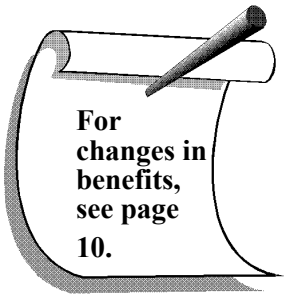
Group Health Plan

http://www.ghp.com

2008

A Health Maintenance Organization and a High Deductible Health Plan

Serving: St. Louis/Metro East area, Central Missouri, and Central and Southern Illinois



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

Enrollment code for this Plan:

- **MM1 High Option – Self Only**
- **MM2 High Option – Self and Family**
- **MU4 Standard Option – Self Only**
- **MU5 Standard Option – Self and Family**
- **MM4 High Deductible Health Plan (HDHP) – Self Only**
- **MM5 High Deductible Health Plan (HDHP) – Self and Family**

This Plan has full three-year accreditation from URAC.

Special Notice:Effective January 1, 2008, GHP will offer a Standard Option (MU4 and MU5).

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Group Health Plan About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that'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 Group Health Plan under our contract (CS 1930) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Group Health Plan's administrative offices is:

Group Health Plan
550 Maryville Centre Drive, Suite 300
St. Louis, MO 63141-5818

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, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your 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) 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 800/755-3901 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

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

Preventing medical mistakes

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

1.Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about the medicication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3.Get the results of any test or procedure.

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

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

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

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

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

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. 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

General features of our High and Standard Options

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 or 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 and coinsurance 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.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

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.

General features of our High Deductible Health Plan (HDHP)

We give you a choice of enrollment in a High Option or a High Deductible Health Plan (HDHP). Our High Deductible Health Plan offers POS benefits. This means you can receive covered services from a participating provider or a non-participating provider. Out-of-network benefits have higher out-of-pocket costs than our in-network benefits. HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally paid as first dollar coverage after a small deductible or copayment.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $5,250 for Self Only enrollment, or $10,500 family coverage.

Health education resources and account management tools

We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.ghp.com for information to help you take command of your health. This section is organized in simple, user-friendly sections:

- Assess Your Health – where you will find a simple, free online health risk assessment tool to benchmark your wellness, and better understand your overall health status and risks.
- About Your Health – for information about a specific condition or general preventive guidelines.
- Patient Safety
- WebMD – our link to this health site also provides wellness and disease information to help improve health.
- Prescription Drugs - educational materials are also accessible through our Web site, through a link to our pharmacy benefit manager, Caremark. There, you will find:
  - Detailed information about a wide range of prescription drugs;
  - A drug interaction tool to help easily determine if a specific drug can have any adverse interactions with each other, with over-the-counter drugs, or with herbals and vitamins;
  - Facts about why FDA-approved generic drugs should be a first choice for effective economical treatment.

Another key health information tool that we make available to you is our online quality tools, powered by Ingenix. You can review the frequency of procedures performed by a provider, knowing the correlation between frequency of service and quality of outcomes. We post additional quality outcome information, such as re-admission rates within 30 days, post-operative complications, and even death rates.

In addition, we augment our health education tools with access to our Nurse Advisor Services. Experienced RNs are available through an inbound call center 24 hours a day, 7 days a week, 365 days a year to assist you and help you to maximize your benefits by providing clinical and economic information to make an informed decision on how to proceed with care.

For each HSA and HRA account holder, we maintain a complete claims payment history online through www.ghp.com.

- Your balance will also be shown on your explanation of benefits (EOB) form.
- You will receive an EOB after every claim.
- If you have an HSA,
  - You will receive a quarterly statement by mail outlining your account balance and activity for the month.

- You may also access your account and review your activity on a daily basis online via My Online Services at www.ghp.com.

- If you have an HRA,
  - You will receive a quarterly statement by mail outlining your account balance and activity for the month.
  - You may also access your account and review your activity on a daily basis online via My Online Services at www.ghp.com.

GHP is excited to offer an innovative wellness program called *Coventry WellBeing*. By capitalizing on the best aspects of the current member-focused wellness support and integrating them with an array of new services, *Coventry WellBeing* assists valued members in enjoying a healthier lifestyle.

Coventry WellBeing is designed to help members by using a behavior change model of PLAN, COACH, and REWARD.

PLAN: First, members are provided with three highly customized plans designed to help achieve personal health and wellness goals.

COACH: Members have the ability to contact a coach via email, 24 hours a day, 7 days a week, to receive answers to any questions they may have.

REWARD: Members who participate in the program and make continual progress qualify for prize drawings and earn valuable points that can be redeemed for merchandise.

In addition, *Coventry WellBeing* includes a virtual trainer, online coaching and tracking capabilities. The Virtual Trainer provides hundreds of multi-media exercise demonstrations teaching proper techniques, spotting guidelines, and tips to ensure members get the most out of their exercise plan. With the Online Coaching, members are given 24-hour access to a nationwide staff of certified personal trainers, registered dieticians, and psychologists who answer personal questions about fitness, nutrition, and life skills. With eTRACKER, members have the ability to track daily, weekly, and monthly progress on personal goals and objectives such as weight, body fat, BMI, etc.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB 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
- Profit status

Group Health Plan is in compliance with the state requirements of Missouri and Illinois. In addition, Coventry Health Care, our parent company, has had a comprehensive system in place to identify and prevent medical errors and to ensure that all providers credentialed are competent. Through the Quality Improvement Program, medical errors and other adverse events are monitored to identify patterns of preventable events and events related to individual network providers. Patterns or individual cases are investigated and action is taken to make improvements.

If you want more information about us, call 800-755-3901, or write to 550 Maryville Centre Drive, Suite 300, St. Louis, MO 63141-5818. You may also contact us by fax at 866-465-9494 or visit our Web site at www.ghp.com.

Your medical and claims records are confidential

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

Service Area

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

St. Louis City, St. Louis County, and the Missouri counties of Boone, Callaway, Cole, Crawford, Franklin, Gasconade, Jefferson, Lincoln, Montgomery, St. Charles, St. Francis, Ste. Genevieve, Warren, and Washington.

The Illinois counties of Bond, Calhoun, Cass, Christian, Clinton, Cole, Franklin, Green, Jackson, Jefferson, Jersey, Johnson, Macon, Macoupin, Madison, Marion, Menard, Monroe, Montgomery, Morgan, Moultrie, Perry, Randolph, Saline, Sangamon, Schuyler, Scott, Shelby, St. Clair, Union, Washington, and Williamson.

With the HMO plans, 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 2008

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

Changes to this Plan

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 111.
- We added a Standard Option.
- We will cover hearing aids for medical necessity with a $500 copay per ear up to a maximum benefit of $2,600 per calendar year.

Changes to High Option only

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 111.
- We will increase the catastrophic protection out-of-pocket maximum from $1,000 per person or $2,000 per family to $2,500 per person or $5,000 per family.
- We will increase the office visit copayment from $20 to $25 per visit.
- We will increase the surgery copay at an outpatient hospital or free standing ambulatory surgical center from $50 per visit to $150 per visit.
- We will increase the copay for emergency care as an outpatient at a hospital from $75 per visit to $100 per visit.

Changes to our High Deductible Health Plan

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 111.
- We will cover hearing aids for medical necessity with a $500 copay per ear up to a maximum benefit of $2,600 per calendar year.
- The administrator for the HRA will change from Corporate Benefit Services of America (CBSA) to Coventry Consumer Advantage.

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 800-755-3901 or write to us at 550 Maryville Centre Drive, Suite 300, St. Louis, MO 63141-5818. You may also request replacement cards through our Web site: www.ghp.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. If you use our HDHP plan, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program, you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **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.

- **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

GHP's Open Access HMO product means that you are not required to choose a primary care physician or obtain a referral to see specialists. You will receive HMO benefits when you see a participating physician for health services. You or your covered dependents may use any participating internal medicine physician, family practice physician, general practice physician, pediatrician, OB/GYN, or specialists participating in the network for your care.

Within the HDHP option, in order to utilize the highest available benefit, you will need to follow the same outline as for the HMO. A physician referral is not necessary to utilize the out-of-network benefit for covered services; however, any services requiring prior authorization will still need to be prior authorized through GHP's Medical Management Department. When utilizing the out-of-network benefit, it is the member's responsibility to obtain prior authorization.

