GHI Health Plan

http://www.EMBLEMHEALTH.com

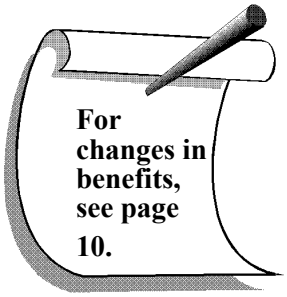
2012

A Prepaid Comprehensive Medical Plan

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

Standard Option Plan Serving: New York City plus most New York Counties, and Northern New Jersey

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



Enrollment codes for this Plan:

801 High Option – Self Only
802 High Option – Self and Family

804 Standard Option – Self Only
805 Standard Option – Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from the GHI Health Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that the GHI 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 (October 15th thru December 7th) 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 1-877-486-2048).

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Introduction

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

Group Health Incorporated
441 Ninth Avenue
New York, NY 10001

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized beginning 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 easy to understand. Here are some examples:

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 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 (FEHB) premium.

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

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

- Do not give your plan identification (ID) over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) forms that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-888-456-3728 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, 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 age 26 or over (unless he/she was disabled and incapable of self support prior to age 26.)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have seperated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsiblity to know when you or a family member is no longer eligible to use your health insurance coverage.

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

3. Get the results of any test or procedure.

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

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

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

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

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

Patient Safety Links

- www.ahrq.gov/consumer. 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 healthcare 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 healthcare professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use GHI providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs neither your FEHB plan nor you will incur cost to correct the medical error.

Section 1. Facts about this Prepaid Plan

This Plan offers two distinct benefit packages, High Option Preferred Provider Option (PPO) with Point of Service (POS) coverage and Standard Option Exclusive Provider Option (EPO) coverage. GHI seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, we can afford to offer a comprehensive range of benefits.

We strongly encourage you to select a personal GHI participating doctor who will provide and/or arrange your care within the Plan's participating provider network. This will ensure that you pay only the designated deductible, copayment, or coinsurance for all covered services. GHI is solely responsible for the selection of the providers in our service area. Please contact us for a copy of our most recent provider directory or visit us online at www.emblemhealth.com for the most up-to-date information on our provider network.

In addition to providing comprehensive health care services for illness and injury, we emphasize preventive benefits such as routine office visits, physicals, immunizations, and well-baby care. We encourage you to seek medical attention at the first sign of illness. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network. If you are enrolled in the High Option with POS coverage, you may seek treatment outside our participating provider network. However, you will pay a substantial portion of the charges for electing non-participating providers and the available benefits may not be as comprehensive as benefits within the GHI network.

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

Both options (High and Standard) are "non-grandfathered" under the Affordable Care Act. This means that both options satisfy the immediate health care reforms legislated by the Affordable Care Act. Specifically, we provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at 212/501-4GHI (4444). You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General Features of our High Option with POS coverage

The enrollment codes for the High Option with POS are 801 (Self only) and 802 (Self and Family). If you are enrolled in our High Option with POS coverage, you have access to in-network covered care from participating providers under our Preferred Provider Option (PPO) or you may obtain covered care for certain services from non-network providers under POS benefits. Please refer to Section 5(i) High Option Point of Service Benefits for specific information on the POS coverage. Our High Option coverage offers a PPO network(s) of participating providers and uses provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long term cost savings. Your out-of-pocket costs are lower when you seek covered care from within our PPO network because participating providers have agreed to accept GHI's schedule of allowances or negotiated rate as payment in full for a covered service. You will only owe your deductible, copayment and/or coinsurance for covered services.

The High Option coverage POS feature allows you freedom of choice in seeking care from non-network providers. However, your out-of-pocket costs are much higher as covered care will be subject to a deductible, copayment, and coinsurance plus any portion of the charge that exceeds our fee schedule allowance for a covered service. Non-network providers do not have a contract with us and have not agreed to accept GHI's allowance or negotiated rate as payment in full. Consequently, you owe all balances after we determine our payment for services from non-network or non-participating providers.

General Features of our Standard Option coverage

The enrollment codes for the Standard Option coverage are 804 (Self only) and 805 (Self and Family). If you are enrolled in our Standard Option coverage, you have access to covered care only from within our network participating providers under our Exclusive Provider Option (EPO). We will not cover care that you receive from non-network (non-participating) providers. Contracted providers within our EPO network have agreed to accept our schedule of allowances or negotiated rate as payment in full for a covered service. Our EPO offers a network(s) of participating providers and uses provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long term cost savings. Since you must seek care from within the EPO network, you will only owe your deductible, copayment and/or coinsurance for covered services. You are not responsible for balances that exceed our payment for covered services from EPO network providers.

How we pay providers

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

When you use a participating hospital, keep in mind that the professionals who provide services to you in the hospital may not all be participating providers. When you receive non-emergency services at a participating hospital but are seen by a non-participating anesthesiologist, radiologist, pathologist, or assistant surgeon, we will calculate payment based on an allowance that we determine under the High and the Standard options. Our allowance may not cover the full charges and you will owe that portion of the charges that exceeds our payment. This policy does not apply to services that you receive at non-participating hospitals.

