

# Group Health Cooperative

<http://www.ghc.org/groups/fehb>



## 2007

### A Health Maintenance Organization

**Serving:** Most of Washington State and Northern Idaho

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



This Plan has an Excellent Accreditation from the NCQA. See the 2007 guide for more information on NCQA.

Western Washington

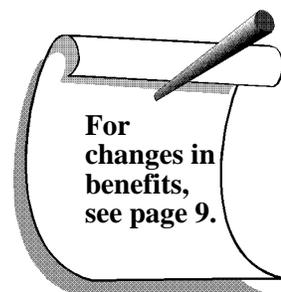
**Enrollment codes for this Plan:**

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

Eastern & Central Washington and Northern Idaho

**Enrollment codes for this Plan:**

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



Authorized for distribution by the:



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

## **Important Notice from Group Health Cooperative About**

### **Our Prescription Drug Coverage and Medicare Part D**

OPM has determined that the Group Health Cooperative Federal plan prescription drug coverage is, on average, 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 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.

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### **Please be advised**

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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 each month 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 also 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](http://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](http://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

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

Group Health Cooperative 521 Wall Street Seattle, WA 98121

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 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 8. Rates are shown at the end of this brochure.

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## Plain Language

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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.
- 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](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto: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.

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## Stop Health Care Fraud!

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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 1-888/901-4636 and explain the situation.

If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management**

**Office of the Inspector General Fraud Hotline**

**1900 E Street NW Room 6400**

**Washington, 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); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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## **Preventing medical mistakes**

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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.
- Contact your doctor or pharmacist if you have any questions.

### **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.

Visit these Web sites for more information about patient safety.

[www.ahrq.gov/path/beactive.htm](http://www.ahrq.gov/path/beactive.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 healthcare providers and improve the quality of care you receive.

[www.npsf.org](http://www.npsf.org) The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

[www.talkaboutrx.org](http://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](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.

[www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

[www.quic.gov/report](http://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 healthcare delivery system.

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## Section 1 Facts about this HMO plan

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

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

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

**You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans 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.**

### **General features of our High and Standard Options**

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

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

### **How we pay providers**

We contract with individual 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.

### **Who provides my health care?**

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

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

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

### **Your Rights**

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site ([www.opm.gov/insure](http://www.opm.gov/insure)) lists the specific types of information that we must make available to you.

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

**Service Area**

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

Western Washington (entire counties):

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

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

Elma (98541)	McCleary (98557)
Malone (98559)	Oakville (98568)

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

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

Central and Eastern Washington (entire counties):

Benton	Spokane
Columbia	Walla Walla
Franklin	Whitman
Kittitas	Yakima

Northern Idaho (entire counties):

Kootenai
Latah

If you receive care outside our service area, we will pay only for emergency services as described on pages 36 and 37, or those services covered under the “Travel Benefit” described on page 44. We will not pay for any other health care services.

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

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

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## Section 2 How we change for 2007

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

Changes to this Plan

**High Option only:**

Your share of the non-Postal premium for Enrollment Code 54 will increase by 28.4% for Self Only or 29.2% for Self and Family. Your share of the non-Postal premium for Enrollment Code VR will increase by 49.2% for Self Only or 48.1% for Self and Family.

**Standard Option only:**

Your share of the non-Postal premium for Enrollment Code 54 will increase by 15.9% for Self Only or 15.9% for Self and Family. Your share of the non-Postal premium for Enrollment Code VR will increase by 11.6% for Self Only or 11.6% for Self and Family.

**Changes to both High and Standard Options**

Your out-of-pocket maximum will be \$3,000 per person or \$6,000 per family enrollment in any calendar year.

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## Section 3. How you get care

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### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, please call our Customer Service at 1-888/901-4636 or write to us at Group Health Cooperative, Customer Service, P.O. Box 34590, Seattle WA 98124-1590.

### Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

### What you must do to get covered care

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

- **Primary care**

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

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

- **Specialty care**

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

Here are some other things you should know about specialty care:

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

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact our Customer Service Department at 1-888/901-4636 or, if we drop out of the Program, contact your new plan.

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

**• Hospital care If you are hospitalized when your enrollment begins**

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 1-888/901-4636. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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

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

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

**Circumstances beyond our control**

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

- **Services requiring our prior approval**

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

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

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## Section 4 Your costs for covered services

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

### **Copayments**

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

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

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

### **Deductible**

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

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

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

### **Coinsurance**

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

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

### **Your catastrophic protection out-of-pocket maximum**

After your copayments, coinsurance and deductibles total \$3,000 per person or \$6,000 per family enrollment in any calendar year for either the High Option or Standard Option plans, you do not have to pay any more for covered services. However, copayments, coinsurance and deductibles for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments, coinsurance, and deductibles for these services under both the High Option and Standard Option Plans:

Infertility services

Medical devices, equipment and supplies

Dental care

\$125 non-Plan emergency care copayment

Ambulance services

Pharmacy copays

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

**High and Standard Option Benefits**

See page 8 for how our benefits changed this year. Page 66 and page 67 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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## **Section 5 High and Standard Option Benefits Overview**

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

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

1-888/901-4636 or at our Web site at [www.ghc.org/fehb](http://www.ghc.org/fehb).

Each option offers unique features.

