

GHI HMO

<http://www.ghi.com>

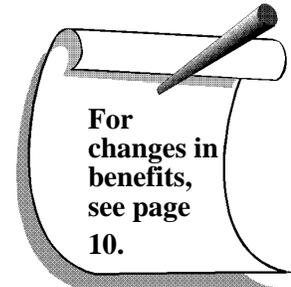


2007

A Health Maintenance Organization

Serving: Albany – Capital District Area, New York’s Hudson Valley, New York City Area

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 9 for requirements.



Enrollment codes for this Plan:

Albany – Capital District, Hudson Valley Area

- X41 High Self Only
- X42 High Self and Family
- X44 Standard Self Only
- X45 Standard Self and Family

New York City Area

- 6V1 High Self Only
- 6V2 High Self and Family
- 6V4 Standard Self
- 6V5 Standard Self and Family



GHI HMO has Excellent accreditation for commercial products from the National Committee for Quality Assurance (NCQA). See the 2007 Guide for more information on accreditation.

Authorized for distribution by the:



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



OPM has determined that the GHI HMO's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. 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 GHI HMO coverage and your GHI HMO plan will coordinate benefits with Medicare.

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

Please be advised

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

Medicare's Low Income Benefits

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

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

- Visit www.medicare.gov for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of under our contract (CS2655) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for GHI HMO administrative offices is:

GHI HMO, 789 Grant Avenue, Lake Katrine, NY 12449

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure. OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

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

- If the provider does not resolve the matter, call us at 877-244-4466 and explain the situation.
- If we do not resolve the issue:

CALL ¾ THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
- Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.

You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication 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 reactions to anesthesia, and any medications you are taking.
- Visit these Web sites for more information about patient safety.
- 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 health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

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

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

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.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Who provides my health care?

GHI HMO, an individual practice prepayment plan, is a New York State certified, for-profit community-sponsored, primary care network model Health Maintenance Organization (HMO). GHI HMO organizes preventive and routine health care as well as needed services for serious illness or injury. Care and coverage is provided by approximately four thousand three hundred and forty three (4,343) individually affiliated primary care doctors, one hundred fourteen (114) area hospitals, twenty six thousand five hundred and sixty six (26,566) local specialists. GHI HMO administrative offices are located at 789 Grant Avenue, Lake Katrine, NY 12449; and at 80 Wolf Road, Albany, NY 12205. Affiliated primary care doctors, specialists and other health care providers are conveniently located throughout the service area.

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) lists the specific types of information that we must make available to you. Some of the required information is listed below.

Years in existence - GHI HMO is a subsidiary of GHI, the largest, not-for profit health services corporation operating state-side in New York, and has been operating in 26 counties in NYS since July 1999. GHI HMO is now operating in 28 counties throughout New York State.

- **Profit status** - GHI HMO is a for-profit HMO
- **Drug Formulary** - GHI HMO offers an open drug formulary
- **Percentage of Board Certified Physicians** - 86% of GHI HMO physicians are Board Certified.

If you want more information about us, call 877-244-4466, or write to GHI HMO, Customer Service, PO Box 4332, Kingston, NY 12402 . You may also contact us by fax at 845-334-8823 or visit our Web site at www.ghi.com

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:

Albany – Capital District Area: Albany, Broome, Columbia, Delaware, Fulton, Greene, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties.

Hudson Valley Area: Dutchess, Orange, Putnam, Rockland, Sullivan, and Ulster Counties.

New York City Area: Bronx, Brooklyn, Manhattan, Nassau, Queens, Richmond, Suffolk and Westchester.

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

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

Section 2 How we change for 2007

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

Changes to this Plan:

- Your share of the non-Postal premium for High Option will increase by 30% for Self Only and increase by 27.2% for Self and Family for Code 6V.
- Your share of the non-Postal premium for Standard Option will increase by 51.6% for Self Only and increase by 58.1% for Self and Family for Code 6V.
- Your share of the non-Postal premium for High Option will increase by 68.9% for Self Only and increase by 54.8% for Self and Family for Code X4.
- Your share of the non-Postal premium for Standard Option will increase by 35.1% for Self Only and increase by 50.9% for Self and Family for Code X4.
- No benefit changes for 2007.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 877-244-4466 or write to us at GHI HMO, 789 Grant Avenue, Lake Katrine, NY 12449. You may also request replacement cards through our Web site: www.GHI.com

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site at www.ghi.com. Please select the GHI HMO Commercial provider network to access participating providers.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a doctor who specializes in Family Practice, Internal Medicine, or Pediatrics. Your primary care physician will provide 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 us 877-244-4466 We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. 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. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may self refer to a GHI HMO mammography center following the recommendations of the American Cancer Society for mammogram screenings. Although authorization is not required for these services, it is a good idea to keep your PCP and OB/GYN informed of the results of those visits.

- 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).
- How members are re-assigned when their doctor has left the plan: In an unforeseen instance where your physician discontinues participation with GHI HMO you will be notified within fifteen (15) days of the date we become aware of the change in status. You will need to choose a new physician. If you are in an ongoing course of treatment, we will arrange for you to continue care with the physician for up to ninety (90) days from the date of our notice to you. If you are in your second trimester of pregnancy, we will arrange for you to continue to receive care from the physician until the postpartum care is complete.
- 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 us, or if we drop out of the Program, contact your new plan.

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 877-244-4466. 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 cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for...

Your hospital stay

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.

How to precertify an admission

Call GHI HMO at 1-877-244-4466.

Maternity care

You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you and your baby.