- **Primary care**

We urge members to establish a relationship with a participating physician. Through regular office visits, the physician becomes the member's health care advisor and advocate. Frequently, members choose a physician specializing in internal medicine, family practice or pediatrics.

The provider directory lists primary care physicians (family/general practitioners, pediatricians, internists, and OB/GYNs) and specialists with their locations and phone numbers. Directories are available by calling 800-755-3901 or by visiting our Web site at www.ghp.com.

- **Specialty care**

A specialist is a Medical Doctor (MD), Doctor of Osteopathy (DO), or other health care professional who is an expert in a specific branch of medicine such as orthopedics, neurology, surgery, cardiology, endocrinology, etc. Group Health Plan members who have the Open Access HMO product may see a participating specialist at any time without a referral. The participating physician is responsible for obtaining prior authorization from Group Health Plan for treatment from a chiropractor or a physician specializing in pain management or infertility services. If your health care provider believes these services are appropriate, he or she will obtain an authorization for you.

Within the HDHP option, members may see a participating or non-participating specialist without a referral. Prior authorization is the member's responsibility for all out-of-network services.

Here are some other things you should know about specialty care within the HMO option:

- If your current specialist does not participate with GHP, you must receive treatment from a specialist who does. Generally, we will not pay for you to see another specialist.
- If you are seeing a specialist and your specialist leaves the Plan, call your participating health care advisor who can help arrange for you to see another specialist.
- 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.

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

- **Hospital care**

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

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

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.

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-755-3901. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

How to get approval for…

For the HMO plan, it is the responsibility of the participating physician to obtain any necessary authorizations from the Plan before making arrangements for services requiring prior authorization.

For the HDHP plan, if the member stays within GHP's network, it is the primary care physician's responsibility to obtain any necessary prior authorizations. Should the member choose to seek services outside the network, it is the member's responsibility to ensure that the physician has obtained any necessary prior authorizations.

- **Your hospital stay**

Hospitalization requires your attending physician to obtain prior authorization. Prior authorization is based on whether the service is covered, medically necessary, and follows generally accepted medical practice.

- **How to precertify an admission**

For the HMO plan, it is the responsibility of the participating physician to obtain any necessary authorizations from the Plan before rendering certain procedures or making arrangements for hospitalization.

For the HDHP plan, if the member stays within GHP's network, it is the primary care physician's responsibility to obtain any necessary prior authorizations. Should the member choose to seek services outside the network, it is the member's responsibility to make sure that any necessary prior authorizations are obtained.

- **Maternity care**

Global obstetric services require your attending physician to obtain prior authorization. Prior authorization is based on whether the service is covered, medically necessary, and follows generally accepted medical practice.

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

For the HMO plan, any service provided which is not medically necessary, as well as any services described in the prior authorization list, will be denied if unauthorized. The member is usually held harmless if the provider fails to obtain prior authorization when required.

For the HDHP plan, any service provided which is not medically necessary, as well as any services described in the prior authorization list, will be denied if unauthorized. The member is held responsible when using a non-network provider in a non-emergency or non-urgent situation if the provider fails to obtain prior authorization when required.

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 physician has authority to refer you for most services. For certain services, however, approval must be obtained 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 precertification. Precertification must be obtained for services such as, but not limited to inpatient admissions, skilled nursing or rehabilitation admissions, transplants, outpatient surgeries, dialysis, certain outpatient diagnostics, cardiac rehabilitation, pulmonary rehabilitation, ancillary services, pain management, infertility services, maternity, self-injectable drugs, botox, visudyne, chiropractic manipulations, speech therapy, and observation hospital stays. The Prior Authorization Department is available weekdays from 8:00 a.m. to 5:00 p.m. central standard time at 800-546-4603.

Prior authorization is required for, but not limited to the following health services:

- All hospital admissions, including observations
- All admissions to skilled nursing facilities or inpatient specialty care programs such as rehabilitation, hospice, mental health and substance abuse
- Surgical procedures at an outpatient or surgical center
- Mental health and substance abuse (outpatient services)
- Pain management injections including epidural, facet and trigger point injections

- Transplants
- Rehabilitation/therapy: cardiac, occupational, physical, pulmonary, speech
- Outpatient diagnostics/services including CT scans, PET scans, all cardiac stress imaging, Cardiac nuclear scans, and MRI/MRA
- Brachytherapy
- Chiropractic services (notification only)
- Chemotherapy (off label use only)
- Clinical trials
- Dialysis (notification only)
- Durable medical equipment over $250 and all rental equipment
- Experimental or investigational treatments/services
- Genetic counseling
- Global OB care (notification only)
- Home health care
- Home hospice care
- Hyperbaric treatment
- In-home infusion therapy
- Infertility services
- Injectable medications
- Lesion removal in office or facility
- Intensity modulated radiotherapy
- Orthopedic footwear, shoe modifications and additions
- Orthotic devices over $250
- Non-emergency ambulance transfers
- Sclerotherapy
- Prosthetics
- Proton beam treatment

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 in the High Option HMO plan, you pay a copayment of $25 per office visit and when you go in the hospital, you pay $200 per admission.

Cost-sharing

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

Deductible

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

- We do not have a deductible for the HMO options.
- The calendar year deductible is $1,250 per person for in-network services and $2,500 per person for out-of-network services under the HDHP Option. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $2,500 for in-network services and $5,000 for out-of-network services under the HDHP Option.

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our High Option HMO Plan, you pay 20% of our allowance for durable medical equipment.

Differences between our Plan allowance and the bill

- **In-network providers** agree to limit what they will bill you. Because of that, when you use a network provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a network physician who charges $150, but our allowance is $100. You are only responsible for your coinsurance. That is, you pay just – 10% of our $100 allowance ($10). Because of the agreement, your network physician will not bill you for the $50 difference between our allowance and his bill.
- **Out-of-network providers**, on the other hand, have no agreement to limit what they will bill you. When you use an out-of-network provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and charges on the bill. Here is an example: You see an out-of-network physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Additionally, because there is no agreement between the out-of-network physician and us, he can bill you for the $50 difference between our allowance and his bill.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total reaches $2,500 per person or $5,000 per family enrollment in the High Option HMO plan or $3,000 per person or $6,000 per family enrollment in the Standard Option HMO in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription Drugs

For the HDHP plan, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments, and deductibles total $5,000 per person or $10,000 per family enrollment in-network and $10,000 per person or $20,000 per family out-of-network in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).

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

Carryover

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

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

When Government facilities bill us

Facilities of the Department of VeteransAffairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

High and Standard Option Benefits

See page 10 for how our benefits changed this year. Page 108 and page 109 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 both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain more information about High and Standard Option benefits, contact us at 800-755-3901 or at our Web site www.ghp.com.

Each option offers unique features.

- **High Option** — When you receive services from Plan providers, you will not have to submit claim forms or pay bills. When you receive emergency services from non-Plan providers, you may have to submit claim forms. You pay only the copayments or coinsurance as described in this brochure.
- **Standard Option** — When you receive services from Plan providers, you will not have to submit claim forms or pay bills. When you receive emergency services from non-Plan providers, you may have to submit claim forms. For some services, you pay both a copayment and a coinsurance that apply to the same benefit.

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility	Nothing	Nothing
• Office medical consultations • Second surgical opinion • At home	$25 per office visit	$30 per office visit
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $25 per visit Note: The office visit copay will apply if provided within the physician office setting, otherwise the outpatient facility copay will apply.	Nothing if you receive these services during your office visit; otherwise, 20% coinsurance per visit Note: The office visit copay will apply if provided within the physician office setting, otherwise the outpatient facility copay will apply.