### **High Option Plan:**

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

### **Standard Option Plan:**

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

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

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

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

Benefit Description	You pay After the calendar year deductible...	
<b>Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.</b>		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> </ul>	\$15 per office visit	\$20 per office visit  The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.  (This is subject to any combination of covered office visits per calendar year.)
Professional services of physicians <ul style="list-style-type: none"> <li>• In an urgent care center</li> <li>• Office medical consultation</li> <li>• Second surgical opinion</li> </ul>	\$15 per office visit	\$20 per office visit  The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.  (This is subject to any combination of covered office visits per calendar year.)
At home	Nothing	Nothing
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> </ul>	Nothing	Nothing for the first \$500 of covered services per calendar year then 20% plan Coinsurance after the deductible is satisfied.

*Lab, X-ray and other diagnostic tests - continued on next page*

Benefit Description	You pay After the calendar year deductible...	
<b>Lab, X-ray and other diagnostic tests (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Electrocardiogram and EEG</li> </ul>	Nothing	Nothing for the first \$500 of covered services per calendar year then 20% plan Coinsurance after the deductible is satisfied.
<b>Preventive care, adult</b>	<b>High Option</b>	<b>Standard Option</b>
Routine physical every xx which includes:  Routine screenings, such as: <ul style="list-style-type: none"> <li>• Total Blood Cholesterol</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>- Fecal occult blood test</li> <li>- Sigmoidoscopy, screening – every five years starting at age 50</li> <li>- Double contrast barium enema – every five years starting at age 50</li> <li>- Colonoscopy screening – every ten years starting at age 50</li> </ul> </li> </ul>	Nothing	\$20 per office visit  (No Deductible or plan Coinsurance)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	\$20 per office visit  (No Deductible or plan Coinsurance)
Routine Pap test	Nothing	\$20 per office visit  (No Deductible or plan Coinsurance)
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> </ul>	Nothing	\$20 per office visit  (No Deductible or plan Coinsurance)
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul>	Nothing	Nothing
<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>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<b>Preventive care, children</b>		
<ul style="list-style-type: none"> <li>Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	Nothing	\$20 per office visit  (No Deductible or plan Coinsurance)
<ul style="list-style-type: none"> <li>Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> </ul>	Nothing	\$20 per office visit  (No Deductible or plan Coinsurance)
<ul style="list-style-type: none"> <li>Examinations, such as:                             <ul style="list-style-type: none"> <li>Eye exams to determine the need for vision correction once every 12 months</li> <li>Ear exams to determine the need for hearing correction</li> </ul> </li> </ul>	\$15 per office visit	\$20 per office visit  (No Deductible or plan Coinsurance)
<b>Maternity care</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>Prenatal care</li> <li>Delivery</li> <li>Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>You do not need to have “prior approval” for your normal delivery; see below for other circumstances, such as extended stays for you or your baby.</li> <li>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.</li> <li>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.</li> <li>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	Copays are waived for routine prenatal and postnatal care	Copays, Deductible and plan Coinsurance are waived for routine prenatal and postnatal care
<i>Not covered: Routine sonograms to determine fetal age, size, or sex</i>	<i>All charges.</i>	<i>All charges.</i>



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

*Treatment therapies - continued on next page*

Benefit Description	You pay After the calendar year deductible...	
<b>Treatment therapies (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
		(This is subject to any combination of covered office visits per calendar year.)
<i>Not covered: over the counter formulas</i>	<i>All charges.</i>	<i>All charges.</i>
<b>Physical and occupational therapies</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Physical therapy, occupational therapy, and speech therapy are subject to a combined limit of sixty (60) visits per condition per calendar year. Speech therapy benefit is described in the next section. The following physical and occupational therapy benefits are covered:</p> <ul style="list-style-type: none"> <li>• Qualified physical therapists; and</li> <li>• Qualified occupational therapists</li> <li>• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction when provided at a Plan facility.</li> </ul>	<p>\$15 per office visit</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>See Section 5(c) for Hospital charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term rehabilitative therapy</i></li> <li>• <i>Exercise programs</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Speech therapy</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Speech therapy, physical therapy and occupation therapy are subject to a combined limit of sixty (60) visits per condition per calendar year. The physical and occupational therapy benefits are described under “Physical and Occupational therapies.” Speech therapy is covered:</p> <ul style="list-style-type: none"> <li>• Qualified speech therapists</li> </ul>	<p>\$15 per office visit</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>See Section 5(c) for Hospital charges</p>
<b>Hearing services (testing, treatment, and supplies)</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Hearing testing to determine hearing loss</p>	<p>\$15 per office visit</p>	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Hearing aids, testing and examinations for them</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>

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

Benefit Description	You pay After the calendar year deductible...	
<b>Orthopedic and prosthetic devices</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• Ostomy supplies necessary for the removal of bodily secretions or waste through an artificial opening</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, intraocular lenses, and surgically implanted breast implant following mastectomy.</li> </ul> <p>Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device.</p> <ul style="list-style-type: none"> <li>• Occlusal splints (including fittings) for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</li> <li>• Therapeutic shoe inserts for severe diabetic foot disease</li> <li>• Braces, such as back, knee, and leg braces, but not dental braces</li> </ul>	<p>\$15 per office visit</p>	<p>20% of all charges  (No Deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>orthopedic and corrective shoes</i></li> <li>• <i>arch supports</i></li> <li>• <i>foot orthotics</i></li> <li>• <i>heel pads and heel cups</i></li> <li>• <i>lumbosacral supports</i></li> <li>• <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>cost of artificial or mechanical hearts</i></li> <li>• <i>cost of penile implanted device</i></li> <li>• <i>orthopedic and prosthetic replacements provided except when medically necessary</i></li> <li>• <i>replacement of devices, equipment and supplies due to loss, breakage or damage</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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



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

**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.
- Under Standard Option –The calendar year Deductible is \$500 per person (\$1500 per family). The calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We added “(No Deductible, No Coinsurance)” to show when they do not apply.
- Under High Option –We have no calendar year Deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for charges billed by a physician or other health care professional for your surgical care (not billed by the facility). 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 “prior approval” information shown in Section 3 to be sure which services require “prior approval” and identify which surgeries require “prior approval.”