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 pre-certification. Your physician must obtain prior authorization from the GHI HMO Medical Director. These services may include but are not limited to:

- a) Specialist Referrals
- b) Ambulatory Surgery
- c) Hospital/Nursing Home admissions and any care rendered during stay
- d) Physical Therapy and Cardiac Rehabilitation
- e) Home Care and Hospice
- f) Durable Medical Equipment over \$250 and all Orthotics
- g) Non-Participating Providers
- h) Member requests for experimental or investigative health care services.
- i) Mental Health and Substance Abuse (MH/SA)

GHI HMO may request supporting documentation from your provider to substantiate Medical Necessity of the requested service. All inpatient admissions are reviewed to evaluate that the services are covered services, Medically Necessary and being rendered at the appropriate level of care.

You have the right to designate a representative for utilization review. GHI HMO will notify you and your provider, by phone and in writing for prospective, concurrent and retrospective utilization review decisions. If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing
2. Refer to specific brochure wording in explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

Section 4 Your costs for covered services

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of \$10 per office visit under the High Option and \$20 per office visit under the Standard Option and when you go in the hospital, you pay nothing.

Deductible

We do not have a deductible

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for.

Example: In our plan, you pay 20% for durable medical equipment up to a maximum of \$1500 per person, per year under the High Option and up to a maximum of \$10,000 per person per year under the Standard Option.

Your catastrophic protection out-of-pocket maximum

We do not have a catastrophic protection out-of-pocket maximum.

High and Standard Option Benefits

See page 9 for how our benefits changed this year. Page 66 and page 68 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

This Plan offers a High and Standard Option. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

The High and Standard Option in Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 877-244-4466 or at our Web site at www.ghi.com

Our benefit package offers the following unique features:

<ul style="list-style-type: none"> • High Option • No calendar year deductible • Emergency care at an urgent care center - \$10.00 per visit • 28 County service area • \$0 copayment for Professional ambulance services when medically appropriate • Educational classes and programs 	
<ul style="list-style-type: none"> • Standard Option • No calendar year deductible • No co-payment for children through age 18 (per office visit) • 28 County service area • \$50 co-payment for Professional ambulance services when medically appropriate • Educational classes and programs 	

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

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan physicians must provide or arrange your care.

We do not have a 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...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians	\$10 per office visit	\$20 per office visit
<ul style="list-style-type: none"> • In physician’s office • Physical examinations 		Nothing for children (through age 18) per office visit
<ul style="list-style-type: none"> • Routine eye exams • Chiropractic services (with referral from PCP) 	\$10 per office visit	\$20 per visit
At home	\$10 per office visit	\$20 per visit
<ul style="list-style-type: none"> • Routine cervical Cytology (PAP smear) • Well Baby and Well Child Care visits (including immunizations) • Mammogram exam 	Nothing	Nothing
Professional services of physicians	\$10 per office visit	\$20 per office visit
<ul style="list-style-type: none"> • In an urgent care center • Office medical consultations • Second surgical opinion • During a hospital stay • In a skilled nursing facility/120 day limit 	Nothing	Nothing for children (through age 18) per office visit
	Nothing	Nothing
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as:	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit	Nothing if you receive these services during your office visit; otherwise, \$20 copay at outpatient facility
<ul style="list-style-type: none"> • Blood Tests • Urinalysis • Non-Routine Pap tests • Pathology • X-Rays • Non-Routine Mammograms 		

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

Benefit Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • CAT Scans/MRI • Ultrasound <p>Electrocardiogram and EEG</p>	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit	Nothing if you receive these services during your office visit; otherwise, \$20 copay at outpatient facility
Preventive care, adult	High Option	Standard Option
Routine physical every year which includes: Routine screenings, such as:	\$10 per office visit	\$20 per office visit
<ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including • Fecal occult blood test • Sigmoidoscopy, screening – every five years starting at age 50 • Double contrast barium enema – every five years starting at age 50 <p>Colonoscopy screening – every ten years starting at age 50</p>		
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$10 per office visit	\$20 per office visit
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services, above.</i>	\$10 per office visit	\$20 per office visit
Routine mammogram – covered for women age 35 and older, as follows:	Nothing	Nothing
<ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 		
Routine immunizations, limited to:	\$10 per office visit	\$20 per office visit
<ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 		
<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
Preventive care, children		
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing	Nothing
<ul style="list-style-type: none"> Examinations, such as: <ul style="list-style-type: none"> -Ear exams through age 19 to determine the need for hearing correction via primary care physician. 	\$10 per office visit	Nothing for children (through age 18) per office visit
<ul style="list-style-type: none"> -Eye exams through age 19 to determine the need for vision correction. 	\$10 per office visit	\$20 per office visit
<ul style="list-style-type: none"> -Examinations done on the day of immunizations (under age 22) -Well Child Care charges for routine examinations, immunizations and care (under age 22) 	Nothing	Nothing
Maternity care	High Option	Standard Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal Care Delivery Postnatal Care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery, see page 11 for other circumstances, such as extended stays for you and your baby You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will need to extend your inpatient stay if medically necessary. <p>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.</p>	<p>\$10 Initial visit only; nothing for other pre and postnatal visits.</p> <p>Nothing for delivery</p>	<p>\$20 initial visit only, nothing for other pre and postnatal visits.</p> <p>Nothing for delivery</p>
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>	<i>All charges</i>
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) Surgically implanted contraceptives (such as Norplant) Injectable contraceptive drugs (such as Depo provera) 	\$10 per office visit	\$20 per office visit