Benefit Description	You pay	
Preventive care, adult	**High Option**	**Standard Option**
Routine physical which may include: Routine screenings, such as: • 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 • Colonoscopy screening – every ten years starting at age 50 Routine annual digital rectal exam (DRE) for men age 40 and older	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	$25 per office visit	$15 PCP/$30 specialist copay 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 *Diagnostic and treatment services*, above	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • Starting at age 40, one every calendar year	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction	$25 per office visit	$15 PCP/$30 specialist copay per office visit

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
- Examinations done on the day of immunizations (up to age 22)	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Immunizations, boosters, and medications for travel.*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$25 per office visit for initial visit only; no charge thereafter	$15 per office visit for initial visit only; no charge thereafter
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera)	$25 per office visit	$15 PCP/$30 specialist copay per office visit

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High Option**	**Standard Option**
• Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit. Prior authorization required.	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling.*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs and oral fertility drugs under the prescription drug benefit.	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg.*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Allergy serum	Nothing	Nothing
Not covered: Provocative food testingand sublingual allergy desensitization.	*All charges*	*All charges*

Benefit Description	You pay	
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 32. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We only cover GHT when we preauthorize the treatment. Your physician will arrange coverage for GHT with GHP. We will ask your physician to submit information that establishes that the GHT is medically necessary. Request prior authorization for 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. See *Services requiring our prior approval* in Section 3.	Nothing	Nothing
Physical and occupational therapies	**High Option**	**Standard Option**
60 visits for the services of each of the following: • 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 and if significant improvement can be expected within two consecutive months. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.	20% coinsurance for therapies performed in the office or outpatient setting	20% coinsurance for therapies performed in the office or outpatient setting
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*

Benefit Description	You pay	
Speech therapy	**High Option**	**Standard Option**
Limited to 20 visits or two consecutive months (whichever is greater) per condition per year	20% coinsurance for therapies performed in the office or outpatient setting	20% coinsurance for therapies performed in the office or outpatient setting
Not covered: Speech therapy services that are not medically necessary.	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Medically necessary authorized hearing aid and testing • Hearing exam for children through age 17 (see *Preventive care, children)*	$500 per ear up to a maximum benefit of $2,600 per calendar year	$500 per ear up to a maximum benefit of $2,600 per calendar year
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing	Nothing
• Eye exam to determine the need for vision correction for children through age 17 *(see Preventive care, children)*	$25 per office visit	$15 PCP/$30 specialist copay per office visit
• Annual eye exam • Annual eye refractions Note: *See Preventive care, children* for eye exams for children.	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery.*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges*	*All charges*

Foot care - continued on next page

Benefit Description	You pay	
Foot care (cont.)	**High Option**	**Standard Option**
• *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).*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• 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: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	$25 per office visit 20% coinsurance for orthotic or prosthetic device Note: Office visit copay is in addition to the 20% coinsurance for the device whether billed separately or together.	$15 PCP/$30 specialist copay per office visit 20% coinsurance for orthotic or prosthetic device Note: Office visit copay is in addition to the 20% coinsurance for the device whether billed separately or together.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements* • *Testicular implants.*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. Note: Your physician will arrange coverage for durable medical equipment with GHP and a Plan provider.	20% coinsurance	20% coinsurance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
Not covered: • *Motorized wheelchairs* • *Non-durable medical supplies such as foley catheters, dressings and leg bags* • *Repair or replacement of purchased equipment.*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	20% coinsurance	20% coinsurance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• Up to 26 visits; treatment plan is required	$25 per office visit	$30 per office visit
Alternative treatments	**High Option**	**Standard Option**
Biofeedback when all other conservative measures have been exhausted	$25 per office visit	$15 PCP/$30 specialist copay per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Acupuncture.*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
• Childbirth classes Note: Members may submit a receipt and the Plan will reimburse charges up to $100.	All charges after $100	All charges after $100
• Diabetes education classes with plan authorization	Nothing	Nothing
• Nutritional counseling related to Diabetes from a dietician	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Smoking cessation - Quit for Life/ WellBeing	Nothing	Nothing
Not covered: Weight loss program.	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) • Vertical-banded gastroplasty (gastric stapling), and roux-en-y gastric bypass (Roux-en-Y) of morbid obesity will be covered by Group Health Plan when all of the following criteria are met. A complete description of our policy, including contraindications, and requirements following the scheduled surgery, is available. - The patient is an adult (> 18 years of age) with morbid obesity that has persisted for at least 3 years and for which there is no treatable metabolic cause for the obesity.	$25 per office visit $150 for outpatient facility	$15 PCP/$30 specialist copay per office visit $500 for outpatient facility

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity, and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity, and social support; and, - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions. • 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	$25 per office visit $150 for outpatient facility	$15 PCP/$30 specialist copay per office visit $500 for outpatient facility

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done.	$25 per office visit $150 for outpatient facility	$15 PCP/$30 specialist copay per office visit $500 for outpatient facility
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Replacement of penile prosthesis.*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$25 per office visit $150 for outpatient facility	$15 PCP/$30 specialist copay per office visit $500 for outpatient facility
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Scar revision.*	*All charges*	*All charges*

Benefit Description	You pay	
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures	$25 per office visit $150 for outpatient facility	$15 PCP/$30 specialist copay per office visit $500 for outpatient facility
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone).*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Kidney/Pancreas • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas	Nothing	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses; medical necessity limitation is considered satisfied for other tissue transplants if the patient meets staging description: • Allogeneic (donor) transplants for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Severe combined immunodeficiency disease - 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 bone marrow transplants for recurrent germ cell tumors (including testicular cancer) Blood or marrow stem cell transplants for: • Allogeneic (donor) transplants for - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced myelodysplastic syndromes (e. g., DeNovo, secondary, high dose) not previously treated - Advanced neuroblastoma - Infantile malignant osteopetrosis - Mucolipidosis (e.g., adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillipo's syndrome, Maroteaux-Lamy syndrome variants)	Nothing	Nothing
• Autologous transplants for - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Multiple myeloma - Epithelial ovarian cancer	Nothing	Nothing
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 • Allogeneic transplants for - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Chronic and juvenile myelomonocytic leukemia • Nonmyeloablative allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkins lymphoma - Advanced non-Hodgkins 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 - Sarcomas • Autologous transplants for - Multiple myeloma - Amyloidosis (single) - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Systemic sclerosis • National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Non-human organs* • *Hair transplants.*	*All charges*	*All charges*

Benefit Description	You pay	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing
Not covered: Anesthesia for dental procedures.	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 per admission up to a $400 maximum	$500 per day up to a $1,000 maximum then 20% coinsurance
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary.*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• 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 Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$150 for outpatient facility	$500 for outpatient facility
Not covered: Storage of blood donated before surgery, designated donor fees.	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
• Extended care benefit • Skilled nursing facility (SNF) Up to 30 days per calendar year when full-time skilled nursing care is necessary and confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	$200 per admission up to a $400 maximum	$500 per day up to a $1,000 maximum then 20% coinsurance
Not covered: Custodial care.	*All charges*	*All charges*

Benefit Description	You pay	
Hospice care	**High Option**	**Standard Option**
Inpatient and home health care when authorized and approved by the Plan	20% coinsurance	20% coinsurance
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service when medically appropriate • Air ambulance when medically necessary and approved by the Plan Note: Ambulance coverage in non-emergency situations must be prior authorized.	20% coinsurance	20% coinsurance

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

If you are in an emergency situation, please call your health care advisor. In medical emergencies, if you are unable to contact your health care advisor, contact the local emergency system (e.g. the 911 telephone system) or go to the nearest emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely manner.

If you need to be hospitalized in a non-Plan facility, the Plan should be notified by you or a family member within 48 hours unless it is not reasonably possible to do so. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

The Plan, or your health care advisor in conjunction with the Plan, must approve follow-up care recommended by non-Plan providers. Normally, you will be required to return to the Plan's service area for follow-up care.