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.		
Surgical procedures	High Option	Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see reconstructive surgery)</li> <li>• Surgical treatment of morbid obesity (bariatric surgery), subject to the following criteria:                             <ul style="list-style-type: none"> <li>- The enrollee must be at least 20 years of age</li> <li>- The enrollee’s BMI (Body Mass Index) must be 50 or greater (or between 35 and 49, with medical record documentation of one or more complicating medical conditions)</li> <li>- The enrollee must have failed all non-surgical methods of weight loss</li> </ul> </li> </ul>	<p>\$15 per office visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>

*Surgical procedures - continued on next page*

Benefit Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> <li>- The enrollee must enroll in the required prepaid weight management program</li> <li>- The enrollee’s medical record must show the absence of medical contraindications for the procedure.</li> <li>- <b>Note:</b> You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the Group Health clinical review physician.</li> <li>• Insertion of internal prosthetic devices. See Section 5(a) – “Orthopedic and prosthetic devices” for device coverage information.</li> <li>- <b>Note:</b> Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</li> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>• Treatment of burns</li> <li>• Circumcision</li> </ul>	<p>\$15 per office visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> <li>• <i>Cost of penile implanted device</i></li> <li>• <i>Cost of an artificial or mechanical heart</i></li> <li>• <i>Weight loss programs</i></li> <li>• <i>Adjustable gastric banding. Laparoscopic or Open</i></li> <li>• <i>Bilio-pancreatic bypass</i></li> <li>• <i>Distal gastric bypass</i></li> <li>• <i>Duodenal Switch</i></li> <li>• <i>Mini-gastric bypass</i></li> </ul>	<p><i>All Charges.</i></p>	<p><i>All Charges</i></p>

Benefit Description	You pay After the calendar year deductible...	
<b>Reconstructive surgery</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member’s appearance; and</li> <li>- the condition can reasonably be expected to be corrected by such surgery.</li> </ul> </li> <li>• 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; and webbed fingers and toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance of breasts;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- compression garments to treat lymphedemas (see Durable Medical Equipment)</li> <li>- breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>)</li> </ul> </li> </ul> <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 visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <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></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<p><i>All Charges.</i></p>	<p><i>All Charges</i></p>
<b>Oral and maxillofacial surgery</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones</li> <li>• Surgical correction of cleft lip or cleft palate</li> <li>• Removal of stones from salivary ducts</li> <li>• Excision of malignancies</li> <li>• Excision of non-dental cysts and incision of non-dental abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures</li> </ul>	<p>\$15 per office visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>Nothing when provided on an inpatient basis</p>

*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
<ul style="list-style-type: none"> <li>• TMJ related services (non-dental)</li> </ul>	<p>\$15 per office visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Oral implants including preparation for implants and transplants</li> <li>• Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</li> <li>• Surgical correction of malocclusion done solely to improve appearance</li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges</i></p>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single or Double</li> <li>• Pancreas</li> <li>• Intestinal transplants               <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> <li>- Small intestine with multiple organs, such as the liver, stomach, and pancreas</li> </ul> </li> </ul>	<p>\$15 per office visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description and can safely tolerate the procedure.):</p>	<p>\$15 per office visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p>	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p>

*Organ/tissue transplants - continued on next page*  
High and Standard Option Section 5(b)

Benefit Description	You pay After the calendar year deductible...	
<b>Organ/tissue transplants (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Allogeneic transplants for               <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Chronic myelogenous leukemia</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> </ul> </li> <li>• Autologous transplant for               <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Advanced neuroblastoma</li> </ul> </li> <li>• Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</li> </ul> <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for               <ul style="list-style-type: none"> <li>- <u>Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</u></li> </ul> </li> <li>• Autologous transplants for               <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> <li>- Breast cancer</li> <li>- Epithelial ovarian cancer</li> </ul> </li> </ul>	<p>\$15 per office visit for outpatient care</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>	<p>\$20 per office visit for outpatient care</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>Nothing when provided on an inpatient basis</p> <p>See Section 5(c) for Hospital charges</p>
<p>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"> <li>• National Transplant Program (NTP)</li> </ul>	<p>GHC contracts with transplant centers who deal directly with a National Organ Transplant Clearinghouse</p>	<p>GHC contracts with transplant centers who deal directly with a National Organ Transplant Clearinghouse</p>
<p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. These expenses are limited to procurement center fees, travel costs for a surgical team, excision fees, and matching tests.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> </ul>	<p><i>All Charges</i></p>	<p><i>All Charges</i></p>

Benefit Description	You pay After the calendar year deductible...	
<b>Organ/tissue transplants (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> <li>• <i>Transportation and living expenses</i></li> </ul>	<i>All Charges</i>	<i>All Charges</i>
<b>Anesthesia</b>	<b>High Option</b>	<b>Standard Option</b>
Professional services provided in – <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Skilled nursing facility</li> </ul>	Nothing	\$20 Copay and 20% plan Coinsurance per office visit or on an inpatient basis.
Professional services provided in – <ul style="list-style-type: none"> <li>• Hospital outpatient department</li> <li>• Ambulatory surgical center</li> <li>• Provider's office</li> </ul>	\$15 per office visit	\$20 per office visit  The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.  (This is subject to any combination of covered office visits per calendar year.)