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Family planning (cont.)		
<ul style="list-style-type: none"> Intrauterine devices (IUDs) Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$10 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> Genetic counseling 	<i>All charges.</i>	<i>All charges</i>
Infertility services	High Option	Standard Option
Diagnosis of infertility	\$10 per office visit	\$20 per office visit
<p>Treatment of Infertility such as:</p> <ul style="list-style-type: none"> Artificial insemination Intravaginal insemination (IVI) Intracervical insemination (ICI) Intrauterine insemination (IUI) Fertility Drugs <p>Note: members must be at least 21 years of age but no more than 44 years of age to be covered for infertility services. Services are limited to three (3) cycles to achieve pregnancy.</p> <p>Note: Fertility drugs are covered under the prescription drug benefit. See page 49.</p>	\$10 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Assisted reproductive technology (ART) procedures, such as: 	<i>All charges.</i>	<i>All charges</i>
<p>- <i>in vitro fertilization</i></p> <p>- <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></p> <ul style="list-style-type: none"> <i>Services and supplies related to ART procedures</i> <i>Cost of donor sperm</i> <i>Cost of donor egg</i> 		

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Allergy care		
<ul style="list-style-type: none"> • Testing and treatment • Allergy injection 	\$10 per office visit	\$20 per office visit Nothing for children (through age 18) per office visit
Diabetic Supplies and equipment		
Blood glucose monitors, data management systems, test strips for glucose monitoring, insulin, injection aids, cartridges for legally blind, syringes, insulin pumps, insulin infusion devices, oral agents for controlling blood sugar.	\$10 copay for supplies	\$20 copay for supplies
Treatment therapies		
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis <p>Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</p>	Nothing	Nothing
<ul style="list-style-type: none"> • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit. See page 47.</p> <p>Note: We will only cover GHT when we preauthorize the treatment. Call or have your physician call 877-244-4466 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. This benefit I provided under our Prescription Drug Benefits. See Services requiring our prior approval in Section 3.</p>	\$10/\$20/\$30 copay for prescriptions	\$10/\$20/\$30 copay for prescriptions
<p><i>Not covered:</i></p> <p><i>Treatment for experimental or investigational procedures</i></p> <p><i>Therapy necessary for transsexual surgery</i></p>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Physical and occupational therapies		
<p>Up to two consecutive months per condition if significant improvement can be expected within two months for the following services:</p> <ul style="list-style-type: none"> • Qualified physical therapists and • Occupational therapists. • Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Physical and occupational therapy is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months; you pay \$10 copay per outpatient visit. Speech therapy is limited to treatment if certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 30 visits within 60 days</p>	<p>\$10 per visit</p> <p>Nothing per visit during covered inpatient admission</p>	<p>\$20 per office visit</p> <p>Nothing per visit during covered inpatient admission</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges.</i>	<i>All charges</i>
Speech therapy	High Option	Standard Option
Up to two consecutive months per condition when medically necessary.	\$10 per office visit	\$20 per office visit
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 18 (<i>see Preventive care, children</i>) 	\$10 per office visit	<p>\$20 per office visit</p> <p>Nothing for children (through age 18) per office visit</p>
<p><i>Not covered:</i></p> <p><i>All other hearing testing</i></p> <p><i>Hearing aids, testing and examinations for them</i></p>	<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"> • Eye exam to determine the need for vision correction (see preventive care) • Annual eye refractions <p>Note: See preventive care, children for eye exam</p>	\$10 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <p><i>Eyeglasses or contact lenses</i></p> <p><i>Eye exercises and orthoptics</i></p> <p><i>Radial keratotomy and other refractive surgery</i></p>	<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>	\$10 per office visit	\$20 per office visit Nothing for children (through age 18) per office visit
<p><i>Not covered:</i></p> <p><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></p> <p><i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></p>	<i>All charges.</i>	<i>All charges</i>
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section © for payment information. See 5(b) for coverage of the surgery to insert the device. <p>Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</p>	20% coinsurance up to the Plan's maximum benefit of \$1,500 per person, per calendar year	20% coinsurance up to the Plan's maximum benefit of \$10,000 per person, per calendar year
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> 	<i>All charges</i>	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Arch supports • Foot orthotics • Heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements provided less than 3 years after the last one we covered 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)	High Option	Standard Option
<p>Rental or purchase, as determined by GHI HMO, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Standard wheelchairs; • Apnea monitors; • Nebulizers; • Crutches and; • Walkers <p>Note: Call us at 877-244-4466 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment and will tell you more about this service when you call.</p>	\$20% coinsurance up to the Plan's maximum benefit of \$1,500 per person, per calendar year	20% coinsurance up to the Plan's maximum benefit of \$10,000 per person, per calendar year
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Motorized wheelchairs • Hearing aids 	<i>All charges.</i>	<i>All charges</i>
Home health services	High Option	Standard Option
<p>Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or other Home Health Care Agency personnel licensed vocational nurse (L.V.N.), or home health aide.</p> <ul style="list-style-type: none"> • Services include oxygen therapy, intravenous therapy and medications. 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family; • Home health care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative. 	<i>All charges.</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...	
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application • Chiropractic services when authorized by PCP 	\$10 per office visit	\$20 per office visit
Alternative treatments	High Option	Standard Option
No Benefit	<i>All charges.</i>	<i>All charges</i>
Educational classes and programs	High Option	Standard Option
Disease Management Programs available to GHI HMO members: Smoking Cessation Diabetes Management Asthma Management Post Partum Depression Management Post Cardiac Depression Management Cardiac Management Prenatal Management To enroll in these Programs, please contact a Care Manager at 1-877-244-4466.	Nothing	Nothing

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

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan physicians must provide or arrange your care.