Emergencies within our service area: $100 per visit in a hospital (waived if admitted)

Emergencies outside our service area: $100 per visit in a hospital (waived if admitted)

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$25 per office visit	$15 PCP/$30 specialist copay per office visit
• Emergency care at an urgent care center	$75 per visit	$50 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.	$100 per visit for emergency room	$100 per visit for emergency room
Not covered: Elective care or non-emergency care.	*All charges*	*All charges*

Benefit Description	You pay	
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$25 per office visit	$15 PCP/$30 specialist copay per office visit
• Emergency care at an urgent care center	$75 per visit	$50 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.	$100 per visit for emergency room	$100 per visit for emergency room
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
• Professional ambulance service when medically appropriate • Air ambulance when medically necessary and approved by the Plan Note: See 5(c) for non-emergency service.	20% coinsurance	20% coinsurance
Not covered: Non-emergency use of ambulance.	*All charges*	*All charges*

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.
- 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 FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
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 may include services, drugs and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists or clinical social workers • Medication management	$25 per visit	$30 per visit
• Diagnostic tests	Nothing	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, full-day hospitalization, facility based intensive outpatient treatment	$200 per admission up to a $400 maximum	$500 per day up to a $1,000 maximum then 20% coinsurance
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*All charges*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

	Please call GHP's Behavioral Health Line toll-free at 877-227-3520 to access mental health and substance abuse services. GHP's Behavioral Health Line provides 24-hour access for these benefits. The Behavioral Health Line will be able to help you identify participating providers and initiate referral procedures.
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.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating local pharmacy or for maintenance medications, through the mail order benefit or at a participating 90-day pharmacy. Our participating pharmacies are listed in the GHP directory.
- **We use a formulary.** A formulary is a list of specific generic and brand name prescription drugs authorized by the Plan and subject to periodic review and modification. The purpose of the formulary is to assist physicians in prescribing cost effective, quality drug therapy for members. Drugs from all therapeutic groups are available on the drug formulary. The formulary has a mandatory generic policy when there is a generic medication that has been proven by the FDA to be equivalent of the name brand. If a member or physician prefers the name brand or non-formulary drug when a generic is available, the member will be charged the difference in cost plus the copayment. Since there is a copayment for non-formulary drugs, there will be no exceptions to the formulary. If a doctor prescribes a non-formulary drug, you can go back to the doctor and ask them to prescribe something from the formulary or pay the higher copayment. You may obtain a copy of our formulary list by contacting our Member Services department or by visiting our Web site at www.ghp.com.
- **We cover non-formulary drugs prescribed by a Plan doctor.** We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-755-3901.
- **These are the dispensing limitations.** You may obtain up to a 31-day supply or 100-unit supply (whichever is less) at a participating retail Plan pharmacy. Prescriptions dispensed as a unit (such as 1 box, 1 tube, 1 inhaler) will have a copayment per unit. Selected products or prescription drugs may require prior approval from the Plan or have quantity limits (such as Imitrex or sexual dysfunction drugs). Please have your doctor call for prior approval. When a generic substitution is permissible but you or your doctor request the name brand drugs, you pay the price difference between the generic drug and name brand drugs, as well as the appropriate copay per prescription unit or refill. Your prescription drug copay will never exceed the retail price of the drug.
- **Prescriptions by Mail Order.** GHP's mail order program and participating 90-day pharmacies will dispense a 90-day supply (when the prescription is written for 90 days) for two copayments. Simply ask your physician to write your maintenance medication prescription for at least a 90-day supply. Complete a mail order form (available through Member Services) or go to a participating 90-day pharmacy. For commercially prepackaged drugs such as topicals, inhalers, and vials, you will pay the appropriate copay for each container. Please note that not all maintenance medications are available by mail order.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding name brand drug. Generic drugs are less expensive than name brand drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.

- **When you do have to file a claim.** You will only have to file a claim if you are out of our service area and unable to use one of the national chains participating in the Plan in an emergency situation. In this case, please submit an itemized bill to GHP with an explanation and we will reimburse you all but your copayment.

Benefit Description	You pay	
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: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies limited to disposable syringes, blood glucose strips, and diabetic lancets for members on insulin for use in the treatment of diabetes • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction *(see Prior authorization)* • Contraceptive drugs and devices • Self-injectable medications Note: Self-injectable medications are provided by Caremark Therapeutics.	**At a Plan Retail Pharmacy:** $10 copay for generic formulary $20 copay for name brand formulary $45 copay for non-formulary or **Through our Mail Order Pharmacy:** $20 copay for generic formulary $40 copay for name brand formulary $90 copay for non-formulary Out-of-network: All charges. Note: If there is no generic equivalent available, you will still have to pay the brand name copay. Note: For commercial containers through mail order, you pay the appropriate copay for each container.	**At a Plan Retail Pharmacy:** $12 copay for generic formulary $30 copay for name brand formulary $50 copay for non-formulary or **Through our Mail Order Pharmacy:** $24 copay for generic formulary $60 copay for name brand formulary $100 copay for non-formulary Out-of-network: All charges. Note: If there is no generic equivalent available, you will still have to pay the brand name copay. Note: For commercial containers through mail order, you pay the appropriate copay for each container.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs available without a prescription for which a non-prescription equivalent is available* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Medical supplies such as dressings and antiseptics* • *Diabetic supplies not listed as covered* • *Smoking cessation drugs and medication including nicotine patches*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Drugs for weight loss* • *Refills for prescriptions resulting from loss or theft* • *Prescription drugs for travel.*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan contracted oral maxillofacial specialists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	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 within two days. The need for these services must result from an accidental injury.	$25 per office visit $150 per visit for outpatient surgical procedure	$15 PCP/$30 specialist copay per office visit $500 per visit for outpatient surgical procedure

Dental benefits	You Pay	
Dental benefits		
We have no other dental benefits.		

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	The TDD toll-free number is 877-231-0573 for people who have difficulties with hearing or speech. You do need special equipment to use the TDD number.
Complex case management	GHP's Complex Case Management Department is staffed with registered nurses and social workers who are assigned to oversee the care of members with complex, chronic or catastrophic illnesses. The Complex Case Managers develop member-specific online care coordination plans that can be accessed by all Complex Case Managers and Disease Managers. The Complex Case Managers monitor the member's progress toward their goals and make adjustments to the care coordination plan as necessary.
Disease management programs	GHP offers disease-specific programs for high risk pregnancy, asthma, diabetes, congestive heart failure and chronic obstructive pulmonary disease. Members identified for these programs receive disease-specific educational mailings, preventive health mailings and telephonic reminders. These programs are supported by a wide range of educational material and are staffed by registered nurses and social workers.
Centers of excellence	GHP provides members with access to nationally recognized transplant programs. The programs are "Centers of Excellence" offering members quality transplant services. GHP provides the opportunity for members to have access to some of the nation's leading transplant centers.
WellBeing	GHP is committed to supporting our members' health. Through our *WellBeing* program, we provide education materials and wellness programs that support our members' efforts to take accountability for their health and prevent illness. All members are encouraged to take advantage of a health risk assessment (HRA) every year. You will receive a comprehensive report upon completion. Get all of this and more through My Online Services at www.ghp.com.

High Deductible Health Plan Benefits

See page 10 for how our benefits changed this year and page 110 for a benefits summary.

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Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice or more information about HDHP benefits, contact us at 800-755-3901 or at our Web site at www.ghp.com.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** — The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, disease management and wellness programs. These services are covered at 100% after copayment if you use a network provider and the services are described in Section 5 *Preventive care*. Y*ou do not have to meet the deductible before using these services.*

- **Traditional medical coverage** — After you have paid the Plan's deductible, we pay benefits under HDHP medical coverage described in Section 5. The Plan typically pays 90% for in-network and 70% for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits
  - Dental benefits.

- **Savings** — Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 53 for more details).

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2008, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $41.67 per month for a Self Only enrollment or $83.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $2,900 for an individual and $5,800 for a family. See maximum contribution information on page 54. You can use funds in your HSA to help pay your health plan deductible, copayments and non-covered medical services. **You** own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by Corporate Benefit Services of America, Inc. (CBSA)
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2008, we will give you an HRA credit of $41.67 per month for a Self Only enrollment and $83.33 per month for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Coventry Consumer Advantage

- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

- **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,000 per person or $10,000 per family enrollment. When you use out-of-network providers, your annual maximum for out-of-pocket expenses (deductibles, coninsurance and copayments) for covered services is limited to $10,000 per person or $20,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum* and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Corporate Benefit Services of America, Inc. (CBSA), this HDHP's administrator, trustee or custodian as defined by Federal tax code and approved by IRS.	Coventry Consumer Advantage is the HRA administrator for this Plan.
Fees	None.	None.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork.	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• **Self Only enrollment**	For 2008, a monthly premium pass through of $41.67 will be made by the HDHP directly into your HSA each month.	For 2008, your HRA annual credit is $500 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2008, a monthly premium pass through of $83.33 will be made by the HDHP directly into your HSA each month.	For 2008, your HRA annual credit is $1,000 (prorated for med-year enrollment).

Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $2,900 for an individual and $5,800 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 57.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.
• **Self Only enrollment**	You may make an annual maximum contribution of $2,400.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $4,800.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods:	You can access your HRA by the following methods:

	• Debit card • Withdrawal form	• Withdrawal form • Automatic crossover election
Distributions/withdrawals • **Medical**	You can pay the deductible, copayment and coinsurance for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. The deductible, coinsurance, and copays are the only qualified medical expenses under the HRA. See *Availability of funds* below for information on when funds are available in the HRA.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.	Not applicable - distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • The fiduciary sends you HSA paperwork for you to complete and fiduciary receives the completed paperwork back from you.	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	GHP HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 53 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.

		If you terminate employment or change health plans, only deductibles, copyaments and coinsurance incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirments. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions** — All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective data is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions** — If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. In 2008, you may contribute up to $900 in catch-up contributions. The allowable catch-up contribution will be $1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die** — If you do not have a named beneficiary, if you are married, it becomes your spouse's HSA; otherwise, it becomes part of your taxable estate.

- **Qualified expenses** — You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on "Forms and Publications." Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses** — You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

- **Tracking your HSA balance** — You will receive a periodic statement that shows the "premium pass through", withdrawals and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

- **Minimum reimbursements from your HSA** — You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least $25.

If you have an HRA

- **Why an HRA is established**

  If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review the chart on page 53 which details the differences between an HRA and an HSA. The major differences are:

  - You cannot make contributions to an HRA
  - Funds are forfeited if you leave the HDHP
  - An HRA does not earn interest, and
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible. You only owe your copay for covered preventive care services.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening — every five years starting at age 50, - Double contrast barium enema — every five years starting at age 50; - Colonoscopy screening — every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older • Routine well-woman exam including Pap test • Routine mammogram — covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40, one every calendar year	In network: $15 per visit to a primary care physician, no deductible Out-of-netowrk: 30% of covered expenses after deductible
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Routine physicals which include: - One exam every 12 months • Routine exams limited to: - 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services - 1 routine hearing exam every 24 months	In-network: $15 per visit to a primary care physician, no deductible Out-of-network: 30% of covered expenses after deductible
Not covered: • *Routine eye exams* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters and medications for travel or work-related exposure.*	*All charges.*

Benefit Description	You pay
Preventive care, children	
• Professional services, such as: • Well-child visits for routine examinations, immunizations and care (up to age 22)	In-network: $15 per visit to a primary care physician, no deductible Out-of-network: 30% of covered expenses after deductible
• Professional services, such as: • Childhood immunizations recommended by the American Academy of Pediatrics	In-network: Nothing Out-of-network: Nothing
• Examinaations, such as: • Eye exam - one routine exam every 12 months • Hearing exams - one routine exam every 24 months	In-network: $15 per visit to a primary care physician, no deductible Out-of-network: 30% of covered expenses after deductible
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations, boosters and medications for travel.*	*All charges.*

Section 5. Traditional medical coverage subject to the deductible

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.
- In-network preventive care is covered at 100% (see page 59) and is not subject to the calendar year deductible.
- The deductible is $1,250 per person or $2,500 per family enrollment for in-network benefits and $2,500 per person or $5,000 per family enrollment for out-of-network benefits. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $5,000 per person or $10,000 per family enrollment in-network and $10,000 per person or $20,000 per family out-of-network in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	In-network: 100% of allowable charges until you meet the deductible of $1,250 per person or $2,500 per family enrollment Out-of-network: 100% of allowable charges until you meet the deductible of $3,000 per person or $5,000 per family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket. Maximum out-of-pocket for in-network services is $5,000 per person or $10,000 per family in any calendar year.

Deductible before Traditional medical coverage begins - continued on next page

Benefit Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins (cont.)	
	Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount. Maximum out-of-pocket for in-network services is $10,000 per person or $20,000 per family in any calendar year.

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.
- The deductible is $1,250 for Self Only enrollment and $2,500 for Self and Family enrollment for in-network benefits and $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment for out-of-network benefits each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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…
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion	In-network: $15 per visit to a primary care physician; $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Professional services of physicians • During a hospital stay • In a skilled nursing facility	In-network: Nothing Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	In-network: Nothing Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible…
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits* (Section 5c) and *Surgery benefits* (Section 5b).	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: Routine sonograms to determine fetal age, sex or size.	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit. Prior authorization is required for these services.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling.*	*All charges*
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs	In-network: $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
Note: We cover injectable fertility drugs and oral fertility drugs under the prescription drug benefit.	In-network: $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg.*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections	In-network: $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Allergy serum	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization.	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 73. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We only cover GHT when we preauthorize the treatment. Call toll-free at 800-546-4603 for prior authorization. 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. See *Services requiring our prior approval* in Section 3.	In-network: $15 per visit to a primary care physician; $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies	
60 visits for the services of each of the following: • 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 and if significant improvement can be expected within two consecutive months. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions	In-network: 10% of Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs.*	*All charges*
Speech therapy	
Limited to 20 visits or two consecutive months (whichever is greater) per condition per year	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered:Speech therapy services that are not medically necessary.	*All charges*
Hearing services (testing, treatment, and supplies)	
• Medically necessary authorized hearing aid and testing • Hearing exams for children through age 17 (see *Preventive care, children)*	$500 per ear up to a benefit maximum of $2,600 per calendar year
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing
Not covered: • *Annual eye refraction* • *Eyeglassesor contact lenses, except as shown above, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. *Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.*	In-network: $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*
Orthopedic and prosthetic devices	
• 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: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose and other supportive devices* • *Prosthetic replacements* • *Testicular implants.*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	
• Insulin pumps. Note: Your physician will arrange coverage for durable medical equipment with GHP and the provider. Out-of-network services require prior authorization.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • Motorized wheelchairs • Non-durable medical supplies such as foley catheters, dressings and leg bags • Repair or replacement of purchased equipment.	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.*	*All charges*
Chiropractic	
Up to 26 visits; treatment plan is required	In-network: $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Alternative treatments	
No benefit	*All charges*
Educational classes and programs	
• Childbirth classes Note: Members may submit a receipt and the Plan will reimburse charges up to $100.	All charges after $100
• Diabetes education classes	In-network: $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
• Nutritional counseling related to Diabetes from a dietician	In-network: $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs (cont.)	
• Smoking cessation – Quit for Life/WellBeing	Nothing
Not covered: Weight loss program.	*All charges*