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

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

*Inpatient hospital - continued on next page*  
High and Standard Section 5(c)

Benefit Description	You pay	
	High Option	Standard Option
<b>Inpatient hospital (cont.)</b>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care, rest cures, domiciliary or convalescent care</li> <li>• Non-covered facilities, such as nursing home, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care, except when medically necessary</li> </ul>	<i>All Charges</i>	<i>All Charges</i>
<b>Outpatient hospital or ambulatory surgical center</b>		
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood derivatives</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Outpatient surgery is subject to a \$75 Copayment per procedure or visit	<p>\$20 per procedure or visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>
<b>Extended care benefits/Skilled nursing care facility benefits</b>		
Skilled nursing facility (SNF) benefit: When full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and authorized by the Plan you will receive up to 60 days per calendar year.	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Rest cures</li> <li>• Domiciliary or convalescent care</li> <li>• Personal comfort items such as telephone or television</li> </ul>	<i>All Charges.</i>	<i>All Charges</i>

<b>Benefit Description</b>	<b>You pay</b>	
	<b>High Option</b>	<b>Standard Option</b>
<b>Hospice care</b>		
<p>Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services could include:</p> <ul style="list-style-type: none"> <li>• Inpatient and outpatient care</li> <li>• Drugs</li> <li>• Biologicals</li> <li>• Medical appliances and supplies that are used primarily for the relief of pain and symptom management</li> <li>• Family counseling</li> </ul> <p>These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less</p>	Nothing	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>	<i>All Charges</i>
<b>Ambulance</b>	<b>High Option</b>	<b>Standard Option</b>
Ground and air ambulance transportation to a Plan facility, Plan designated facility, or non-Plan designated facility, when medically appropriate and ordered or authorized by a Plan doctor.	20% of charges	20% of charges (No Deductible)
<b>Rehabilitative therapies</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Physical therapy, occupational therapy, speech therapy- Two months per condition per calendar year for the services of each of the following in a certified rehabilitation facility:</p> <ul style="list-style-type: none"> <li>• Qualified physical therapist</li> <li>• Qualified speech therapists; and</li> <li>• Qualified occupational therapists</li> </ul>	A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization	A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization  (No plan Coinsurance, Deductible applies)
<i>Not covered: Long-term rehabilitative therapy</i>	<i>All charges</i>	<i>All charges</i>

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

**What is a medical emergency?**

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

**What to do in case of emergency:**

**Emergencies within our service area:** If you are in an emergency situation, please call your primary care physician. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Remember, it is your responsibility to notify the Plan.

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

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

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

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

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

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

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

Benefit Description	You pay After the calendar year deductible...	
<b>Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.</b>		
<b>Emergency within our service area</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>Emergency or urgent care at a Plan doctor's office</li> <li>Emergency or urgent care at a Plan urgent care center</li>   <li>Emergency care at a plan or plan designated emergency department</li> <li>Emergency care at a non-plan facility, including doctors' services</li> </ul>	<p>\$15 per office visit</p> <p>\$75 Copay per member per visit</p> <p>\$125 Copay per member per visit</p>	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>\$75 Copay per member per visit</p> <p>\$125 Copay per member per visit</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges except at Plan doctor's office or Plan urgent care center</i>	<i>All charges except at Plan doctor's office or Plan urgent care center</i>
<b>Emergency outside our service area</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>Emergency or urgent care at a doctor's office</li> <li>Emergency or urgent care at an urgent care center</li> <li>Emergency care at a hospital, including doctors' services</li> </ul>	<p>\$125 Copay per member per visit</p>	<p>\$125 Copay per member per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All Charges.</i>	<i>All Charges</i>
<b>Ambulance</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Professional ambulance service which include both ground and air ambulance transportation, when medically appropriate and approved by the plan.</p> <p>See Section 5(c) for non-emergency service.</p>	<p>20% of charges</p>	<p>20% of charges</p> <p>(No Deductible)</p>
<i>Not covered: Cabulance</i>	<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 clinically appropriate to treat your condition.
- Plan doctors must provide or arrange your care.
- Under Standard Option –The calendar year Deductible is \$500 per person (\$1500 per family). The calendar year Deductible and plan Coinsurance applies to almost all benefits in this Section. We added “(No Deductible, No Coinsurance)” to show when they do not apply.
- Under High Option –We have no calendar year Deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...	
<p><b>Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.</b></p>		
Mental health and substance abuse benefits	High Option	Standard Option
<p>We will cover all diagnostic and treatment services for the treatment of mental health and substance abuse conditions that are clinically necessary and recommended by the member’s primary physician and approved by the Plan Medical Director or designee.</p>	<p>Cost sharing and limitations for benefits that we cover (for example, visit/day limits, copayments, and out-of-pocket maximums) for mental health and substance abuse are based on the cost sharing and limits for similar benefits under our Plan medical, hospital, prescription drug, diagnostic testing, and surgical benefits.</p>	<p>Cost sharing and limitations for benefits that we cover (for example, visit/day limits, copayments, and out-of-pocket maximums) for mental health and substance abuse are based on the cost sharing and limits for similar benefits under our Plan medical, hospital, prescription drug, diagnostic testing, and surgical benefits.</p>
<p>Mental health inpatient and outpatient treatment can include:</p> <ul style="list-style-type: none"> <li>• Diagnostic evaluation</li> <li>• Diagnostic tests</li> <li>• Consultation services</li> <li>• Psychiatric treatment (individual, family and group therapy) by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Hospitalization (including professional services)</li> <li>• Services in approved alternative care settings such as partial hospitalization</li> <li>• Medication management visits</li> </ul>	<p>\$15 per visit</p> <p>A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization</p> <p>\$15 Copay for generic formulary drugs or a \$25 Copay for brand name formulary drugs and a \$50 Copay for non formulary drugs when prescribed by a Plan Doctor, to treat a mental health or substance abuse condition.</p>	<p>\$20 per office visit</p> <p>The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p> <p>A \$200 inpatient Copayment per day for 3 days; maximum of \$600 per person per hospitalization.</p> <p>(No plan Coinsurance for inpatient facility charges)</p>