We do not have a 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 a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the pre-certification information shown in Section 3 to be sure which services require pre-certification and identify which surgeries require pre-certification.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Surgical procedures	High Option	Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre-and post operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) <p>Note: The plan covers bariatric surgery when medically necessary and meet the following criteria:</p> <ul style="list-style-type: none"> • BMI greater than 40 • Life threatening or disabling morbid conditions such as diabetes mellitus, dyslindrmia, hypertension or serious cardiopulmonary disorders • Obesity has been present for at least 5 years • No history of alcoholism or major psychiatric disorder is noted <p>Members must be between 18 and 65 years of age</p>	<p>\$10 per office visit; nothing for hospital visits</p> <p>\$10 per outpatient visits</p>	<p>\$20 per office visit; nothing for hospital visits</p> <p>Nothing for children (through age 18)</p> <p>\$20 per outpatient visit</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"> • Insertion of internal prosthetic devices See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>Note: 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.</p>	<p>\$10 per office visit; nothing for hospital visits</p> <p>\$10 per outpatient visits</p>	<p>\$20 per office visit; nothing for hospital visits</p> <p>Nothing for children (through age 18)</p> <p>\$20 per outpatient visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All Charges.</i></p>	<p><i>All charges</i></p>
Reconstructive surgery	High Option	Standard Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness; if: <ul style="list-style-type: none"> • the condition produced a major effect on the member’s appearance and • the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> • surgery to produce a symmetrical appearance on the other breast; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure</p>	<p>\$10 per office visit; nothing for hospital visits</p> <p>\$10 per outpatient visit</p>	<p>\$20 per office visit; nothing for hospital</p> <p>Nothing for children (through age 18)</p> <p>\$20 per outpatient visits</p>
<p><i>Not covered:</i></p>	<p><i>All Charges.</i></p>	<p><i>All charges</i></p>

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Reconstructive surgery (cont.)	High Option	Standard Option
<p><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></p> <p><i>Surgeries related to sex transformation</i></p>	<p><i>All Charges.</i></p>	<p><i>All charges</i></p>
Oral and maxillofacial surgery	High Option	Standard Option
<ul style="list-style-type: none"> • Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Temporomandibular Joint treatment (TMJ); and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$10 per office visit; nothing for hospital visit</p> <p>\$10 per outpatient visit</p>	<p>\$20 per office visit; nothing for hospital visits</p> <p>Nothing for children (through age 18)</p> <p>\$20 per outpatient visit</p>
<p><i>Not covered:</i></p> <p><i>Oral implants and transplants</i></p> <p><i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></p> <p><i>All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</i></p>	<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"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants • Small intestine 	<p>Nothing</p>	<p>Nothing</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas 	Nothing	Nothing
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic myelogenous leukemia • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	Nothing	Nothing
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Advanced forms of myelodysplastic syndromes • Advanced neuroblastoma • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucopolysaccharidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Sickle cell anemia • Thalassemia major (homozygous beta-thalassemia) 	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • X-linked lymphoproliferative syndrome • Autologous transplants for • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer • Amyloidosis • Ependyoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma 	Nothing	Nothing
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: • Chronic lymphocytic leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Nonmyeloablative allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced forms of myelodysplastic syndromes • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Myeloproliferative disorders • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma 	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Sarcomas • Autologous transplants for • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple sclerosis • Systemic lupus erythematosus • Systemic sclerosis • National Transplant Program (NTP) - <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled Nursing facility • Ambulatory surgical center • Office 	Nothing	Nothing

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.

We do not have a 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).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require pre-certification.

Benefit Description	You pay	
Note: The calendar year deductible applies only when we say below: “(calendar year deductible applies)”.		
Inpatient hospital	High Option	Standard Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets • Special duty nursing and private rooms during inpatient hospitalization when medically necessary and approved by GHI HMO Medical Director. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	Nothing	Nothing
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items 	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital (cont.)		
<ul style="list-style-type: none"> • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing	Nothing
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care, except when medically necessary 	<i>All Charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment if in connection with an accidental injury to sound natural teeth within twelve (12) months of the accident, or in the judgment of GHI HMO’s Medical Director, a hazardous concurrent medical condition requires hospitalization. Hospital care is only available when a medical condition necessitates such care. We do not cover the dental procedures.</p>	Nothing	\$75 copay per visit
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<i>All charges.</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Extended care benefits/Skilled nursing care facility benefits		
Skilled nursing facility (SNF): Limited to 120 days per person per calendar year : • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your plan doctor.	Nothing	Nothing
<i>Not covered: Custodial care</i>	<i>All Charges.</i>	<i>All charges</i>
Hospice care	High Option	Standard Option
Supportive and palliative care for the terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling. Benefits are limited to 210 days; bereavement counseling services are covered up to five (5) days.	Nothing	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate	Nothing	\$50 copay per service

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.

We do not have a 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 a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in a condition 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. These conditions would be defined as **urgent care**. 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

In the event of a medical emergency you should seek immediate medical treatment at the nearest emergency facility anywhere in the world whether or not they participate with GHI HMO. You do not need prior approval by GHI HMO or your PCP to receive emergency treatment. However, you or a family member must contact your PCP, unless it not reasonably possible to do so. If you are unable to contact your PCP, please call GHI HMO at 1-877-244-4466. It is your PCP's responsibility to contact GHI HMO with this information. All emergency room visits that do not result in a hospital admission will require an emergency room copay.

Urgent care is defined as a sudden onset of illness or accident that does not require acute care treatment and would not result in a several disability. Examples of conditions we do not consider to be emergencies are but are not limited to: head colds, influenza, tension headaches, toothaches, minor cuts and bruises, muscle strain, hemorrhoids and intoxication. You must contact your PCP prior to obtaining care. Your PCP will provide care for your situation, arrange for you to receive care in a GHI HMO affiliated facility or refer you to the nearest emergency room. You will be responsible for the full cost of the visit if you do not contact your PCP. If referred to the emergency room by PCP, you will pay a copay. If you are unable to reach your PCP, please call GHI HMO at 877-244-4466.