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.
- The deductible is $1,250 for Self Only enrollment and $2,500 for Self and Family enrollment for in-network benefits and $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment for out-of-network benefits each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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 FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) • Vertical-banded gastroplasty (gastric stapling), and roux-en-y gastric bypass (Roux-en-Y) of morbid obesity will be covered by Group Health Plan when all of the following criteria are met. A complete description of our policy, including contraindications, and requirements following the scheduled surgery, is available. - The patient is an adult (> 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity.	In-network: $15 per visit to a primary care physician; $25 per visit to a specialist; 10% of the Plan allowance for inpatient or outpatient surgery Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
- There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions. • 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 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.	In-network: $15 per visit to a primary care physician; $25 per visit to a specialist; 10% of the Plan allowance for inpatient or outpatient surgery Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Replacement of penile prosthesis.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Scar revision.*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures • Non-dental treatment of Temporomandibular joint (TMJ) pain dysfunction syndrome	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)*	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	
• *Dental care involved in the treatment of TMJ.*	*All charges*
Organ/tissue transplants	
Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Kidney/Pancreas • Intestinal transplants • Small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach and pancreas	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Blood or marrow stem cell transplants limited to the stages of the following diagnoses; medical necessity limitation is considered satisfied for other tissue transplants if the patient meets staging description: • Allogeneic (donor) 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 disease - 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 bone marrow transplants for recurrent germ cell tumors (including testicular cancer) Blood or marrow stem cell transplants for: • Allogeneic (donor) transplants for - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced myelodysplastic syndromes (e.g., DeNovo, secondary, high dose) not previously treated	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Advanced neuroblastoma - Infantile malignant osteopetrosis - Mucolipidosis (e.g., adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillipo's syndrome, Maroteaux-Lamy syndrome variants) • Autologous transplants for - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors - Breast cancer - Multiple myeloma - Epithelial ovarian cancer	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
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 • Allogeneic transplants for - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Chronic and juvenile myelomonocytic leukemia • Nonmyeloablative allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkins lymphoma - Advanced non-Hodgkins 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 - Sarcomas • Autologous transplants for	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Multiple myeloma - Amyloidosis (single) - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Systemic sclerosis • National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Non-human organs* • *Hair transplants.*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Professional services provided in – • Office	In-network: Nothing Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: Anesthesia for dental procedures.	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,250 for Self Only enrollment and $2,500 for Self and Family enrollment for in-network benefits and $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment for out-of-network benefits each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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 FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment and any covered items billed by a hospital for use at home	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary.*	*All charges*
Outpatient hospital or ambulatory surgical center	
• 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 Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: • *Storage of blood donated before surgery* • *Designated donor fees.*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
• Extended care benefit • Skilled nursing facility (SNF) Up to 30 days per calendar year when full-time skilled nursing care is necessary and confinement is medically appropriate as determined and approved by the Plan.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: Custodial care.	*All charges*
Hospice care	
Inpatient and home health care when authorized and approved by the Plan	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: Independent nursing, homemaker services.	*All charges*

Benefit Description	You Pay
Ambulance	
• Local professional ambulance service when medically appropriate • Air ambulance when medically necessary and approved by the Plan Note: Ambulance coverage in non-emergency situations must be prior authorized.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

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.
- The deductible is $1,250 for Self Only enrollment and $2,500 for Self and Family enrollment for in-network benefits and $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment for out-of-network benefits each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

If you are in an emergency situation, please call your health care advisor. In medical emergencies, if you are unable to contact your health care advisor, contact the local emergency system (e.g. the 911 telephone system) or go to the nearest emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified. If you need to be hospitalized in a non-Plan facility, the Plan should be notified by you or a family member within 48 hours unless it is not reasonably possible to do so.

Emergencies within our service area: $100 copay per visit after deductible; waived if the patient is admitted

Emergencies outside our service area: $100 copay per visit after deductible; waived if the patient is admitted

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• Emergency care at a doctor's office	$15 per visit to a primary care physician; $25 per visit to a specialist
• Emergency care at an urgent care center	$50 per visit
• Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit
Not covered: Elective care or non-emergency care.	*All charges*

Benefit Description	You pay After the calendar year deductible…
Emergency outside our service area	
• Emergency care at a doctor's office	In-network: $15 per visit to a primary care physician; $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
• Emergency care at an urgent care center	$50 per visit
• Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges*
Ambulance	
• Professional ambulance service when medically appropriate • Air ambulance when medically necessary and approved by the Plan Note: See 5(c) for non-emergency service.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: Non-emergency use of ambulance without Plan authorization.	*All charges*

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 to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,250 for Self Only enrollment and $2,500 for Self and Family enrollment for in-network benefits and $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment for out-of-network benefits each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- 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 FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists or clinical social workers • Medication management	In-network: $25 per visit to a specialist Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
• Diagnostic tests	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, full-day hospitalization, facility based intensive outpatient treatment	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount
Not covered: Services we have not approved.	*All charges*

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.)	
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	*All charges*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

Please call GHP's Behavioral Health Line toll-free at 877-227-3520 to access mental health and substance abuse services. GHP's Behavioral Health Line provides 24-hour access for these benefits. The Behavioral Health Line will be able to help you identify participating providers and initiate referral procedures.

Limitation

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

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,250 for Self Only enrollment and $2,500 for Self and Family enrollment for in-network benefits and $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment for out-of-network benefits each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating local pharmacy or for maintenance medications, through the mail order benefit or at a participating 90-day pharmacy. Our participating pharmacies are listed in the GHP directory.
- **We use a formulary.** A formulary is a list of specific generic and brand name prescription drugs authorized by the Plan and subject to periodic review and modification. The purpose of the formulary is to assist physicians in prescribing cost effective, quality drug therapy for members. Drugs from all therapeutic groups are available on the drug formulary. The formulary has a mandatory generic policy when there is a generic medication that has been proven by the FDA to be equivalent of the name brand. If a member or physician prefers the name brand or non-formulary drug when a generic is available, the member will be charged the difference in cost plus the copayment. Since there is a copayment for non-formulary drugs, there will be no exceptions to the formulary. If a doctor prescribes a non-formulary drug, you can go back to the doctor and ask them to prescribe something from the formulary or pay the higher copayment. You may obtain a copy of our formulary list by contacting our Member Services department or by visiting our Web site at www.ghp.com.
- **We cover non-formulary drugs prescribed by a Plan doctor.** We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-755-3901.
- **These are the dispensing limitations.** You may obtain up to a 31-day supply or 100-unit supply (whichever is less) at a participating retail Plan pharmacy. Prescriptions dispensed as a unit (such as 1 box, 1 tube, 1 inhaler) will have a copayment per unit. Selected products or prescription drugs may require prior approval from the Plan or have quantity limits (such as Imitrex or sexual dysfunction drugs). Please have your doctor call for prior approval. When a generic substitution is permissible but you or your doctor request the name brand drug, you pay the price difference between the generic drug and name brand drug, as well as the appropriate copay per prescription unit or refill. Your prescription drug copay will never exceed the retail price of the drug.
- **Prescriptions by Mail Order.** GHP's mail order program and participating 90-day pharmacies will dispense a 90-day supply (when the prescription is written for 90 days) for two copayments. Simply ask your physician to write your maintenance medication prescription for at least a 90-day supply. Complete a mail order form (available through Member Services) or go to a participating 90-day pharmacy. For commercially prepackaged drugs such as topicals, inhalers and vials, you will pay the appropriate copay for each container. Please note that not all maintenance medications are available by mail order.

- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding name brand drug. Generic drugs are less expensive than name brand drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When do you have to file a claim?** You will only have to file a claim if you are out of our service area and unable to use one of the national chains participating in the Plan in an emergency situation. In this case, please submit an itemized bill to GHP with an explanation and we will reimburse you all but your copayment.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to disposable syringes, blood glucose strips and diabetic lancets for members on insulin for use in the treatment of diabetes • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see *Prior authorization*) • Contraceptive drugs and devices • Self-injectable medications Note: Self-injectable medications are provided by Caremark Therapeutics.	**At a Plan Retail Pharmacy:** $15 copay for generic formulary $25 copay for name brand formulary $50 copay for non-formulary or **Through our Mail Order Pharmacy:** $30 copay for generic formulary $50 copay for name brand formulary $100 copay for non-formulary Out-of-network: All charges. Note: Prescriptions must be filled at a participating pharmacy. Note: If there is no generic equivalent available, you will still have to pay the name brand copay.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medical supplies such as dressings and antiseptics* • *Diabetic supplies not listed as covered* • *Smoking cessation drugs and medication including nicotine patches* • *Drugs for weight loss* • *Refills for prescriptions resulting from loss or theft*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
• *Prescription drugs for travel.*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage*.
- Plan contracted oral maxillofacial specialists must provide or arrange your care.
- The deductible is $1,250 for Self Only enrollment and $2,500 for Self and Family enrollment for in-network benefits and $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment for out-of-network benefits each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- 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.

Accidental injury benefit	You pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance and any differences between our allowance and the billed amount

Dental benefits	You pay
Dental benefits	
We have no other dental benefits.	