*Mental health and substance abuse benefits - continued on next page*

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

*Mental health and substance abuse benefits - continued on next page*

Benefit Description	You pay After the calendar year deductible...	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
		Nothing for the first \$500 per calendar year, then covered at the 20% plan Coinsurance for diagnostic tests.
<p><i>Not covered:</i></p> <p><i>Mental health inpatient and outpatient treatment that the Plan excludes are:</i></p> <ul style="list-style-type: none"> <li>• <i>Psychiatric evaluation or therapy that is court ordered as a condition of parole or probation unless determined by a Plan provider to be necessary and appropriate</i></li> <li>• <i>Psychological testing that is not medically necessary</i></li> <li>• <i>Services that are custodial in nature</i></li> <li>• <i>Assessment and treatment services that are primarily vocational and academic in nature (i.e., educational testing)</i></li> <li>• <i>Services provided under a Federal, state, or local government</i></li> <li>• <i>Services rendered or billed by a school or a member of its staff</i></li> <li>• <i>Continued services if you do not substantially follow your treatment plan</i></li> <li>• <i>Treatment not authorized by a Plan provider, provided by the Plan, or specifically contracted for by the Plan</i></li> </ul> <p><i>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></p>	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>

**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.
- Under Standard Option –We have no calendar year Deductible or Coinsurance under the prescription drug benefits.
- Under High Option –We have no calendar year Deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

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

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The Standard Option calendar year Deductible and plan Coinsurance apply to almost all benefits in this Section. We say “(No Deductible, No Coinsurance)” when they do not apply.</p>		
Covered medications and supplies	High Option	Standard Option

*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
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy:</p> <ul style="list-style-type: none"> <li>• Drugs (including injectibles) for which a prescription is required by Federal law</li> <li>• Insulin</li> <li>• Diabetic supplies, including needles, syringes, lancets, urine and blood glucose testing reagents; a copay charge applies per item per each 30-day supply</li> <li>• Oral, injectable, and implanted contraceptive drugs and devices</li> <li>• Compound dermatological preparations</li> <li>• Disposable needles and syringes for the administration of covered prescribed medications</li> <li>• Allergy serum</li> </ul> <p>Intravenous fluids and medication for home use are covered under (Section 5(a) – “Treatment Therapies”) Mail Order Drug Program</p> <ul style="list-style-type: none"> <li>• Prescription medications mailed to your home by the Group Health mail order pharmacy. (Mail order issues up to a 90 day supply)</li> </ul> <p>Limited Benefits:</p> <ul style="list-style-type: none"> <li>• Drugs to aid in tobacco cessation. Participation in the Plan’s designated tobacco cessation program is required in order to receive coverage for one course of nicotine replacement therapy per calendar year.</li> </ul>	<p>A \$15 Copay for generic formulary drugs or a \$25 Copay for brand name formulary drugs, per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).</p> <p>A \$50 Copay for non-formulary drugs when prescribed by a plan doctor.</p> <p>Nothing for allergy serum</p> <p>\$10 - 30 day supply; \$20 - 60 day supply; \$20 - 90 day supply for generic drugs \$20 - 30 day supply; \$40 - 60 day supply; \$50 - 90 day supply for brand formulary drugs. \$45 - 30 day supply; \$90 - 60 day supply; \$125 - 90 day supply for non-formulary drugs.</p> <p>\$15 Copay for generic formulary drugs or a \$25 Copay for brand name formulary drugs, for each 30-day supply.</p> <p>A \$50 Copay for non-formulary drugs when prescribed by a Plan doctor.</p>	<p>A \$20 Copay for generic formulary drugs or a \$30 Copay for brand name formulary drugs, per prescription unit or refill for up to a 30- day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).</p> <p>A \$60 Copay for non-formulary drugs when prescribed by a Plan doctor.</p> <p>(No Deductible or plan Coinsurance for pharmacy)</p> <p>Nothing for Allergy serum</p> <p>\$15 - 30 day supply; \$30 - 60 day supply; \$30 - 90 day supply for generic drugs \$25 - 30 day supply; \$50 - 60 day supply; \$60 - 90 day supply for brand formulary drugs. \$55 - 30 day supply; \$110 - 60 day supply; \$150 - 90 day supply for non-formulary drugs.</p> <p>(No Deductible or plan Coinsurance for pharmacy)</p> <p>\$20 Copay for generic formulary drugs or a \$30 Copay for brand name formulary drugs for each 30-day supply.</p> <p>A \$60 Copay for non-formulary drugs when prescribed by a Plan doctor.</p>