When you use non-participating hospitals for covered care under the High option, we will apply POS benefits to covered services from all non-participating providers which means that our allowance will be 50% of the fee schedule. You are responsible for all charges that exceed our payment which could be a considerable expense. **Under the Standard Option benefit package, we do not cover care from non-participating providers** and will not pay them for covered services even if Medicare is your primary health insurance coverage. To get full maximum use of the Standard Option package, you must use GHI's participating EPO provider network for all covered services.

Please refer to the emergency benefits for information concerning emergency services.

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 website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- GHI is URAC-accredited and is licensed under Article 43 of the New York State Insurance Law as a health services corporation.
- GHI has been in continuous existence for over seventy (70) years.
- GHI is a New York corporation.

If you want more information about us, call 212/501-4GHI (4444), or write to GHI, PO Box 1701, New York, NY 10023-9476. You may also visit our website at www.emblemhealth.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 with us in the High Option you must live or work in our service area. Our service area is: all of New York and the New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union.

To enroll with us in the Standard Option, you must live or work in our service area. Our service area is: New York City (the Boroughs of Manhattan, Brooklyn, Bronx, Queens, and Staten Island) all of Nassau, Suffolk, Rockland, Westchester Brrome, Cayuga, Chemung, Columbia, Cortland, Delaware, Dutchess, Franklin, Greene, Hamilton, Herimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Orange, Oswego, Ostego, Putnam, St. Lawrence, Schuyler, Steuben, Sullivan, Tioga, Tompkins, Ulster , New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union.

With the Standard Option, 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 moves 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 moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2012

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.

Program-wide changes:

- Sections 3, 7, and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to High Option:

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See the rates that appear on the back cover of this brochure.

Changes to Standard Option:

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See the rates that appear on the back cover of this brochure.
- GHI will eliminate the $50 annual prescription drug deductible. See Section 5(f) Prescription Drug Benefits.
- The generic prescription drug copay will be $5 per 30-day supply from a retail pharmacy. The mail-order copay for generic maintenance drugs will be $12.50.

Changes to both High and Standard Options:

- Private Duty Nursing is no longer a covered benefit.
- The Plan will eliminate the $25,000 combined annual maximum for durable medical equipment and orthopedic/prosthetic devices. See Section 5(a).
- We will provide benefits for up to ten out-of-area hemodialysis treatments performed by non-participating providers.

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. Your member ID card will indicate the provider network that is applicable to your coverage. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 212/501-4GHI (4444). You may also request replacement cards through the GHI website, www.emblemhealth.com

Where you get covered care

You get care from "Plan providers" and "Plan facilities." Network providers file claims for you and we reimburse them directly for covered services. You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you are enrolled in our High Option with POS Plan, you may also seek care from non-Plan providers but you will have higher out-of-pocket costs than if you had obtained care within the network and you are responsible for filing a claim to GHI. Under the Standard Option coverage, we will not provide benefits for services that you receive from non-network providers.

- **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.

Your ID card will indicate the GHI network for your coverage. We list Plan providers in the provider directory, which we update periodically. The list is also on our website. We recommend that you confirm that the provider is a participating network provider prior to seeking services or upon scheduling an appointment.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. Your ID card will indicate the GHI network for your coverage. We list Plan facilities in the provider directory, which we update periodically. The list is also on our website. We recommend that you confirm that the plan facility is a participating network provider prior to seeking services or upon scheduling an appointment.

What you must do to get covered care

Whether you are enrolled in the High Option with POS or the Standard Option coverage, you are free to choose any participating provider within your Plan's GHI network. We strongly encourage you to select a doctor within the GHI network who will provide or arrange your care.

- **Primary care**

You may seek care from a doctor, dentist, podiatrist, qualified clinical psychologist, optometrists, chiropractor, nurse, certified midwife, nurse practitioner/clinical specialist, or qualified clinical social worker and any other duly-licensed, registered or certified practitioner or privately-operated facility permitted to perform or render care or service described in this brochure.

- **Specialty care**

You may see the specialist whenever you and your family feel you need care.

Here are other things you should know about specialty care:

- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

- reduce our service area and you enroll in another FEHB Plan

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact 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**

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 212/501-4GHI (4444). 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.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertifcation) and for other services are detailed in this section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval, or referral.

- **Inpatient hospital admission**

Pre-certification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. We perform pre-admission review for all non- emergency hospitalizations and must be notified of emergency hospital admissions within a specified time frame. GHI's Coordinated Care Department will review the proposed hospital confinement to determine the length of stay in addition to confirming the medical necessity of hospitalization.