Section 5(h). Special features

Feature	Description
24 hour nurse line	We offer a 24 hour nurse line to provide clinical and economic advice to help you make informed decisions. Registered nurses will interpret clinical information, help you develop a list of questions to ask your physician, and help you to understand the available quality tools and indicators. The toll-free number is 888-662-2997.
Flexible benefits option	• Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	The TDD toll-free number is 877-231-0573 for people who have difficulties with hearing or speech. You do need special equipment to use the TDD number.
Complex case management	GHP's Complex Case Management Department is staffed with registered nurses and social workers who are assigned to oversee the care of members with complex, chronic or catastrophic illnesses. The Complex Case Managers develop member-specific online care coordination plans that can be accessed by all Complex Case Managers and Disease Managers. The Complex Case Managers monitor the member's progress toward their goals and make adjustments to the care coordination plan as necessary.
Disease management programs	GHP offers disease-specific programs for high risk pregnancy, asthma, diabetes, congestive heart failure and chronic obstructive pulmonary disease. Members identified for these programs receive disease-specific educational mailings, preventive health mailings, and telephonic reminders. These programs are supported by a wide range of educational material and are staffed by registered nurses and social workers.
Centers of excellence	GHP provides members with access to nationally recognized transplant programs. The programs are "Centers of Excellence" offering members quality transplant services. GHP provides the opportunity for members to have access to some of the nation's leading transplant centers.
WellBeing	GHP is committed to supporting our members' health. Through our *WellBeing* program, we provide education materials and wellness programs that support our members' efforts to take accountability for their health and prevent illness. All members are encouraged to take advantage of a health risk assessment (HRA) every year. You will receive a comprehensive report upon completion. Get all of this and more through My Online Services at www.ghp.com.

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources	We publish an e-newsletter, *Living Well,* to keep you informed on a variety of issues related to your good health. Past editions of this publication are also available on our Web site. Visit our Web site at www.ghp.com for information to help you take command of your health. This section is organized in simple, user-friendly, sections: • ***Assess Your Health***– where you will find a simple, free, online health risk assessment tool to benchmark your wellness and better understand your overall health status and risks. • ***About Your Health***– for information about a specific condition or general preventive guidelines. • ***Patient Safety*** • ***WebMD***– our link to this health site also provides wellness and disease information to help improve health. • ***Prescription Drugs***- educational materials are also accessible through our Web site, through a link to our pharmacy benefit manager, Caremark. There, you will find: - Detailed information about a wide range of prescription drugs; - A drug interaction tool to help easily determine if a specific drug can have any adverse interactions with each other, with over-the-counter drugs, or with herbals and vitamins; - Facts about why FDA-approved generic drugs should be a first choice for effective, economical treatment. Another key health information tool that we make available to you is our online quality tools, powered by Ingenix. You can review the frequency of procedures performed by a provider, knowing the correlation between frequency of service and quality of outcomes. We post additional quality outcome information such as re-admission rates within 30 days, post-operative complications and even death rates. In addition, we augment our health education tools with access to our Nurse Advisor Services. Experienced RNs are available through an inbound call center 24 hours a day, 7 days a week, 365 days a year to assist you and help you to maximize your benefits by providing clinical and economic information to make an informed decision on how to proceed with care.
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through www.ghp.com. • Your balance will also be shown on your explanation of benefits (EOB) form. • You will receive an EOB after every claim. • If you have an **HSA**, - You will receive a quarterly statement by mail outlining your account balance and activity for the month. - You may also access your account and review your activity on a daily basis online via My Online Services at www.ghp.com. • If you have an **HRA**, - You will receive a quarterly statement by mail outlining your account balance and activity for the month. - You may also access your account and review your activity on a daily basis online via My Online Services at www.ghp.com.

Special features	Description
Consumer choice information	• As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Our provider search function on our Web site (www.ghp.com) is updated every week. It lets you easily search for a participating physician based on the criteria *you* choose, such as provider specialty, gender, secondary languages spoken or hospital affiliation. You can even specify the maximum distance you're willing to travel and, in most instances, get driving directions and a map to the offices of identified providers. • Pricing information for medical care is available at www.ghp.com. There, you will find our ***Health Services Pricing Tools*** which provide average cost information for some of the most common categories of service. The easy-to-understand information is sorted by categories of service including physician office visits, diagnostic tests, surgical procedures and hospitalization. • Pricing information for prescription drugs is available through our link to the Web site of our pharmacy benefit manager, Caremark (which you can access via www.ghp.com). Through a password-protected account, you will have the ability to estimate prescription costs before ordering. • Link to online pharmacy through the Web site of our pharmacy benefit manager, Caremark (which you can access via www.ghp.com). • Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.ghp.com.
Care support	• Our complex case management programs offer special assistance to members with intricate, long-term medical needs. Our disease management program fosters a proactive approach to managing care from prevention through treatment and management. Your physician can help arrange for participation in these programs, or you can simply contact our Member Service Department. • Patient safety information is available online at www.ghp.com. • Care support is also available to you in the form of a relationship that we have established with the College of American Pathologists for e-mail reminder notifications. We'll send a message to the e-mail address you provide on a scheduled basis reminding you to arrange for screening tests.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 800-755-3901 or visit their website at www.ghp.com.

MEMBERS CHOICE PROGRAM

GHP offers members a health care program called Members Choice for a nominal fee of $50. Through this program, GHP members have additional choices for a healthier lifestyle. Members Choice features discounts on massage therapy, acupuncture, dietary supplements and vitamins, as well as health club memberships at a reduced rate. Members Choice is offered through GHP's relationship with American Specialty Health Networks (ASHN). To find a contracted provider or fitness club in your area, visit GHP's Web site at www.ghp.com and click on the Members icon, then Member Benefit Information, then Members Choice. Or you may call ASHN Member Services toll-free at 877-355-2746 for assistance.

VOLUNTARY DENTAL PROGRAM

With your continued or new enrollment with GHP for 2008, you have the opportunity to select a low-cost voluntary dental program offered by CompDent. Highlights of the benefits available with this plan are as follows:

- No waiting periods
- No deductible
- No benefit maximum
- No claims to file
- Oral evaluations at no charge
- X-rays at no charge
- Cleanings – once every six months at no charge
- Basic and major services
- 25% discount for specialty services including orthodontia

COST PER MONTH: Employee Only $7.66 Employee + Family $17.04

If you choose to enroll in this value-added benefit, the cost for single coverage or family coverage will be automatically deducted from your checking account on a monthly basis, or you may pay on an annual basis by using a major credit card. Participation is voluntary so you will not be automatically enrolled in this program.

For more information regarding this voluntary dental program, please refer to the CompDent introduction letter in your GHP enrollment packet.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your doctor determines it is medically necessary to prevent, diagnose or treat your illness, disease, injury or condition (see specifics regarding transplants).**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

You may be responsible for filing a claim when you receive 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 800-755-3901.

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: ***Group Health Plan, PO Box 7374, London, KY 40742-7374***

Prescription drugs

Submit your claims to: ***Group Health Plan, Attn: Pharmacy Department, 550 Maryville Centre Drive, Suite 300, St. Louis, MO 63141-5818***

Other supplies or services

Submit your claims to: ***Group Health Plan, PO Box 7374, London, KY 40742-7374***

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. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Group Health Plan, Attn: Member Correspondence Unit, 550 Maryville Centre Drive, Suite 300, St. Louis, MO 63141-5818; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call.

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

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

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

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

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

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

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

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-755-3901 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 has coverage under any other health plan or has 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. Your care must continue to be arranged by the GHP participating physician or the Plan.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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. To find out if you need to do something to file your claim, call us at 800-755-3901 or see our Web site at www.ghp.com.

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

- **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.

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

TRICARE and CHAMPVA	TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs. **Suspended FEHB coverage to enroll in TRICARE or CHAMPVA**: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.
Workers' Compensation	We do not cover services that: • You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or • OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws. Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.
Medicaid	When you have this Plan and Medicaid, we pay first. **Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.
When other Government agencies are responsible for your care	We do not cover services and supplies when a local, State or Federal government agency directly or indirectly pays for them.
When others are responsible for injuries	If it is determined that another party is responsible for your injuries (i.e., car accident) and damages are payable, GHP will seek reimbursement for benefits paid. This is called subrogation. If you need more information, contact us for our subrogation procedures.
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage	Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, 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.

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 15.