*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"> <li>• Sexual dysfunction drugs; dosage limits set by the Plan. Contact Customer Service at 1-888/901-4636 for details.</li> </ul>	50% Coinsurance	(No Deductible or plan Coinsurance for pharmacy) 50% Coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy except when due to an out-of-area emergency</i></li> <li>• <i>Vitamins and nutritional substances, including dietary formulas and special diets, except for the treatment of phenylketonuria (PKU); total parenteral; and enteral nutrition therapy</i></li> <li>• <i>Oral nutritional supplements</i></li> <li>• <i>Medical supplies such as dressings, antiseptics, etc</i></li> <li>• <i>Experimental drugs, devices and biological products</i></li> <li>• <i>Drugs for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Fertility drugs</i></li> <li>• <i>Replacement of lost or stolen drugs, medicines or devices</i></li> </ul>	<i>All Charges.</i>	<i>All Charges</i>

**Section 5(g) Special features**

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

**Section 5(h) Dental benefits**

**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.
- You are not required to receive your care from specified dental providers, although your out-of-pocket costs will be less if you obtain services from providers in the PPO network.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, “*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 following is a summary of the Plan’s dental benefits. Please call the Plan’s member Services Department at 1-206/522-2300 or 1-800/554-1907 or you may visit our website at [www.deltadentalwa.com](http://www.deltadentalwa.com) for a listing of preferred providers or more information on additional exclusions and limitations.

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

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

Dental Benefits Service	You Pay	
	High Option	Standard Option
<p><b>Preventive Care services include:</b></p> <ul style="list-style-type: none"> <li>• Prophylaxis (cleaning and polishing of teeth) not more than two (2) procedures in a calendar year</li> <li>• Routine oral examinations, except for orthodontics</li> <li>• Flouride treatment for children under age 16</li> <li>• Fissure sealants for children through age 14</li> <li>• Dental X-rays, except for orthodontics</li> <li>• Bacteriologic cultures and biopsies of tissue</li> <li>• Emergency palliative treatment for relief of dental pain</li> <li>• Space maintainers, except for orthodontics</li> </ul>	Nothing after the deductible	Not Covered
<p><b>Basic Dental Care includes:</b></p> <ul style="list-style-type: none"> <li>• Fillings (restorations) using amalgam, silicate, acrylic synthetic porcelain and composite fill materials to restore teeth broken down by decay or injury; on posterior teeth, an allowance will only be made for an amalgam filling</li> <li>• Endodontic treatment as follows: root canal therapy, pulpotomy, apicoectomy, and retrograde fillings</li> </ul>	<p>PPO Network - 50% of reasonable and customary charges after the deductible</p> <p>Non- PPO Network - 50% of reasonable and customary charges after the deductible</p>	Not Covered

*Service - continued on next page*

Dental Benefits	You Pay	
Service (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> <li>• Simple extractions</li> <li>• Oral surgery</li> <li>• Basic periodontal services, limited to occlusal adjustment when performed with a covered root scaling</li> <li>• Study models</li> <li>• Crown build-up on non-vital teeth</li> <li>• Pin retention of fillings</li> <li>• Recementing inlays, onlays, and crowns</li> <li>• Recementing bridges</li> <li>• Repairs to full and partial dentures and bridges</li> <li>• General anesthetics and analgesics</li> <li>• Injectable antibiotics</li> </ul>	<p>PPO Network - 50% of reasonable and customary charges after the deductible</p> <p>Non- PPO Network - 50% of reasonable and customary charges after the deductible</p>	Not Covered
<p><b>Major dental care includes:</b></p> <ul style="list-style-type: none"> <li>• Major periodontal treatment of the gums and supporting structure of the teeth</li> <li>• Bridges and dentures</li> <li>• Crowns and gold restorations</li> <li>• Replacement of damaged appliances</li> </ul>	<p>PPO Network - 50% of reasonable and customary charges after the deductible</p> <p>Non PPO Network - 70% of reasonable and customary charges after the deductible</p>	Not Covered
<p><i>Not covered: other dental services not shown as covered.</i></p>	<i>All charges</i>	<i>All charges</i>