Your physician must obtain precertification for the following services:

- Skilled Nursing Facility
- All elective or non-emergency hospital admissions

You do not need precertification in the following situations:

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

Warning: If no one contacts us for precertification and we determine that the hospital admission is not medically necessary, we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

- **Other services**

For certain services, you or your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, is medically necessary, and follows generally accepted medical practice. If your physician does not contact us, we will not pay for the services. You or your physician must obtain prior approval for the following services:

- Organ/tissue transplants
- High-tech radiology
- High-tech nursing
- Infusion therapy
- Mental Health and Substance Abuse
- Infertility Services
- Bariatric Surgery
- Growth Hormone Therapy

How to request precertification for an admission or get prior approval for Other services

When you use a network provider for covered services, the network provider will initiate the precertification or prior approval process on your behalf. You, a family member, or your physician must contact GHI's Coordinated Care Program at 800-223-9870 for precertification of the hospital admission:

- At least ten (10) days prior to the date of admission of elective procedures, or as soon as reasonably possible;
- Within two (2) business days of an emergency admission, or as soon as reasonably possible.

Under the High Option with POS, you are responsible for ensuring that your hospital admission has been precertified or your admission will be subject to a penalty in addition to costs that you normally pay. To precertify your hospital admission call GHI's Coordinated Care Department at 800-223-9870.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

We do not require precertification of hospital admissions for delivery.

- **If your treatment needs to be extended**

If your physician requests an extension of an ongoing course of treatment at lease 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

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

Failure to comply with pre - admission review or the concurrent review will result in the following reductions in health benefit reimbursment: $125 per day to a maximum of $250 per confinment as long as we determine that the inpatient admission or service was medically necessary.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a post-service claim and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. 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.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditions methods.

• **To file an appeal with OPM**	After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.
Circumstances beyond our control	Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to assist you with the necessary care.

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 network provider, facility, pharmacy, etc. when you receive certain covered services.

Example: When you see your primary care physician you pay a copayment of $15 per office visit under the High Option and a $25 per office visit under the Standard Option.

Cost-sharing

A comprehensive term for the deductible, copayment, and coinsurance provisions of the coverage.

Deductible

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

The calendar year deductible for certain services is:

- For orthopedic and prosthetic devices, oxygen and other covered durable medical equipment you pay an annual deductible of $100 per individual or family.

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

A percentage of GHI's allowance(s) payable by you for covered services. Expenses credited toward your deductible, copayments, and charges for non-covered services are not considered to be coinsurance.

Differences between our Plan allowance and the bill

When you use network providers, you are not responsible for differences between GHI's allowance and the provider's charge. Non-network providers do not have an agreement with GHI to accept the GHI allowance as payment in full. Under the High Option with POS coverage, you are responsible for any amount of the charge that exceeds our payment for services from non-network providers. The GHI fee schedule allowance for POS services is 50% of the GHI fee schedule allowance for services provided by non-participating providers. See *"Section 5(i) High Option Point of Services (POS) Benefits"* for more information.

Your catastrophic protection out-of-pocket maximum

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

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

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

Carryover

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

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

When Government facilities bill Us

Facilities of the Department of Veterans Affairs, 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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 10 for how our benefits changed this year and pages 76 and 77 for 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

We offer two different benefits packages. We offer High Option with POS and Standard Option. We describe the available benefits under each package in Section 5 of this brochure. Make sure that you review the benefits that are available under the option in which you are enrolled. The enrollment codes for the High Option with POS are 801 Self Only and 802 Self and Family. The enrollment codes for Standard Option are 804 Self Only and 805 Self and Family.

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 212/501-4GHI (4444) or at our Web site at www.emblemhealth.com.

High Option with POS features:

- Access to GHI's network of participating Preferred Provider Option (PPO)
- $15 copayment per office visit to participating network doctors
- Nothing for surgery (office visit may be subject to the office visit copay)
- $100 per covered inpatient admission at participating hospitals
- Nothing for up to 30 days of GHI approved skilled nursing facility benefits
- POS benefits for certain services from non-network providers (See Section 5(i) for specific information)

Standard Option features:

- Access to GHI's Exclusive Provider Option (EPO) network
- $25 copayment per office visit to participating network doctors
- No copayment for pediatric and primary care office visits, specialty care visits, lab tests and x-rays for dependent children who are under the age of 26 as long as the services are performed by a participating network provider.
- Nothing for surgery (office visit may be subject to the office visit copay)
- $250 per day up to a maximum of $750 per admission for covered inpatient hospital admissions
- Nothing for up to 30 days of GHI approved skilled nursing facility benefits

Both Options offer the following unique features:

- Flexible benefit options
- Large Case Management
- Disease Management
- Customer Service AnswerLine
- Services for deaf and hearing impaired
- Coverage for high risk pregnancies
- Centers of excellence for transplants/heart surgery/etc.
- Travel benefit/services overseas

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- POS benefits apply only if you are enrolled in the High Option coverage.
- 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	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers Nothing per office visit for children (under age 26) for participating providers All charges for non-participating providers
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion • Routine physical examination every year	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers Nothing per office visit for children (under age 26) for participating providers All charges for non-participating providers
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	Nothing for participating providers All charges for non-participating providers
• At home	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers Nothing for children (under age 26) for participating providers All charges for non-participating providers

