicians and pharmacists, also known as the Pharmacy and Therapeutics Committee. If the panel determines that the drug is clinically effective, the drug is further evaluated on an economic basis.
- We have an open formulary.** If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-877- 534-3682.
- These are the dispensing limitations.** Prescription drugs prescribed by a doctor and obtained at a pharmacy that participates under the program through Express Scripts PERxCare Retail Pharmacy Program. Drugs are prescribed by doctors and dispensed in accordance with the Plan's drug formulary. Under the High Option, you pay a **\$15** copay for a generic drug, a **\$25** copay per prescription unit or refill for a name brand drug listed on the preferred prescriptions drug formulary and a **\$50** copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary. Under the Standard Option benefit package, after **\$50** per person calendar year deductible you pay a **\$10** copay for a generic drug, a **\$25** copay per prescription unit or refill for a name brand drug listed on the preferred prescriptions drug formulary and a **\$50** copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "dispense as written" for the name brand drug, you have to pay the brand name copay.
- Mandatory Mail:** Your prescription coverage also includes a mandatory mail program. All maintenance medications must be sent to Express Scripts Mail Service Pharmacy. Two refills per prescription will be allowed at any local "preferred" Express Scripts PERxCare Pharmacy. When a new maintenance medication is prescribed the patient should request 2 prescriptions. The initial for a 31-day supply to be filled at a retail pharmacy, and the second, for up to a 90-day supply, to be submitted to Express Scripts Mail Service Pharmacy. For all existing maintenance medications at a retail pharmacy, the patient is required to obtain a new prescription, for up to a 90-day supply, to be sent to Express Scripts Mail Service Pharmacy.
- Maintenance Drug Program:** The maintenance drug program permits long-term prescriptions to be filled for up to a 90-day supply. Under the High Option, you pay a \$35 copay for a generic drug, a \$60 copay per prescription unit or refill for a name brand drug listed on the preferred prescriptions drug formulary and a \$75 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary. Under the Standard Option benefit package, you pay a \$25 copay for a generic drug, a \$50 copay per prescription unit or refill for a name brand drug listed on the preferred prescriptions drug formulary and a \$80 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary.
- Prescription Drug Programs**
 - Step Therapy Prior Authorization Program** The Step Therapy Prior Authorization Prescription Program refers to a "step approach" in requiring you to use one or more "first-line" drugs before a more costly "second-line" is approved.
 - Drug Quantity Management Program** The DQM Program refers to quantity limits implemented on pre-selected medications, based on FDA recommendations for dosing.
 - Diabetic Supplies Close Category Program** The Diabetic Supplies Category Program refers only to prescriptions for test strips and meters. You will be granted authorization for test strips and meters when you present a prescription for a covered diabetic supply product (Roche and J&J products are covered)
 - Non-Sedating Antihistamines Program** The NSAH Program allows for the coverage of generic prescription antihistamines. Most NSAH medications now have, or will have in the very near future, an over-the-counter (OTC) equivalent product on the market. As a result of the OTC's available on the market, brand name NSAH's will not be covered under your prescription drug benefits.
- A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- Why use a generic drug?**
 - Generic drugs may have unfamiliar names, but they are safe and effective.**
 - Generic drugs contain the same active ingredients, in the same dosage form as their brand name counterparts, and are manufactured according to the same strict federal regulations.**
 - Generic drugs may differ in color, size, or shape, but they have the same strength, purity, and quality as the brand-name alternatives.**
 - Prescriptions filled with generic drugs often have lower co-payments. Therefore, you may be able to get the same health benefits at a lower cost. You should ask your physician or pharmacist whether a generic version of your medications is available. By using a generic drug, you may be able to receive the same high-quality medication but reduce your expenses.**
 - When you have to file a claim.** In an emergency, a direct reimbursement claim form must be filed for prescriptions that you obtained through a non-participating retail pharmacy. Upon filling your prescriptions through non-participating pharmacies:
 - You**