Emergencies outside our service area

If you are out of the GHI HMO Service Area, your PCP or the on-call physician will authorize your care at the nearest emergency facility as appropriate. It is your responsibility or that of a family member to contact your PCP prior to receiving non-emergency care, unless it was not reasonably possible to do so.

Your membership card instructs physicians and hospitals outside the GHI HMO Service Area to send all claims for services rendered directly to GHI HMO. However, if the emergency care you receive is relatively minor in cost, you may be asked to pay for services rendered. In these cases, keep all receipts and bills (indicating the provider's name, date of service, procedures performed, amount charged and amount paid) and present them along with an explanation to GHI HMO's Customer Service department for review and appropriate reimbursement. GHI HMO, Customer Service, PO Box 4332, Kingston, NY 12402.

If you were admitted to the hospital from the Emergency Room the copay is waived. Follow-up care after an emergency must be provided with a participating GHI HMO provider. Care provided by a non-participating provider will not be covered for follow-up visits.

Benefit Description	You pay After the calendar year deductible...	
Emergency within our service area	High Option	Standard Option
Emergency care at a doctor's office	\$10 per office visit	\$20 per office visit Nothing for children (through age 18) per office visit
Emergency care at an urgent care center	\$10 per visit	\$35 per visit
Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital	\$35 copay	\$50 per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>	<i>All charges</i>
Emergency outside our service area	High Option	Standard Option
Emergency care at a doctor's office	\$10 per office visit	\$20 per office visit, Nothing for children (through age 18) per office visit
Emergency care at an urgent center	\$10 per visit	\$35 per visit
Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	\$35 per visit	\$50 per visit
<i>Not covered:</i> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i>	<i>All Charges.</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing	\$50 copay
<i>Not covered: Air ambulance unless medically necessary and approved by GHI HMO's Medical Director</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 medically necessary.

We do not have a 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.

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Mental health and substance abuse benefits	High Option	Standard Option
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan includes services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions	Your cost sharing responsibilities are no greater than for other illness or conditions
Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, nurse, or clinical social workers.	\$10 per office visit	\$20 per office visit
Medication Management		
Lab work <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit Nothing	Nothing if you receive these services during your office visit; otherwise \$20 per office visit Nothing
X-rays	\$10 copay at an outpatient facility	\$20 copay at an outpatient facility
Diagnostic test		
Services provided by a hospital or other facility	Nothing	Nothing
Services in approved alternative care settings such as:		

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
<ul style="list-style-type: none"> • partial hospitalization • residential treatment • full-day hospitalization • facility based intensive outpatient treatment 	Nothing	Nothing

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all of our network authorization processes.

Magellan Behavioral Health has been contracted to manage your behavioral health benefits. In order to access your benefits; please call the Magellan Behavioral Health Care toll free number at 1-800-836-2256. You will be connected to a customer service representative who will be able to assist you in identifying a behavioral health care provider in your area or to verify if your current provider is a participating provider in the Behavioral Health network.

If participating, the customer service representative will verify benefits/eligibility and an authorization for treatment will be sent out to your provider. They will continue to follow their contractual obligations and submit treatment plan reports for continued authorization. The treatment reports will be reviewed by a New York State licensed clinician to determine if the treatment you are receiving meets medical necessity criteria for the level of care and the intensity of treatment you are receiving.

If non-participating, the customer service representative will either offer you a provider participating in the network that specializes in your area of need or will offer to forward a treatment report to you. You will be responsible for your provider completing the forms in their entirety and returning them to the address provided. The treatment reports will be reviewed by a New York State licensed clinician to determine if the treatment you are receiving meets medical necessity criteria for the level of care and the intensity of treatment you are receiving.

Treatment will not be interrupted if the licensed clinician reviewer finds your treatment to be needed and appropriately provided. At that point, your non-participating provider will be required to sign an ad hoc agreement, which will allow you to continue in treatment. Your non-participating provider will be required to accept contracted rates. They will be required to follow all the same contract requirements as a participating provider.

Inpatient and alternative levels of care, which are more intense, than routine outpatient therapy must be called in by using the same toll free number. New York State licensed staff is available 24 hours a day, 7 days a week, 365 days a year.

Participating provider directories can be obtained by calling the Customer Service department at GHI HMO at 1-877-244-4466 or view the directory on our website at www.ghi.com.

How to submit claims

There are no claim forms. You must work through participating providers. In the event you are in the transitional period, you must notify the Plan and have the provider contact the Plan. If you have mistakenly received a bill for covered services or your provider needs to contact GHI HMO, please contact customer service at 1-877-244-4466. Mail billing statements to GHI HMO, Attn: Claims, PO BOX 4332, Kingston, NY 12402.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits

We cover prescribed drugs and medications, as described in the chart beginning on the next page.

Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.

We do not have a 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.

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

Who can write your prescription. A licensed physician is the only individual authorized to write your prescription.

Where you can obtain them Your prescription can be obtained through a large network of retail pharmacies that participate in the Express Scripts PERxCare Retail Pharmacy Program. This network consists of over 59,000 pharmacies nationwide.

For your short-term prescription needs, such as an antibiotic to treat an infection, you may fill your prescription at any network participating retail pharmacy that is convenient to you. A network participating pharmacy will accept your prescription ID card and charge you the appropriate co-payment when you fill a prescription covered by your plan.

For your long-term prescription needs, such as you might need to treat High Blood Pressure or High Cholesterol, it is more advantageous to fill your prescription by mail, through the Express Scripts Mail Service Pharmacy.