Benefit Description	You pay	
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	$15 per each diagnostic x-ray + laboratory test performed by a participating provider (a maximum of two diagnostic copays will apply per date of service) POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount	$25 per each diagnostic x-ray + laboratory test performed by a participating provider (a maximum of two diagnostic copays will apply per date of service) Nothing for children (under age 26) when performed by a participating provider All charges for non-participating providers.
Preventive care, adult	**High Option**	**Standard Option**
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including - Fecal occult blood test • Osteoporosis screening	Nothing for preventive x-ray + laboratory test performed by a participating provider POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount	Nothing for preventive x-ray + laboratory test performed by a participating provider All charges for non-participating providers
Sigmoidoscopy, screening – every five years starting at age 50	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	Nothing for participating providers All charges for non-participating providers
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing for preventive x-ray + laboratory test performed by a participating provider POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount	Nothing for preventive x-ray + laboratory test performed by a participating provider All charges for non-participating providers
Routine Pap test	Nothing for preventive x-ray + laboratory test performed by a participating provider POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount	Nothing for preventive x-ray + laboratory test performed by a participating provider All charges for non-participating providers

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
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 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing for preventive x-ray + laboratory test performed by a participating provider POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount	Nothing for preventive x-ray + laboratory test performed by a participating provider All charges for non-participating providers.
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) such as: • Tetanus-diptheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine annually • Pneumococcal vaccine, age 65 and over • Varicella (Chickenpox) – for all persons aged 19-49 • Tetanus, Diptheria and Pertussis (TDAP) – for persons aged 19-64, with a booster every 10 years	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule	Nothing for participating providers All charges for non-participating providers
Not covered: *Physical exams 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 • ACIP's recommendation for the vaccine to prevent Rotavirus for infants between 8 and 32 weeks of age.	Nothing for participating providers POS: 50% of the Plan's fee schedule for non participating providers, and any difference between our fee schedule and the billed amount	Nothing for participating providers All charges for non-participating providers
• Well-child care charges for routine examinations, immunizations and care (up to age 26)	Nothing for participating providers 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	Nothing for participating providers All charges for non- participating providers

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
• Examinations, such as: - Eye exams to determine the need for vision correction - Ear exams to determine the need for hearing correction	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	Nothing for participating providers All charges for non-participating providers
• Examinations done on the day of immunizations (up to age 26)	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	Nothing for participating providers All charges for non-participating providers
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 have to precertify your normal delivery. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical Benefits, not maternity benefits, apply to circumcision if this is the case. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	A single $15 copay for all prenatal and postnatal care from a participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	A single $25 copay for all prenatal and postnatal care from a participating provider All charges for non-participating providers
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*	*All charges*

Benefit Description	You pay	
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5b) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers All charges for non-participating providers
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: • In vitro fertilization (limited to three transfers per lifetime) • Embryo transfer • Artificial insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterinal insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers All charges for non-participating providers
Not covered: • *Cost of donor sperm*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections • Treatment materials (such as allergy serum)	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers Nothing for children (under age 26) per office visit for participating providers All charges for non-participating providers
Not covered: • *Provocative food testing* • *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 are limited to those transplants listed under Organ/ Tissue Transplants on pages 33-38. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis Note: We will provide benfits for up to ten out-of-area hemodialysis treatments performed by non-participating providers under High Option and Standard Option. You are responsible for all charges that exceed our allowable charges.	In a doctor's office, nothing for a participating provider POS: In a doctors office, 50% of the Plan's fee schedule, for non-participating providers, and any difference between our fee schedule and the billed amount	In a doctor's office, nothing for a participating provider All charges for non-participating providers
• High-tech nursing and infusion therapy - IV infusion therapy - Parenteral and enteral therapy - Other home IV therapies Note: Contact us at (800) 223-9870 prior to receiving services to ensure coverage. • Intermittent home nursing service - Provided by a Registered Nurse or Licensed Practitioner - Authorized and supervised by a doctor - Intermittent visits less than 2 hours per day	Nothing for a participating provider POS: All charges for non-participating providers	Nothing for a participating provider All charges for non-participating providers
• Growth hormone therapy (GHT). Note: This benefit is provided under our Prescription Drug Benefits. Please see Section 5(f) Prescription Drug benefits for information on growth hormone. Note: We only cover GHT when we preauthorize the treatment before you begin treatment. We will ask you to submit information that establishes that the GHT is medically necessary.	Applicable prescription drug copay Note: Please see Section 5(f) Prescription Drug Benefits.	Applicable prescription drug copay Note: Please see Section 5(f) Prescription Drug Benefits.
Not covered: • *Treatment for experimental or investigational procedures* • *Therapy necessary for transsexual surgery*	*All charges*	*All charges*

Benefit Description	You pay	
Physical and occupational therapies	**High Option**	**Standard Option**
• 60 visits per condition for the services of each of the following: - qualified physical therapists - occupational therapist Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other daily living activities. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers Nothing for children (under age 26) per office visit for participating providers All charges for non-participating providers
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
• 60 visits per condition	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers Nothing for children (under age 26) per office visit for participating providers All charges for non-participating providers
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing testing • Hearing aids, including the exam, purchase and fitting up to $1,500 every two years.	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers Nothing for children (under age 26) per office visit for participating providers All charges for non-participating providers
Not covered: Hearing aid services or testing that exceeds that exceeds the $1,500 maximum biennial allowance	*All charges*	*All charges*