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</p>		
Covered medications and supplies	High Option	Standard Option
<p>Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope.</p> <p>We cover the following medications and supplies prescribed by a physician and obtained from either a Plan pharmacy or by mail. Note: Mandatory mail requirements apply for maintenance drugs:</p> <ul style="list-style-type: none"> • Drugs for which a prescription is required by law. • FDA-approved prescription drugs and devices for birth control. • Fertility drugs. • Drugs to treat sexual dysfunction (Viagra is limited to six tablets per every thirty-one days). • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape. • Disposable needles and syringes needed for injection of covered prescribed medication. • Smoking cessation drugs and medication, including nicotine patches (up to 90-day supply). • Intravenous fluids and medications for home use through our Participating Provider network for home infusion therapy • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "dispense as written" for the name brand drug, you have to pay the brand name copay. • We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Express Scripts at 1-877-534-3682. 	<p>Network Retail:</p> <p>\$15 generic</p> <p>\$25 brand name listed on the preferred prescription drug formulary</p> <p>\$50 brand name drug not listed on the preferred prescription drug formulary.</p> <p>Network Mail Order:</p> <p>\$35 generic</p> <p>\$60 brand name listed on the preferred prescription drug formulary</p> <p>\$75 brand name drug not listed on the preferred prescription drug formulary.</p>	<p>Network Retail:</p> <p>After \$50 per person calendar year deductible</p> <p>\$10 generic</p> <p>\$25 brand name listed on the preferred prescription drug formulary</p> <p>\$50 brand name drug not listed on the preferred prescription drug formulary.</p> <p>Network Mail Order:</p> <p>\$25 generic</p> <p>\$50 brand name listed on the preferred prescription drug formulary</p> <p>\$80 brand name drug not listed on the preferred prescription drug formulary</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Nonprescription medications • Drugs obtained at a non-participating pharmacy, except for emergencies. 	<i>All Charges.</i>	<i>All Charges.</i>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Vitamins and nutritional substances that can be purchased without a prescription. • Medical supplies such as dressings and antiseptics. • Drugs for cosmetic purposes. • Drugs to enhance athletic performance. 	<i>All Charges.</i>	<i>All Charges.</i>

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. <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
Large Case Management	<p>The Plan provides a large case management program that seeks to provide alternatives for improving the quality and cost effectiveness of care. The large case management program focuses on catastrophic illnesses — for example, major head injury, high-risk infancy, stroke and severe amputations. The large case management process begins when we are notified that you or covered family member has experienced a specific illness or injury with potential long-term effects or changes in lifestyle. Case Managers evaluate individual needs, and the full range of treatment and financial exposures, from the onset of a condition or illness to recovery or stabilization. They review the efforts of the health care team and family with the goal of helping the patient return to pre-illness/injury functioning or of lessening the burden of a chronic or terminal condition. Case Managers provide the family with support and advice ranging from referral to family counseling. If it is determined that involvement of a Case Manager would be both care- and cost-effective, we will obtain the necessary authorization from the patient to proceed. Throughout the process, we will maintain strict confidentiality.</p>
Customer Service AnswerLine	<p>For information and assistance 24 hours a day, 7 days a week, access our automated telephone AnswerLine at 212/501-4GHI (4444).</p>
Services for deaf and hearing impaired	<p>If you have a question concerning Plan benefits or how to arrange for care, contact (212) 721-4962 (Hearing impaired — TDD) or you may write to us at Post Office Box 1701, New York, NY 10023-9476 or contact our office nearest you. You may also contact the Plan at its website at http://www.ghi.com.</p>
High risk pregnancies	<p>The Plan provides an intensive large case management program as described above.</p>
The Plan provides an intensive large case management program as described above.	<p>We have a special network of hospitals that perform a broad range of cardiac care and organ transplants. These centers are recognized leaders in their respective specialties and their services are available to you at no out-of-pocket expense. Call GHI Managed Care at least 10 days before the hospital admission to pre-certify coverage and for details on how to use this program.</p>
Travel benefit/ services overseas	<p>As a GHI subscriber under the High Option Plan benefit package, you are not restricted to just using members of our provider network. However, if you go outside the network, your out-of-pocket expenses will increase significantly. You will receive 50% of our fee schedule if you use a non-participating provider — you are responsible for the balance of the provider’s charge. Also, unlike when you use a network provider, you are responsible for paying the non-participating provider up front and filing a claim form with us for reimbursement.</p>

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- 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, *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	
	High Option	Standard Option
Accidental injury benefit		
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury caused by external means and services must be completed within one year.	Any difference between our fee schedule and the actual charges.	Any difference between our fee schedule and the actual charges.
Not covered: <ul style="list-style-type: none"> • Therapeutic service. • Other dental services not shown as covered. Charges which exceed the Plan's fee schedule.	All charges	All charges

Dental benefits

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

Dental Benefits	You Pay	
	High Option	Standard Option
Service		
Examinations (maximum 2 per calendar year)	Nothing for a participating provider. POS: All charges in excess of \$10.00	Nothing for a participating provider. All charges for non-participating providers.
Prophylaxes (under 12 years - maximum 2 per calendar year)	Nothing for a participating provider. POS: All charges in excess of \$7.00	Nothing for a participating provider. All charges for non-participating providers.
Prophylaxes (over 12 years maximum 2 per calendar year)	Nothing for a participating provider. POS: All charges in excess of \$10.00	Nothing for a participating provider. All charges for non-participating providers.