GHI HMO, through Express Scripts, uses a formulary. The formulary is a list of preferred, clinically effective prescription drugs that are also cost-effective. Express Scripts acts on behalf of GHI HMO to provide affordable access to clinically sound, high quality pharmacy benefits for you. The formulary is developed using an evaluation process. The process begins with an assessment of the drug’s clinical effectiveness by an independent panel of physicians and pharmacists, also known as the Pharmacy and Therapeutics Committee. If the panel determines the drug is clinically effective, the drug is further evaluated on an economic basis.

These are the dispensing limitations. Prescription drugs can be obtained through any retail pharmacy that participates in the Express Scripts PERxCare Retail Pharmacy Network, or through the Express Scripts Mail Service Pharmacy.

Retail Network Pharmacy Service

- You can get up to a 30-day supply of medication
- You pay a \$10 copay for generic drugs
- You pay a \$20 copay for plan preferred brand-name drugs (drugs that are listed on the Express Scripts National Preferred Formulary)
- You pay a \$30 copay for non-preferred brand-name drugs (drugs that are not listed on the Express Scripts National Preferred Formulary)

Dispensing limitations, (continued)

Express Scripts Mail Service Pharmacy

You can get up to a 90-day supply of medication

You pay a \$20 copay for generic drugs

You pay a \$40 copay for plan preferred brand-name drugs (drugs that are listed on the Express Scripts National Preferred Formulary)

You pay a \$50 copay for non-preferred brand-name drugs (drugs that are not listed on the Express Scripts National Preferred Formulary)

Required Mail Service:

Please note that your prescription drug coverage also includes a required mail service program. Therefore, you will be allowed two refills per maintenance prescription at any local network participating retail pharmacy. All future refills must be obtained through the Express Scripts Mail Service Pharmacy.

When a new maintenance medication is prescribed, you should request 2 prescriptions from your physician. The initial, for a 30day supply can be filled at a network participating retail pharmacy, and the second, for up to a 90-day supply, plus appropriate refills for up to one year, is to be sent to the Express Scripts Mail Service Pharmacy.

For all existing maintenance medications at a network participating retail pharmacy, you are required to obtain new prescriptions from your physician and mail them to the Express Scripts Mail Service Pharmacy. By filling your prescriptions through the Express Scripts Mail Service Pharmacy, you will pay just one copayment for each prescription or refill.

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 Department at 1-877-244-4466.

Why use a generic drug?

Generic drugs may have unfamiliar names, but they are safe and effective.

Generic drugs contains the same active ingredients, in the same dosage form as their brand name counterparts, and are manufactured according to the same strict federal regulations.

Generic drugs may differ in color, size, or shape, but the FDA requires that they have the same strength, purity, and quality as the brand-name alternatives.

Prescriptions filled with generic drugs often have lower co-payments. Therefore, you may be able to get the same health benefits at a lower cost. You should ask your physician or pharmacist whether a generic version of your medication is available. By using a generic drug, you may be able to receive the same high-quality medication but reduce your expenses.

When you need to file a claim. A direct reimbursement claims form must be filed for prescriptions that you obtained through a non-participating retail pharmacy. Upon filling your prescriptions through non-participating pharmacies:

You must pay the full cost of the prescription.

You must complete a direct reimbursement claims form, and submit it to Express Scripts. This form can be obtained by calling Express Scripts at (877) 534-3682.

Express Scripts will reimburse you for the amount the medication would have cost your benefit plan at a participating pharmacy, minus the co-payment you would have paid.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Covered medications and supplies	High Option	Standard Option
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:	Retail Pharmacy: \$10 copay generic \$20 copay preferred \$30 copay non-preferred brand (30-day supply) Mail Order: \$20 copay generic	Retail Pharmacy: \$10 copay generic \$20 copay preferred \$30 copay non-preferred brand (30-day supply) Mail Order: \$20 copay generic

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>Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan retail pharmacy will be dispensed for up to a 30-day supply or 100 unit supply, whichever is less, 240 milligrams of liquid (8 oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e. one inhaler, one vial ophthalmic medication or insulin).</p> <p>Contraceptive drugs</p> <p>Fertility Drugs</p> <p>Insulin</p> <p>Disposable needles and syringes for the administration of covered medications</p>	<p>Retail Pharmacy:</p> <p>\$10 copay generic</p> <p>\$20 copay preferred</p> <p>\$30 copay non-preferred brand (30-day supply)</p> <p>Mail Order:</p> <p>\$20 copay generic</p> <p>\$40 copay preferred</p> <p>\$50 copay non-preferred brand (90-day supply for maintenance medications)</p>	<p>Retail Pharmacy:</p> <p>\$10 copay generic</p> <p>\$20 copay preferred</p> <p>\$30 copay non-preferred brand (30-day supply)</p> <p>Mail Order:</p> <p>\$20 copay generic</p> <p>\$40 copay preferred</p> <p>\$50 copay non-preferred brand (90-day supply for maintenance medications)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines:</i> <ul style="list-style-type: none"> • <i>Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below:</i> <ul style="list-style-type: none"> • <i>Prescription drugs for diet or weight control including anorexic agent</i> • <i>Drugs utilized for treatment of sexual dysfunction are limited to 6 doses per month</i> • <i>Prescription drugs not obtained at a GHI HMO participating pharmacy or Mail Order pharmacy</i> • <i>Initial prescriptions or refills in excess of a 30 consecutive days supply or one month's cycle of any oral contraceptive drug (Mail Order available for up to a 90 day supply)</i> • <i>Drugs related to non-covered medical services</i> • <i>OTC drugs</i> • <i>Contraceptive devices such as condoms and spermicidal agents</i> • <i>Drugs not approved by the FDA</i> 	<p><i>All Charges.</i></p>	<p><i>All charges</i></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
• <i>Medications for cosmetic purposes only</i>	<i>All Charges.</i>	<i>All charges</i>