Benefit Description	You pay	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Medical and surgical benefits for diagnosis and treatment of diseases of the eye	$15 per visit for participating provider For non-participating providers, you pay 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount	$25 per visit for participating provider Nothing for children (under age 26) per office visit for participating providers All charges for non-participating providers
• Examination of the eyes to determine if glasses are required: once each calendar year • One set of single vision or bifocal lenses (toric kryptok or flat top 22mm): once each calendar year • One pair of basic frames from available styles: one every two years • Contact lenses for certain unusual medical conditions (such as post cataract surgery or keratoconus treatment) • Replacement of broken lenses with lenses of the same prescription and material originally supplied	Nothing for services provided by participating opticians, optometrists and vision centers POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount	Nothing for services provided by participating opticians, optometrists and vision centers All charges for non-participating providers
Not covered: • *Frames at any time unless lenses are also provided* • *Replacement or repair of frames* • *Certain bifocals and trifocals, tinted, plastic and oversized lenses and sunglasses and frames other than basic frames; contact lenses for cosmetic purposes* • *Charges in excess of the maximum GHI allowance*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
• Podiatric services, including the routine treatment of corns, calluses, and bunions, and the partial removal of toenails Note: There is a limit of 4 visits per calendar year.	$15 per visit for participating provider For non-participating providers, you pay 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount	$25 per visit for participating provider Nothing for children (under age 26) per office visit for participating providers All charges for non-participating providers

Foot care - continued on next page

Benefit Description	You pay	
Foot care (cont.)	**High Option**	**Standard Option**
Not covered: • *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)* • *Orthotics devices for the feet*	*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 • Orthopedic devices, such as braces • Ostomy supplies • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy	20% of the Plan's fee schedule for a participating provider POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider Note: $100 annual deductible applies per individual or family.	20% of the Plan's fee schedule for a participating provider All charges for non-participating providers Note: $100 annual deductible applies per individual or family.
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* • *corrective appliances for treatment of tempormandibular joint (TMJ) pain dysfunction syndrome*	*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 • insulin pumps	20% of the Plan's fee scheduled for a participating provider POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider Note: $100 annual deductible applies per individual or family.	20% of the Plan's fee scheduled for a participating provider All charges for non-participating providers Note: $100 annual deductible applies per individual or family.

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
Note: Call us at 800-223-9870 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of the Plan's fee scheduled for a participating provider POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider Note: $100 annual deductible applies per individual or family.	20% of the Plan's fee scheduled for a participating provider All charges for non-participating providers Note: $100 annual deductible applies per individual or family.
Not covered: • *Air purification devices* • *Alarm and Alert Services*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
Services include: • Part-time or intermittent nursing care by a registered professional nurse (R.N.) or a home health aide under the supervision of a registered professional nurse • Physical therapy • Respiration or inhalation therapy • Prescription drugs • Medical supplies which serve a specific therapeutic or diagnostic purpose • Other medically necessary services or supplies that would have been provided by a hospital if the subscriber were still hospitalized **In order for us to cover home health care services, the following conditions must be met:** 1) Home health care must be provided and billed by a certified home health agency, which has an agreement with GHI to provide home health care services; 2) You must remain under the care of a medical doctor; 3) The services are provided according to a plan of treatment approved by the attending medical doctor; and 4)Medical evidence substantiates that you would have required further inpatient care had the home health care not been available.	Nothing for a participating provider POS: All charges for a non-participating provider	Nothing for a participating provider All charges for a non-participating provider

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**High Option**	**Standard Option**
Not Covered: • *Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter* • *Services and supplies related to normal maternity care* • *Services and supplies provided following a noncovered hospital admission or admission to a facility that is not a participating facility* • *Services and supplies provided when the subscriber would not have required continued inpatient care* • *Services and supplies provided by a non-participating facility for home health care* • *High-tech nursing and infusion therapy* • *Nursing care requested by or for the convenience of the patient's family and/or private duty nursing*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• Manipulation of the spine and extremities • Adjustment procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$15 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$25 per visit for participating providers Nothing for children (under age 26) per office visit for participating providers All charges for non-participating providers
Not covered: • *chiropractic services not shown as covered*	All charges	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Acupuncture – unlimited visits; no utilization management under the Standard Option only • anesthesia • pain relief Note: We do not cover acupuncture treatment under the High Option coverage	All charges	$20 per visit for participating providers Nothing for children (under age 26) per office visit for participating providers All charges for non-participating providers
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges*	*All charges*