Service - continued on next page

High and Standard Option

Dental Benefits	You Pay	
Service (cont.)	High Option	Standard Option
Emergency visits for relief of pain (1 per calendar year)	Nothing for a participating provider. POS: All charges in excess of \$10.00	Nothing for a participating provider. All charges for non-participating providers.
X-rays (Full-mouth series, 1 every 3 years)	Nothing for a participating provider. POS: All charges in excess of \$20.00	Nothing for a participating provider. All charges for non-participating providers.
Bitewings (4 per calendar year)	Nothing for a participating provider. POS: All charges in excess of \$2.50 per each bitewing	Nothing for a participating provider. All charges for non-participating providers.
Space maintainers	Nothing for a participating provider. POS: All charges in excess of \$65.00	Nothing for a participating provider. All charges for non-participating providers.
Fluoride Treatments – dependent children to age 22	Nothing for a participating provider. POS: All charges in excess of \$5.00	Nothing for a participating provider. All charges for non-par provider

Section 5(i) High Option Point of Service benefits

High Option Point of Service (POS) Benefits

Facts about this Plan's High Option POS benefits

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

What is covered

All services are covered under our POS except:

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

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

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

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

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

In most cases, the POS coinsurance is any amount in excess of 50% of the Plan's fee schedule. The Plan's fee schedule is set at approximately 45% of the New York State 2003 HIAA mean. Members, when receiving POS services, will be responsible for 50% of the Plan's fee schedule plus any difference between our fee schedule and the billed amount.

After your out-of-pocket expenses total \$10,000 per person in any calendar year for covered services provided by a non-participating provider, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services. Covered catastrophic services include: 1) surgery, 2) administration of anesthesia, 3) chemotherapy and radiation therapy, 4) covered in-hospital services and diagnostic services, and 5) maternity. However, expenses for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay coinsurance and deductibles for these services:

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

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

• **Emergencies within the service area:**

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

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

You pay the emergency room deductible plus any charges that exceed the emergency fee schedule. You also pay charges that exceed the Plan's emergency fee schedule. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

- **Emergencies outside the service area:**

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

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

You pay the emergency room deductible plus any difference between our emergency fee schedule and billed amount for a non-participating provider. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

- **What is covered**

- Emergency care at a doctor's office or an urgent care center.
- Ambulance service (see page 39).
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.

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

Non-FEHB benefits available to Plan members

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

Dental services are available at reduced fees

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

Dental services available in the reduced fee program include:

	MANHATTAN You Pay	DOWNSTATE* You Pay	UPSTATE** You Pay
RESTORATIVE (Fillings)	\$88.00	\$75.00	\$72.00
Resin (anterior) 1 surface	\$111.00	\$99.00	\$87.00
Resin (anterior) 2 surfaces	\$131.00	\$111.00	\$105.00
Resin (anterior) 3 surfaces			
PROSTHODONTICS REMOVAL	\$803.00	\$715.00	\$671.00
Complete denture (upper)	\$861.00	\$784.00	\$743.00
Upper partial denture, resin base	\$861.00	\$784.00	\$743.00
Lower partial denture, resin base			
PROSTHODONTICS FIXED	\$642.00	\$541.00	\$512.00
Bridge pontic (resin with high noble metal)	\$762.00	\$683.00	\$633.00
Abutment crown-Porcelain fused to high noble metal			
ORAL SURGERY	\$333.00	\$305.00	\$288.00
Removal of impacted tooth - completely bone	\$198.00	\$169.00	\$153.00
Removal of impacted teeth - Soft tissue	\$162.00	\$138.00	\$124.00
Surgical removal of erupted tooth			
PERIODONTICS (Gum Treatment)	\$303.00	\$275.00	\$248.00
Gingivectomy (per quadrant)	\$715.00	\$633.00	\$550.00
Osseous Surgery (per quadrant)	\$119.00	\$103.00	\$95.00
Perio Scaling/planing (per quadrant)			
ENDODONTICS (Root Canal)	\$398.00	\$347.00	\$330.00
	\$481.00	\$411.00	\$385.00