## 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.

<p><b>20% Vision Hardware Discount</b></p> <p>Federal employees and their covered dependents are now eligible for a <b>20%</b> vision hardware discount at our GHC See Centers in Western Washington and Vision Centers East of the Cascades. The discount applies to the cost of one or more pairs of prescription eyeglasses/sunglasses or one purchase of contact lenses per year, when purchased at any of the GHC See or Vision Centers. Fitting and evaluation fees are not included in the discount. For more information, call Customer Service at 1-888-901-4636, or go online to <a href="http://www.seecenter.com">www.seecenter.com</a></p>	<p><b>MySmile</b> – <i>An online oral health website</i></p> <p>Now there’s a personalized, online tool for tracking your dental benefits, tips for lowering out of pocket costs, and much more. Visit MySmile – a new addition to your plan brought to you by Washington Dental Service. Site available to GHC High Option members only. <a href="http://www.deltadentalwa.com/MySmile">www.deltadentalwa.com/MySmile</a></p>
<p><b>Take Care Stores</b> – <i>Health care products</i></p> <p>Our GHC Take Care stores sell self-care and wellness products for knee, back, &amp; neck care, blood pressure monitors, allergy-control bedding, weight management, sports therapy &amp; exercise, and much more. There are four GHC Take Care Stores (located at Group Health Capitol Hill, Group Health Northgate Medical Center, Group Health Eastside Hospital, and Group Health Olympia Medical Center), or you can order directly online from the Take Care website <a href="http://www.take-care.com">www.take-care.com</a></p>	<p><b>MyGroupHealth</b>– <i>An online health center website</i></p> <p>MyGroupHealth is an online health center available to all members. MyGroupHealth provides access to valuable health risk assessment tools, doctor profiles and selection, medical center locations and programs, and 22,000 pages of reliable health care information, and you can:</p> <ul style="list-style-type: none"> <li>Send &amp; receive messages with your doctor/nurse</li> <li>Request an appointment</li> <li>Refill pharmacy prescriptions and drug information</li> <li>Learn about and improve your health</li> <li>Manage your health care business</li> <li>View your brochure online</li> </ul> <p>Visit MyGroupHealth at <a href="http://www.ghc.org/fehb">www.ghc.org/fehb</a></p>
<p><b>Hear Centers</b> – <i>Hearing visits &amp; supplies</i></p> <p>Our GHC Hear Centers offer a full range of the latest hearing aid technology from the world's leading manufacturers, as well as custom noise plugs, swim molds, assistive listening devices, accessories, and batteries. There are five Hear Centers (located in Everett, Redmond/Bellevue, Seattle/Central, Tacoma, and Olympia). For more information, go online to <a href="http://www.thehearcenter.com">www.thehearcenter.com</a></p>	<p><b>Medicare Advantage Plan</b></p> <p>As a member of the FEHB Medicare Advantage Plan, your member ID card entitles you to participate in our popular SilverSneakers program. With over twenty health and fitness facilities to choose from throughout the Puget Sound area, and <b>now in Spokane County</b>, you choose what you want to do: relax in a sauna, improve your posture and flexibility in a SilverSneakers class, or tone your body with weight training, circuit training, or aerobics. Additional benefits include a hearing aid allowance of \$250 (once every 24 months) and an eye glass allowance for standard lenses covered in full and up to \$100 toward the purchase of frames (once every 24 months).</p>
<p><b>Smoking Cessation</b></p> <p>Any currently enrolled Group Health member may participate in the nationally recognized Free &amp; Clear program free of charge. Participants pay extra for any pharmaceuticals used. To learn more, call Group Health Customer Service at 1-800-901-4636 or go online to <a href="http://www.ghc.org/products/freeclr.jhtml">www.ghc.org/products/freeclr.jhtml</a></p>	<p><b>Weight Management Program</b></p> <p>The Weight Management program offers Group Health members a total lifestyle plan. It teaches positive behaviors that promote health, and helps improve overall well-being through weight management. For more information, call 206-527-6920 in Seattle or 1-888-874-7783 or go online to <a href="http://www.ghc.org/products/weight_management">www.ghc.org/products/weight_management</a>.</p>

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

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## Section 6 General exclusions – things we don't cover

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

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Procedures, services, drugs, or supplies related to sex transformations;
- Procedures, services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

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## Section 7 Filing a claim for covered services

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

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

### **Medical and hospital benefits**

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

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

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

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

Phone: 1-888/901-4636

### **Prescription drugs**

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

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

Phone: 1-888/901-4636

### **Other supplies or services**

**Submit your claims to:**

Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585

Phone: 1-888/901-4636

### **Deadline for filing your claim**

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

### **When we need more information**

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

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## Section 8 The disputed claims process

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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/prior approval required by Section 3:

- 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: Group Health Cooperative, Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593; ; and
  - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
  - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** 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 Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

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

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

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

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

## 5

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-888/901-4636 and we will expedite our review; or
- b) We denied your initial request for care or 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 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

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## Section 9 Coordinating benefits with other coverage

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### 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](http://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 will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-888/901-4636.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

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

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

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

**Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage 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.

**TRICARE and  
CHAMPVA**

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

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

**Workers' Compensation**

We do not cover services that:

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

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

**Medicaid**

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

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

**When other Government  
agencies are responsible  
for your care**

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

**When others are  
responsible for injuries**

If you or your covered dependent suffers an injury or illness through the act or omission of another person, you must either (1) reimburse us for any benefits that we have paid, in an amount that will not exceed the amount that you recover, or (2) allow us to be subrogated to your (or your covered dependent's) rights (including the right to bring suit) up to the full amount of the benefits that we have paid. All recoveries that you or your covered dependent receives from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse us for benefits paid. Our share of the recovery will not be reduced because you or your dependent does not receive the full amount of damages claims, unless we agree in writing to a reduction.

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

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## Section 10 Definitions of terms we use in this brochure

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

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## Section 11 FEHB Facts

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### 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](http://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 you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

#### Children's Equity Act

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

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

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

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

**When benefits and premiums start**

The benefits in this brochure are effective 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](http://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](http://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](http://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.

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## Section 12 Three Federal Programs complement FEHB benefits

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### 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

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

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

### 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 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.

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 and LEN 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 care (but not insurance premiums)

For the DCFSA – daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit [www.FSAFEDS.com](http://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](http://www.FSAFEDS.com) or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. 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](http://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.**

**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 Information**

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 complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits 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](http://www.opm.gov/insure/dental/vision). This 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](http://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](http://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 your 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 pays 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.

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## Summary of benefits for the High Option of GHC - 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.