Benefit Description	You pay	
Educational classes and programs	**High Option**	**Standard Option**
Coverage is limited to: • Diabetes self-management • Cholesterol Management • Arthritis • Asthma • Hepatitis C • Multiple Sclerosis • Depression • Osteoporosis • Nutritional Counseling	Nothing For diabetes self management call Diabetes Health Solutions at (800) 881-4008 For arthritis and osteoporosis information call Arthritis Foundation NYC Chapter at (212) 984-8713 To enroll in our Asthma Cholesterol Management, Hepatitis C Multiple Sclerosis & Depression program call GHI Disease Management Line (212) 615-0363	Nothing For diabetes self management call Diabetes Health Solutions at (800) 881-4008 For arthritis and osteoporosis information call Arthritis Foundation NYC Chapter at (212) 984-8713 To enroll in our Asthma program call (212) 615-0363
Tobacco Cessation Program The Program is provided in partnership with the American Cancer Society's Quit For Life (ACSQFL) program implemented by Free & Clear, a vendor with expertise in smoking cessation. Participation is initiated by a phone call to the call center. Under the program, you have access to the following: • Unlimited telephonic access to professional counselors; • Educational information tailored to the member's stage of readiness to quit; • Access to ACSQFL Web site; and • Full coverage for smoking cessation pharmaceutical products (Nicotine Patch, Gum, Lozenge, Bupropion (generic Zyban®) and Chantix™). Note - See Section 5(f) Prescription Drug Benefits for information on physician prescribed smoking cessation medication. See Section 5(e) for information on group and individual psychotherapy.	Nothing	Nothing

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
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)– see Services requiring our prior approval on page 13. • Insertion of internal prostethic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns	$15 per office procedure for a participating provider Nothing for a participating provider in a hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for a participating provider Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in a hospital or a participating ambulatory surgery center All charges for non-participating providers
Not covered: • *Reversal of voluntary sterilization* • *Stand-by services*	*All charges*	*All charges*

Benefit Description	You pay	
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; webbed fingers; and webbed toes.	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; or - 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.	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
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*	*All charges*	*All charges*
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 • Removal of impacted teeth	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• Other surgical procedures that do not involve the teeth or their supporting structures.	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
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 other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of teporomandibular joint (TMJ) pain dysfunction syndrome.*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Lung: single/bilateral • Liver • Kidney • Pancreas • Kidney/Pancreas • Intestinal transplants - small intestine - small intestine with the liver - small intestine with multiple organs such as the liver, stomach, and pancreas	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses (the medical necessity limitation is considered satisfied if patient meets the staging descriptions): • Allogeneic transplants for: - Acute lymphocyic or non- lymphocyic (i.e. myelogenous) leukemia - Chronic Lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Acute Myeloid Leukemia - Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Chronic myelogenous leukemia - Hemoglobinapathy - Myelodysplasia/Mylodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous leukemia) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for: - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - Denovo myeloma	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants for Allogeneic transplants for • Phagocytic/Hemophagocytic deficiency diseases(e.g., Wiskott-Aldrich syndrome) • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Waldenstrom's macroglobulinemia	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participatin providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity Tandem transplants for covered transplants: Subject to medical necessity	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
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/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathies • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Myelodysplasia/Myelodysplastic syndromes • Multiple myeloma • Multiple sclerosis Non-myeloablative allogeneic transplants or Reduced intensity conditioning (RIC) for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Myelodysplasia/myelodysplastic syndromes • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell disease	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Autologous transplants for • Chronic myelogenous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Small cell lung cancer • Multiple sclerosis • Systemic lupus erythematosus	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for: • Allogeneic transplants for - Breast cancer - Epithelial ovarian cancer National Transplant Program (NTP)- We will cover transplants approved as safe and effective for a specific disease by the Federal Drug Administration (FDA) or National Institute of Health, or which our Medical Director determines is medically necessary, appropriate and advisable on a case-by-case basis. We will cover the medical and hospital services, and related organ acquisition costs. Eligibility for transplants will be determined and approved in advance solely by our Medical Director upon recommendation of your PCP. Additionally, all transplants must be performed at hospitals specifically approved and designated by us to perform these procedures. Specialty physician experts from our designated centers of excellence will provide clinical review and support to the Medical Director's decision. **Limited Benefits** – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.	$15 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 per office procedure for participating providers Nothing for children (under age 26) per office visit for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Note: • We cover related medical and hospital expenses of the donor when we cover the recipient up to a maximum of $10,000 per transplant. • Travel expenses up to a maximum of $150 per person per day and $10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center. This includes food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place. Note: The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery.		
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*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient)	Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: Any difference between our fee schedule and the billed amount for non-participating providers	Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Professional services provided in – • Hospital (outpatient) • Skilled nursing facility • Ambulatory surgical center • Office	Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: Any difference between our fee schedule and the billed amount for non-participating providers	Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Not covered: • *Services administered by the same practitioner performing surgery*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
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.	$100 per inpatient admission up to a maximum of $200 per year	$250 per day up to a maximum of $750 per inpatient admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing (included in the inpatient hospital copay)	Nothing (included in the inpatient hospital copay)