Root Canal Therapy – 1 canal	\$732.00	\$639.00	\$592.00
Root Canal Therapy – 2 canal			
Root Canal Therapy – 3 canal			
ORTHODONTICS (Braces) Full course of treatment	\$3,850.00	\$3,850.00	\$3,850.00
<p><i>Benefits on this page are not part of the FEHB contract.</i></p> <p>* Downstate includes Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Putnam, Orange, Rockland and Westchester and New Jersey</p> <p>** Upstate includes Eastern, Central, and Western New York counties.</p>			

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 determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition. (see specific regarding transplants).**

We do not cover the following:

- Care by non-plan providers except by 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 (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations, or
- Services or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs or supplies you receive without charge while in active military service.
- Under the Standard Option benefit package, care by non-participating providers are not covered except for emergencies.

Section 7 Filing a claim for covered services

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

You will only need to file a claim when you receive 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 the form HCFA-1500, Health Insurance Claim Form. Facilities will file the UB-92 form. For claims questions and assistance, call us at (212) 501-4GHI (4444).

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

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

Submit your claims to:

Group Health Inc.

P.O. Box 3000

New York, New York 10116-3000

Prescription drugs

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

Deadline for filing your claim

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

When we need more information

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

Section 8 The disputed claims process

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

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: GHI Customer Service Department, 441 Ninth Avenue, New York, NY 10001; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Program, Health Insurance Group II, 1900 E Street, NW, Washington, D.C. 20415-3620.

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (212) 615-4662 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group II at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other 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, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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 private 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.

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 Original Medicare is the primary payer

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

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

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

- **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:

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 to 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 • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• 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.

Primary Payer Chart

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. You may also be responsible for additional amounts. See page 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.
Experimental or investigational service	<p>Experimental treatment is a treatment that has not been tested in human beings; or that is being tested but has not yet been approved for general use; or that is subject to review or approval by an Institutional Review Board.</p> <p>Investigational treatment includes, but is not limited to, services or supplies which are under study or in a clinical trial to evaluate their toxicity, safety and efficiency for a particular diagnosis or set of indications.</p> <p>Clinical trials include, but are not limited to, controlled experiments having a clinical event as an outcome measurement involving persons having a specific disease or health condition; or involving the administration of different study treatments in a parallel treatment design done to evaluate the efficacy and safety of a test measurement. Clinical trials include Phase I, Phase II, and Phase III studies. Clinical trials also include randomized trials or studies.</p>
Medical necessity	<p>Medically necessary services are services; supplies or equipment provided by a hospital or covered provider of the health care services that the carrier determines:</p> <ul style="list-style-type: none">· are appropriate to diagnose or treat the patient's condition, illness, or injury;· are consistent with standards of good medical practice in the United States;· are not primarily for the personal comfort or convenience of the patient, the family, or the provider;· are not part of or associated with scholastic education or vocational training of the patient; and· in case of inpatient care, cannot be provided safely on an outpatient basis. <p>The fact that a covered provider has prescribed, recommended, or approved a service, supply or equipment does not, in itself, make it medically necessary.</p>
Plan allowance	<p>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:</p> <p>The Plan allowance is the fee schedule or negotiated rate that GHI uses as payment in full for covered services rendered by participating providers.</p>
Us/We	Us and We refer to Group Health Incorporated
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies 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 benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under 22 marries.

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 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 2007 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 2006 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.

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

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

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get 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 Web site, 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 at 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 information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account 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.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

- **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.** 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. 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 about your health. 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.

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.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** –Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

- For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).
- For the LEX HCFSA – Dental and vision care expenses, including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums)
- For the DCFSA –Daycare expenses (including summer camp) for your child(ren) under the age 13, dependent care expenses for dependents unable to care for themselves.

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call as FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

What is an FSAFEDS Debit Card?

xxxxxxxxxxxxxxxxxxxxx (we will put in information the next round)

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important protection

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as a complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period.

Please review the dental plans' benefits material for detailed information on the benefit covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dental/vision. The site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dental/vision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season – November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888-FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage plays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information will reduce your out-of-pocket cost.