High Option Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		
Diagnostic and treatment services provided in the office	\$15 Copay for primary care or specialist	16
<b>Services provided by a hospital:</b>		
• <b>Inpatient</b>	\$200 per day for 3 days; maximum of \$600 per person per hospitalization	33-34
• <b>Outpatient</b>	\$75 Outpatient Surgery Copay	34
<b>Emergency benefits:</b>		
• <b>In-area</b>	\$75 Copay per visit	37
• <b>Out-of-area</b>	\$125 Copay per visit	37
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing	38-39
<b>Prescription drugs:</b>		
• For a 30-day supply per prescription unit or refill	\$15 Copay for generic prescription \$25 Copay for brand name prescription \$50 Copay for non-formulary prescription	42
• Mail order (For a 30-day supply per prescription unit or refill (issued up to a 90-day supply))	\$10 - 30 day supply; \$20 - 60 day supply; \$20 - 90 day supply for generic drugs  \$20 - 30 day supply; \$40 - 60 day supply; \$50 - 90 day supply for brand formulary drugs  \$45 - 30 day supply; \$90 - 60 day supply; \$125 - 90 day supply for non-formulary drugs	42
<b>Dental care:</b> See Dental Schedule for complete coverage	\$50 Deductible per member (\$150 per family) variable coinsurance for most care and any charges beyond the Plan payment.	45-46
<b>Vision care:</b>	\$15 Copay per office visit.	22
• Routine eye exam and refractions for eyeglasses		
<b>Special features:</b>	Flexible benefits option; Consulting Nurse service; Services for deaf and hearing impaired; Reciprocity benefit; and Travel benefit	44

<b>Protection against catastrophic costs</b> (your catastrophic protection out-of-pocket maximum):	Nothing after \$3000/Self Only or \$6000/Self and Family enrollment per year. Some costs do not count toward this protection	12
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## Summary of benefits for the Standard Option of GHC- 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 \$500/individual, \$1,500/family calendar year deductible.

Standard Option Benefits	You Pay	You Pay
<b>*Medical services provided by physicians:</b>		
Diagnostic and treatment services provided in the office	\$20 per office visit. The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.  (This is subject to any combination of covered office visits per calendar year.)	16
<ul style="list-style-type: none"> <li>• Diagnostic tests, lab and X-ray services</li> </ul>	Nothing for the first \$500 per calendar year then covered at the 20% plan Coinsurance after the annual deductible	16
<b>*Services provided by a hospital:</b>		
<ul style="list-style-type: none"> <li>• Inpatient</li> </ul>	\$200 per day for 3 days; maximum of \$600 per person per hospitalization	33-34
<ul style="list-style-type: none"> <li>• Outpatient</li> </ul>	\$20 per office visit. The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.  (This is subject to any combination of covered office visits per calendar year.)	34
<b>*Emergency benefits:</b>		
<ul style="list-style-type: none"> <li>• In-area</li> </ul>	\$75 Copay per visit	37
<ul style="list-style-type: none"> <li>• Out-of-area</li> </ul>	\$125 Copay per visit	37
<b>*Mental health and substance abuse treatment:</b>		
<b>Prescription drugs:</b>		
	(No Deductible or plan Coinsurance for pharmacy)	
<ul style="list-style-type: none"> <li>• For a 30-day supply per prescription unit or refill</li> </ul>	\$20 Copay for generic prescriptions \$30 Copay for brand name prescriptions \$60 Copay for non-formulary prescription	42
<ul style="list-style-type: none"> <li>• Mail order</li> </ul> <p>For a 30-day supply per prescription unit or refill (issued up to a 90-day supply)</p>	(No Deductible or plan Coinsurance for pharmacy)  \$15 - 30 day supply; \$30 - 60 day supply; \$30 - 90 day supply for generic drugs	42

	<p>\$25 - 30 day supply; \$50 - 60 day supply; \$60 - 90 day supply for brand formulary drugs</p> <p>\$55 - 30 day supply; \$110 - 60 day supply; \$150 - 90 day supply for non-formulary drugs.</p>	
<b>Dental care:</b>	Not covered	45
<p><b>*Vision care:</b></p> <ul style="list-style-type: none"> <li>Routine eye exam and refractions for eyeglasses</li> </ul>	<p>\$20 per office visit. The annual Deductible and 20% plan Coinsurance do not apply until the fifth office visit.</p> <p>(This is subject to any combination of covered office visits per calendar year.)</p>	22
Special features:	Flexible benefits option; Consulting Nurse service; Services for deaf and hearing impaired; Reciprocity benefit; and Travel benefit	44
<b>Protection against catastrophic costs</b> (your catastrophic protection out-of-pocket maximum):	Nothing after \$3000/Self Only or \$6000/Self and Family enrollment per year. Some costs do not count toward this protection.	12

## 2007 Rate Information for Group Health Cooperative

**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				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

### Western Washington

High Option Self Only	541	141.92	63.33	307.49	137.22	167.54	37.71
High Option Self and Family	542	321.89	141.48	697.43	306.54	380.01	83.36
Standard Option Self Only	544	129.44	43.15	280.46	93.49	153.17	19.42
Standard Option Self and Family	545	292.22	97.41	633.15	211.05	345.8	43.83

### Eastern and Central Washington and Northern Idaho

High Option Self Only	VR1	141.92	85.22	307.49	184.65	167.54	59.6
High Option Self and Family	VR2	321.89	200.51	697.43	434.44	380.01	142.39
Standard Option Self Only	VR4	132.14	44.04	286.29	95.43	156.36	19.82
Standard Option Self and Family	VR5	303.9	101.3	658.45	219.48	359.62	45.58