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing homes and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Long term rehabilitation*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition. For approved inpatient admissions, you are responsible for the applicable hospital admission copay (see inpatient hospital benefits).	Nothing for a Plan facility	Nothing for a Plan facility
• Diagnostic laboratory tests, X-rays, and pathology services	$25 copayment POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$25 copayment All charges for non-participating providers
• Chemotherapy and radiation	Nothing for chemotherapy and radiation provided in a participating facility POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.	Nothing for chemotherapy and radiation provided in a participating facility All charges for non-participating providers
Not covered: Blood and blood derivatives replaced by the member	*All charges*	*All charges*

Benefit Description	You pay	
Skilled nursing facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF) care is limited to 30 days per calendar year and includes the following: • Bed, board and general nursing care • Drugs, biologicals, supplied and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your doctor as governed by Medicare guidelines.	Nothing for a participating provider POS: All charges for a non-participating provider	Nothing for a participating provider All charges for a non-participating provider
Not Covered: • *Custodial care*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include: • inpatient/outpatient care; and • family counseling under the direction of a doctor. Note: Your provider must certify that you are in the terminal stages of illness, with a life expectancy of approximately six months or less. The hospice must have an agreement with us or recognized by Medicare as a hospice.	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Ambulance services for each trip to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility.	All charges in excess of $100. Note: We will not pay more than $100 for covered ambulance services.	All charges in excess of $100. Note: We will not pay more than $100 for covered ambulance services.
Not covered: • *Air ambulance* • *Ambullette services*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

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

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

What is emergency care? Emergency care means care for a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that absence of immediate medical attention to result in:

- placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral conditionk placing the health of such person or others in serious jeopardy;
- serious impairment to such person's bodily functions;
- serious dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.

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

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

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

Note: If you are admitted to the hospital from the Emergency Room, we waive the emergency care copay. A participating GHI provider must provide your follow-up care. We cover care provided by a non-participating provider at 100% of the Plan's fee schedule.

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency medical/surgical care at a doctor's office • Emergency medical/surgical care at an urgent care center	$15 per office visit for a participating provider. POS: Any difference between our allowance and the billed amount for a non-participating provider.	$25 per office visit for a participating provider. Nothing for children (under age 26) per office visit for participating providers. Any difference between our allowance and the billed amount for a non-participating provider.

Emergency within our service area - continued on next page

Benefit Description	You pay	
Emergency within our service area (cont.)	**High Option**	**Standard Option**
• Emergency care as an outpatient or inpatient at a hospital Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.	$75 copay per hospital emergency room visit. POS: Any difference between our allowance and the billed amount for a non-participating provider	$75 copay per hospital emergency room visit plus all charges that exceed the emergency allowance for non-participating hospitals.
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency medical/surgical care at a doctors' office • Emergency medical/surgical care at an urgent care center	$15 per office visit for a participating provider. POS: Any difference between our allowance and the billed amount for a non-participating provider	$25 per office visit for a participating provider. Nothing for children (under age 26) per office visit for participating providers. Any difference between our allowance and the billed amount for a non-participating provider.
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.	POS: Any difference between our allowance and the billed amount for a non-participating provider. Note: For emergency services billed for by a doctor, you pay any difference between our allowance and the billed amount.	Any difference between our allowance and the billed amount for a non-participating provider. Note: For emergency services billed for by a doctor, you pay any difference between our allowance and the billed amount.
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility. See 5(c) for non-emergency service.	All charges in excess of $100 Note: We do not pay more than $100 for covered ambulance services.	All charges in excess of $100 Note: We do not pay more than $100 for covered ambulance services.
Not covered: air ambulance and ambullette services	*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.
- Under the Standard Option, you must obtain care from within the participating provider network.
- Mental Health and Substance Abuse benefits are eligible for POS benefits under the High Option. However, you are responsible for all balances that exceed our payment.
- **YOU MUST GET PREAUTHORIZATION FOR IN-PATIENT SERVICES.**

Benefit Description	You pay	
Mental health and substance abuse benefits	**High Option**	**Standard Option**
All diagnostic and treatment services obtained from a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	Nothing for outpatient mental health care.	Nothing for outpatient mental health care.
• 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, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing	Nothing

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	**High Option**	**Standard Option**
• Facility charges of a non-participating general hospital or facility • Treatment by a non-participating professional provider Note: See Section 5(d) Emergency Benefits for information on emergency services.	POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.	*All charges*
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 follow your treatment plan and all of our network authorization processes as described in Section 3. Contact us at 1-(800) 692-7311