Summary of benefits for the High Option of the GHI Health Plan- 2007

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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$15 per visit for a Participating Provider. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for a non-participating provider.	20
Services provided by a hospital:		
• Inpatient	\$100 per inpatient admission up to a maximum of \$200.	35
• Outpatient	Note: \$25 deductible per referral for ambulatory laboratory test and diagnostic X-rays when referred and rendered.	36
Emergency benefits:		
• In-area	\$75 per hospital emergency room visit or urgent care center visit and charges that exceed the Plan's emergency fee schedule.	38
• Out-of-area	\$75 plus charges per hospital emergency room visit or urgent care center visit for non-participating facilities.	39
Mental health and substance abuse treatment:	Regular cost sharing	40
Prescription drugs:		42
• Retail pharmacy	\$15 copay for generic drugs; \$25 copay per prescription unit or refill for name brand drugs listed on the preferred prescription drug formulary, and \$50 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary.	44
• Mail order	For mail-order maintenance you pay a \$35 copay for generics and a \$60 copay for name brand name drug listed on the preferred prescription drug formulary and \$75 copay for a name brand drug not listed on the preferred prescription drug formulary	44

	All maintenance medications must be sent to Express Scripts Mail Service Pharmacy. Two refills per prescription will be allowed at any local “preferred” Express Scripts PERxCare.				
Dental care:	Nothing for preventive services provided by Participating Providers. For non-participating providers, you pay any difference between GHI’s fee schedule and the billed amount.	47			
Vision care:	One refraction annually. Lenses (annually) and frames (every two years). Nothing to Participating Vision Centers.	25			
Special features:		46			
	<table border="1"> <tr> <td>• Large Case Management</td> </tr> <tr> <td>• High Risk Pregnancies</td> </tr> <tr> <td>• Centers of Excellence for Transplants/Heart/Surgery/etc</td> </tr> </table>	• Large Case Management	• High Risk Pregnancies	• Centers of Excellence for Transplants/Heart/Surgery/etc	
• Large Case Management					
• High Risk Pregnancies					
• Centers of Excellence for Transplants/Heart/Surgery/etc					
Point of Service benefits:	Yes	49			
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$10,000 per person per year Some costs do not count toward this protection	14			

Summary of benefits for the Standard Option of the GHI Health Plan- 2007

- 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 physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the \$xx calendar year deductible.

Standard Option Benefits	You Pay	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$25 per visit for a Participating Provider. All charges for non-participating providers. Copayment for pediatric visits waived.	20
Services provided by a hospital:		
• Inpatient	\$250 per day inpatient admission up to a maximum of \$750 per admission. (Waived for maternity care)	35
• Outpatient	All charges for non-participating providers.	36
Emergency benefits:		
• In-area	\$75 per hospital emergency room visit or urgent care center visit and charges that exceed the Plan's emergency fee schedule.	38
• Out-of-area	\$75 plus charges per hospital emergency room visit or urgent care center visit for non-participating facilities.	39
Mental health and substance abuse treatment:		
	Regular cost sharing	40
Prescription drugs:		
• Retail pharmacy	After a \$50 deductible. \$10 copay for generic drugs; \$25 copay per prescription unit or refill for name brand drugs listed on the preferred prescription drug formulary, and \$50 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary.	44
• Mail order	For mail-order maintenance you pay a \$25 copay for generics and a \$50 copay for name brand name drug listed on the preferred prescription drug formulary and \$80 copay for a name brand drug not listed on the preferred prescription drug formulary	44

	All maintenance medications must be sent to Express Scripts Mail Service Pharmacy. Two refills per prescription will be allowed at any local “preferred” Express Scripts PERxCare.	
Dental care:	Nothing for preventive services provided by Participating Providers. All charges for non-participating providers.	47
Vision care:	One refraction annually. Lenses (annually) and frames (every two years). Nothing to Participating Vision Centers.	25
Special features:		46
• Large Case Management		
• High Risk Pregnancies		
• Centers of Excellence for Transplants/Heart/Surgery/etc		
Point of Service benefits:	No	N/A
Protection against catastrophic costs (out-of-pocket maximum):	No benefits	N/A

2007 Rate Information for -

Non-Postal rates apply to most non-Postal employees. 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	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	801	141.92	86.96	307.49	188.42
High Option Self and Family	802	321.89	250.33	697.43	542.38
Standard Option Self Only	804	133.68	44.56	289.64	96.55
Standard Option Self and Family	805	312.05	104.02	676.12	225.37