Copayment — A copayment is a fixed amount of money you pay when you receive covered services. See page 15.

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

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

Custodial care — Care that is provided primarily for the purpose of helping the plan member with activities of daily living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. Examples of custodial care include rest cures, respite care and home care. See *Long Term Care* for information that can help you with custodial care.

Deductible — A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.

Experimental or investigational service — A drug device, treatment, therapy, procedure, service or supply of any kind whatsoever (a "Service") that:

1. cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at that time of use or proposed use, and/or
2. is the subject of a current investigational new drug or new device application on file with the FDA, and/or
3. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings or that further research is needed in order to define safety, toxicity, efficacy, or effectiveness of that service compared with conventional alternatives.

Group health coverage — A corporation, partnership, union or other entity that is eligible for group coverage under State or Federal laws and which enters into Agreement with the Plan to offer coverage to employees and their eligible dependents.

Medical necessity — Services which are provided for the diagnosis or care and treatment of a medical condition; appropriate and necessary for the symptoms, diagnosis or treatment of that condition; rendered within standards of generally accepted medical practice; not primarily for the convenience of you, your family or a provider; and performed in the most appropriate setting manner for treating your condition, as determined by the Medical Director.

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:

Group Health Plan determines the plan allowance with each participating provider based upon negotiated charges contained within the provider's participation agreement. The negotiated charge represents the amount a participating provider must accept as payment in full for covered services provided to Plan members.

Us/We — Us and We refer to Group Health Plan.

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

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	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.
Catastrophic limit	You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles reach the limit in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance). Refer to HDHP Section for more details.
Health Reimbursement Arrangement (HRA)	An HRA is a personal health account funded by the employer and used by the employee to cover out-of-pocket health care expenses such as deductibles. Employees decide how the money will be spent and have a greater interest in how health care dollars are spent.
Health Savings Account (HSA)	An HSA is a tax-exempt saving account that is used to pay for an eligible member's qualified medical expenses. HSA funds can be used for non-medical expenses but are then subject to taxes and penalties. To be eligible for an HSA, the subscriber must be enrolled in a Qualified High Deductible Health Plan (QHDHP).
Premium contribution to HSA/HRA	A premium contribution is the portion of the total health plan premium which is automatically passed through monthly to your HSA or HRA account based upon your eligibility as of the first day of the month.

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 Benefits,* brochures for other plans and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

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

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

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

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

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2008 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 2007 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **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 Benefits 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 Benefits 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 **Federal Employees Dental and Vision Insurance Program(FEDVIP**), provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). 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. **Annuitants are not eligible to enroll.**

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 (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any 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 any other insurance.

Dependent Care FSA (DCFSA) – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependants unable to care for themselves 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.

Where can I get more information about FSAFEDS?

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.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all 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 up to a 24-month waiting period.

Vision Insurance

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

Additional Information

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.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

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

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Summary of benefits for the High Option of Group Health Plan - 2008

- **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: $25 per office visit	20
Services provided by a hospital:		
• Inpatient	$200 per admission with a $400 maximum per year	36
• Outpatient	$150 per visit for outpatient surgery	37
Emergency benefits:		
• In-area	$25 per office visit; $100 emergency room (waived if admitted); $75 urgent care	39
• Out-of-area	$25 per office visit; $100 emergency room (waived if admitted); $75 urgent care	40
Mental health and substance abuse treatment:	Regular cost sharing	41
Prescription drugs:		44
• Retail pharmacy	$10 generic formulary; $20 name-brand formulary; $45 non-formulary	
• Mail order	$20 generic formulary; $40 name-brand formulary; $90 non-formulary	
Dental care:	$25 copay for restortive services due to accidental injury	46
Vision care:	$25 per office visit at contracted vendor	25
Special features:	Flexible benefits option, services for deaf and hearing impaired, complex case management, disease management programs, centers of excellence, and WellBeing.	47
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $2,500 Self Only or $5,000 Family enrollment per year Some costs do not count toward this protection	15

Summary of benefits for the Standard Option of Group Health Plan - 2008

- **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 the 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	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $30 specialist	20
Services provided by a hospital:		
• Inpatient	$500 copay per day up to a $1,000 maximum then 20% coinsurance per admission	36
• Outpatient	$500 per visit for outpatient surgery	37
Emergency benefits:		
• In-area	$15 primary care; $30 specialist; $100 emergency room (waived if admitted); $50 urgent care	39
• Out-of-area	$15 primary care; $30 specialist; $100 emergency room (waived if admitted); $50 urgent care	40
Mental health and substance abuse treatement:	Regular cost sharing	41
Prescription drugs:		44
• Retail pharmacy	$12 generic formulary; $30 name-brand formulary; $50 non-formulary	
• Mail order	$24 generic formulary; $60 name-brand formulary; $100 non-formulary	
Dental care:	$15 primary care; $30 specialist for restorative services due to accidental injury	46
Vision care:	$30 specialist per office visit at contracted vendor	25
Special features:	Flexible benefits option, services for deaf and hearing impaired, complex case management, disease management programs, centers of excellence, and WellBeing.	47
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $3,000 Self Only or $6,000 Family enrollment per year Some costs do not count toward this protection	15

Summary of benefits for the HDHP of Group Health Plan - 2008

Do not rely on this chart alone. All benefits are subject to the definitions, limitations and exclusions in this brochure. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

You must satisfy your calendar year deductible of $1,250 for Self Only and $2,500 for Self and Family in-network or $2,500 for Self Only and $5,000 for Self and Family out-of-network for HDHP benefits with the exception of preventive services. Once you satisfy your calendar year deductible, Traditional medical coverage (indicated with an asterisk (*) below) begins.

HDHP Benefits	You Pay	Page
In-network medical and dental preventive care	IN: $15 PCP/$25 SPC; OON: 30% of covered expenses	59
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office*	IN: $15 PCP/$25 SPC; OON: 30% of the Plan allowance and any difference between our allowance and the billed amount	63
Services provided by a hospital:		
• Inpatient* • Outpatient*	IN: 10% of the Plan allowance; OON: 30% of the Plan allowance and any difference between our allowance and the billed amount	76 77
Emergency benefits:		
• In-area*	IN: $15 PCP/$25 SPC; $100 OP facility; $50 urgent care; 10% of the Plan allowance inpatient services	79
• Out-of-area*	IN: $15 PCP/$25 SPC; $100 OP facility; $50 urgent care; 30% of the Plan allowance and any difference between our allowance and the billed amount inpatient services	80
Mental health and substance abuse treatment*:	Regular cost sharing	81
Prescription drugs:		84
• Retail pharmacy*	$15 generic formulary; $25 name brand formulary; $50 non-formulary	
• Mail order*	$30 generic formulary; $50 name brand formulary; $100 non-formulary	
Dental care*:	IN: $15 PCP/$25 SPC for restorative services due to accidental injury; OON: 30% of the Plan allowance and any difference between our allowance and the billed for restorative services due to accidental injury	86
Vision care*:	IN: $25 SPC at contracted vendor; OON: All charges	66
Special features:	24 hour nurse line, flexible benefits option, services for deaf and hearing impaired, complex case management, disease management programs, centers of excellence, and WellBeing	87
Protection against catastrophic costs (out-of-pocket maximum):	IN: Nothing after $5,000 Self Only or $10,000 Family enrollment per year; OON: Nothing after $10,000 Self Only or $20,000 Family enrollment per year. Some costs do not count toward this protection.	15

2008 Rate Information for Group Health Plan

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

Postal Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees,* RI 70-2, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call.

Human Resources Shared Service Center

1-877-477-8273, Option 5

TTY: 1-866-260-7507

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	MM1	145.04	125.60	314.25	272.14	101.42	99.41
High Option Self and Family	MM2	329.30	255.32	713.48	553.20	200.44	195.86
Standard Option Self Only	MU4	145.04	105.13	314.25	227.79	80.95	78.94
Standard Option Self and Family	MU5	329.30	211.07	713.48	457.32	156.19	151.61
HDHP Option Self Only	MM4	145.04	71.46	314.25	154.83	47.28	45.27
HDHP Option Self and Family	MM5	329.30	135.14	713.48	292.81	80.26	75.68