Section 5(g) Special features

Feature	Description
	High Option
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions. Call 877-244-4466.
Services for deaf and hearing impaired	We provide a TDD Line for the deaf and hearing impaired, 1-877-208-7920
Centers of excellence for transplants/heart surgery/etc.	Life Trac – National Ancillary providers for organ transplants utilizing 31 Centers of Excellence throughout the United States.
PHIP - Personal Health Improvement Program	<p>GHI HMO is now offering the Personal Health Improvement Program (PHIP) to our members. PHIP is a behavioral medicine intervention for the following types of patients:</p> <p>those with stress related illnesses such as headaches, back pain, fatigue, insomnia, and gastrointestinal discomfort.</p> <p>those learning to deal with a chronic disease such as multiple sclerosis, fibromyalgia and diabetes.</p> <p>patients whose mood (anxiety, depression, etc.) seems to influence their physical health.</p> <p>PHIP is based on the mind-body theory that mood and physical health are closely correlated. It helps patients reduce suffering and the symptoms of chronic illnesses by allowing participants to become aware of how their bodily reactions are related to behavioral patterns, including coping styles. By making such connections, participants learn to adopt new behaviors that will relieve their pain or discomfort.</p> <p>The program consists of six weekly two hour classes led by a trained facilitator. The classes consist of a combination of group discussion and specific exercises designed to help participants become aware of their own reactions to daily life. Participants are provided with a workbook and home-study questions, as well as an audiotape to guide them through an awareness exercise that they are asked to do daily.</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.

GHI HMO does not provide dental benefits.

We do not have a calendar year deductible.

We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	High Option	Standard Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. The services must be provided within 12 months of the injury.	Nothing	Nothing

We have no other dental benefits.

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.

GHI HMO Good Health Incentives Program. At GHI HMO we have your best health in mind. That's why we are making available to you the Good Health Incentives Program, which offers special discounts on a wide variety of health-related products and services.

General Nutrition Centers (GNC) – Offering a wide variety of discounts on vitamins and health products (participating GNC stores only). For a 15% discount coupon – web site: www.gnc.com.

Wellquest Fitness Network – Discount Health Club Membership – No long-term contracts, lower enrollment fees and monthly dues, opportunity to switch primary clubs at any time. Telephone 1-800-595-8448. Web site: www.wellquestonline.com.

Weight Watchers Online– Internet Weight Loss Program Discount – Offering the best weight-loss tools on the Internet, accessible from your home or office. To receive \$10 off a 3-month subscription – web site: www.weightwatchers.com/cs/ghi/.

Weight Watchers Weight Loss Program Discount – Free registration anytime. Telephone: 1-800-651-6000. Web site: www.weightwatchers.com.

My Medical CDTM – 33% savings on personal medical data credit card size disc, reimbursable for participants in a Flexible Spending Account Program, instant access to your medical information. Telephone: 1-866-MY MED CD (1-866-696-3323). Web site: www.mymedicalcd.com.

Davis Vision – Laser Vision Correction Services Discount – Laser Vision Correction up to 25% off usual and customary fee (in-network only). Telephone: 1-800-584-2866 (refer to client control number 7810). Web site: www.davisvision.com.

Davis Vision Affinity Discount Program – Significant discounts on examinations, eyewear and contact lenses (in-network only) up to 20% savings. Telephone: 1-877-92DAVIS (refer to client control number 7810). Web site: www.davisvision.com.

American Specialty Health Networks (ASHN) –

Acupuncture Therapy Discount Access Program – Significant savings on acupuncture therapy services.

Massage Therapy Discount Access Program - Significant savings on acupuncture therapy services.

Registered Dietician Discount Program – Significant savings up to 25% discount.

Telephone: 1-877-327-2746. Web site: www.healthyroads.com

HEARx – Hearing Aid and Product Discount – Complimentary hearing screening, extended family member discounts, a \$200 discount off the price of any single hearing aid. Telephone: 1-800-323-3277. Web site: www.hearx.com.

CARExpress Benefits Network Discount Health Programs – Discount program for prescription drugs, vision, and dental care, medical supplies and home nursing care (in-network only). Telephone: 1-866-305-7283. Web site: www.carexpress.org

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition and we agree, as discussed under *Services Requiring our Prior Approval* on page 13.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (*see Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services related to the professional fee for treatment of cavities and extractions, care of gums or bones supporting the teeth, orthodontia, false teeth, odontoma (tumors that are of dental origin and comprised of hard dental tissue), or any other dental services; or
- Services, drugs or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

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

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. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 877-244-4466.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on 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:

GHI HMO Claims Department

PO Box 4141

Kingston, NY 12402

**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.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/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: GHI HMO, PO Box 4332, Kingston, NY 12402; and
- c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

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

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

<p>If you do not agree with our decision, you may ask OPM to review it.</p>
<p>You must write to OPM within:</p> <p>90 days after the date of our letter upholding our initial decision; or</p> <p>120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or</p> <p>120 days after we asked for additional information.</p>
<p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance</p> <p>Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <ul style="list-style-type: none">• 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. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>

5

<p>OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.</p>
<p>If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied pre-certification or prior approval. This is the only deadline that may not be extended.</p>
<p>OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.</p>
<p>You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.</p> <p>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</p> <p>a) We haven’t responded yet to your initial request for care or preauthorization/prior approval, then call us at 877-244-4466 and we will expedite our review; or</p> <p>b) We denied your initial request for care or preauthorization/prior approval, then:</p> <p>If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or</p> <p>You may call OPM’s Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.</p>

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 xxx 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.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

People 65 years of age or older;

Some people with disabilities under 65 years of age; and

People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.

Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

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

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

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

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

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

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

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

Claims process when you have the Original Medicare Plan – You 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 877-244-4466 or see our Web site at www.ghi.com

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

Medical services and supplies provided by physicians and other health care professionals.

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

- **Medicare Advantage (Part C)**

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

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

This Plan and 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.

<p>TRICARE and CHAMPVA</p>	<p>TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.</p> <p>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.</p>
<p>Workers' Compensation</p>	<p>We do not cover services that:</p> <p>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</p> <p>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.</p> <p>Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.</p>
<p>Medicaid</p>	<p>When you have this Plan and Medicaid, we pay first.</p> <p>Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.</p>
<p>When other Government agencies are responsible for your care</p>	<p>We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.</p>

When others are responsible for injuries	<p>When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.</p> <p>If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.</p>
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Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	<p>Any service that can be learned and provided by an average individual who does not have medical training. Examples of Custodial Care include :</p> <ul style="list-style-type: none">• Assistance in meeting activities of daily living, such as feeding, dressing and personal hygiene;• Administration of oral medications, routine changing of dressing, or preparation of special diets;• Assistance in walking or getting out bed;• Child care necessitated by the incapacity of a parent; or• Respite Care• Custodial Care that lasts 90 days or more is sometimes known as Long term care.
Experimental or investigational service	<p>Any drug, device or medical treatment or procedure is experimental or investigational:</p> <ul style="list-style-type: none">• If the drug or device has not been approved by the Food and Drug Administration (FDA) <p>If reliable evidence, (reports in respected medical and scientific literature) shows that the opinion of experts is that further study is needed to decide how a drug, device or medical treatments or procedures compares with the standard method of treatment or diagnosis.</p>
Medical necessity	Medically necessary health care services are those necessary to preserve and maintain an Enrollee's health in accordance with acceptable standards of medical practice and received in an appropriate setting. The GHI HMO Medical Director shall determine whether a particular health care service rendered to an Enrollee is Medical Necessary for the purpose of determining whether such health care services are covered services and not for the purpose of practicing medicine or determining a course of treatment, which course is to be determined by the Participating Physician
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:
Us/We	Us and We refer to GHI HMO
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Where you can get information about enrolling in the FEHB Program**

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

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

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

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

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorcé, or when your child under age 22 marries.

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

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

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

If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option;

If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or

If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option.

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

- **When benefits and premiums start** The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2006 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

When you lose benefits

- **When FEHB coverage ends** You will receive an additional 31 days of coverage, for no additional premium, when:
Your enrollment ends, unless you cancel your enrollment, or
You are a family member no longer eligible for coverage.

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

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

- **Upon divorce**

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

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

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

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

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

- **Converting to individual coverage**

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

Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);

You decided not to receive coverage under TCC or the spouse equity law; or

You are not eligible for coverage under TCC or the spouse equity law.

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

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

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

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

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

Section 12 Three Federal Programs complement FEHB benefits

Important information

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

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

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.

Qualified relatives are also eligible to apply. Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

To request an Information Kit and application. Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

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

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

Limited Expense Health Care FSA (LEX HCFSA) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.

Dependent Care FSA (DCFSA) – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA– Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA– Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

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

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

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

When can I enroll?

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

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

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/dentalvision. 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/dentalvision.

Who is eligible to enroll?

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

Enrollment types available

Self-only, which covers only the enrolled employee or annuitant;

Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and

Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

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

When can I enroll?

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

How do I enroll?

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

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

When will coverage be effective?

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits 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 may reduce your out-of-pocket cost.

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Summary of benefits for the GHI HMO High Option - 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
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$10 specialist	17
Services provided by a hospital:		
• Inpatient	Nothing	35
• Outpatient	Nothing	37
Emergency benefits:		
• In-area	\$35 per visit	38
• Out-of-area	\$35 per visit	38
Mental health and substance abuse treatment:	Regular cost sharing	40
Prescription drugs:		
• Retail pharmacy	\$10 copay - generic	42
	\$20 copay - preferred brand	
	\$30 copay - non-preferred brand	
• Mail order	\$20 copay - generic	42
	\$40 copay - preferred brand	
	\$50 copay - non-preferred brand	
Dental care:	Accidental injury to sound natural teeth only. You pay nothing.	36
Vision care:	One refraction annually. You pay \$10 copay per office visit.	25
Special Features		
• Services for deaf and hearing impaired	Nothing	46
• Centers of Excellence for transplants/heart surgeries	Nothing	46

• PHIP – Personal Health Improvement Project	Nothing	46
Protection against catastrophic costs (out-of-pocket maximum)	Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments which are required for a few benefits	13

Summary of benefits for the GHI HMO Standard Option - 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.

Standard Option Benefits	You Pay	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$20 specialist	17
Services provided by a hospital:		
• Inpatient	Nothing	36
• Outpatient	Nothing	36
Emergency benefits:		
• In-area	\$50 per visit	38
• Out-of-area	\$50 per visit	38
Mental health and substance abuse treatment:	Regular cost sharing	40
Prescription drugs:		
• Retail pharmacy	\$10 copay - generic \$20 copay - preferred brand \$30 copay - non-preferred brand	42
• Mail order	\$20 copay - generic \$40 copay - preferred brand \$50 copay - non-preferred brand	42
Dental care:	Accidental injury to sound natural teeth only. You pay nothing.	36
Vision care:	One refraction annually. You pay \$20 copay per office visit	25
Special Features		
Services for deaf and hearing impaired	Nothing	46
Centers of Excellence for transplants/heart surgeries	Nothing	46
PHIP – Personal Health Improvement Project	Nothing	46
Protection against catastrophic costs (out-of-pocket maximum)	Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments which are required for a few benefits	13

2007 Rate Information for GHI HMO

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).

Type of Enrollment	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share