Limitation We will only cover treatment that we determine is medically necessary or clinically appropriate.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We will send each new enrollee a description of the prescription drug program and a mail order form/patient profile and a preaddressed reply envelope. You may use your Plan identification card to access the prescription drug benefits.
- You must fill maintenance medication by mail-order after the first two fills at a retail pharmacy.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed doctor must write the prescription.
- **Where you can obtain them**. You may fill the prescription at a participating pharmacy by presenting your Plan Identification Card. You may obtain certain generic maintenance drugs or name brand formulary drugs by mail order.
- **We use a formulary.** Our formulary is a list of effective medications and other items that we have approved for our members' use. A special committee of medical and pharmacy professionals reviews the formulary annually. We add or delete items on the list based on their findings. We have found that the drugs on our formulary are safe, effective, and therapeutic in the treatment of disease or illness. Please call GHI Pharmacy Services 1-877-444-3614 for a copy of our formulary.
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription. Under the High Option Plan you will pay $15.00 for generic formulary drugs or $25.00 for name brand formulary drugs or $50.00 for non-formulary drugs. Under the Standard Option Plan you pay $5.00 for generic formulary drugs, or $25.00 for name brand formulary drugs or $50.00 non-formulary drugs.
- **You must fill maintenance medication by mail-order**. Your prescription coverage includes a mandatory mail program. Two refills per prescription will be allowed at any local participating pharmacy. When a new maintenance medication is prescribed, the patient should request 2 prescriptions. The initial for a 30-day supply to be filled at a retail pharmacy, and the second, for up to a 90-day supply, to be submitted to GHI Pharmacy Services. For all existing maintenance medications at a retail pharmacy, the patient is required to obtain a new prescription, for up to a 90-day supply, to be sent to GHI Pharmacy Services. Please call GHI Pharmacy Services at 1-877-444-3614. Sexual dysfunction drugs are not available by mail-order and require prior approval.
- **Step Therapy Prior Authorization Program.** For prior authorization, your physician or you should call GHI Pharmacy Services at 1-877-444-3614. Step Therapy programs apply edits to drugs in specific therapeutic classes at the point of service. Coverage for second-line therapies is determined at the member level based on the presence or absence of first-line drugs in the member's claims history. Step Therapy coverage criteria are automated whenever possible so that rejects are further reduced. Only claims for members whose histories do not show use of first-line drugs are rejected for payment at the point of service and online messaging is sent to the pharmacy indicating that prior authorization is required for coverage of the second-line therapy.
- **Drug Quantity Management Program.** The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copayment is consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Clinicians maintain a list of quantity limit drugs, which is based upon FDA-approved dosing guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per copayment and per days' supply.
- **Diabetic Supplies Close Category Program.** The Diabetic Supplies Category Program refers only to prescriptions for test strips and meters. You will be granted authorization for test strips and meters when you present a prescription for a covered diabetic supply product (Roche and J&J products are covered).

- **A generic equivalent will be dispensed if it is available,unless your physician specifically requires a name brand.** If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use a generic drug?**
  - Generic drugs may have unfamiliar names, but they are safe and effective.
  - Generic drugs contain the same active ingredients, in the same dosage form as their brand name counterparts, and are manufactured according to the same strict federal regulations.
  - Generic drugs may differ in color, size, or shape, but they have the same strength, purity, and quality as the brand-name alternatives.
  - Prescriptions filled with generic drugs often have lower co-payments. Therefore, you may be able to get the same health benefits at a lower cost. You should ask your physician or pharmacist whether a generic version of your medications is available. By using a generic drug, you may be able to receive the same high-quality medication but reduce your expenses.
- **When you have to file a claim.** Please call GHI Pharmacy Services 1-877-444-3614 and we will send you a claim form. Under normal circumstances, you do not have to file prescription drug claims. You simply present your GHI card to the participating pharmacy and pay the appropriate copay.

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 either a Plan pharmacy or through our mail order program: • Drugs for which a prescription is required by Federal law of the United States • FDA approved prescription drugs and devices for birth control • Fertility drugs (oral and injectable) • Insulin • Diabetic supplies, including insulin syringes, needles, glucose test tablets, and test tape • Drugs to treat sexual dysfunction (with Prior authorization) • Disposable needles and syringes needed for the administration of covered medication • Smoking cessation drugs and medication, including nicotine patches (up to 90-day supply) • Intravenous fluids and medications for home use through our Participating Provider network for home infusion therapy • Nutritional supplements for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria	**Network Retail:** $15 generic $25 brand name listed on the preferred prescription drug formulary $50 brand name drug not listed on the preferred prescription drug formulary. **Network Mail Order:** $35 generic $60 brand name listed on the preferred prescription drug formulary $75 brand name drug not listed on the preferred prescription drug formulary.	**Network Retail:** $5 generic $25 brand name listed on the preferred prescription drug formulary $50 brand name drug not listed on the preferred prescription drug formulary. **Network Mail Order:** $12.50 generic $50 brand name listed on the preferred prescription drug formulary $80 brand name drug not listed on the preferred prescription drug formulary

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Physician prescribed over-the-counter and prescription smoking cessation medication approved by the FDA to treat tobacco dependence	Nothing	Nothing
Not covered: • *Nonprescription medications* • *Drugs obtained at a non-participating pharmacy, except for emergencies.* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Medical supplies* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance*	*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 payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We will cover dental care for accidental injury only as indicated within the benefits description.
- 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.
- **This Plan provides routine preventive dental coverage only.** The emphasis is on prevention, with preventive and minor diagnostic dental services covered with no copayments through Participating Plan Dentists. Services by non-participating dentists are covered in accordance with the fees listed below. **This Plan does not provide benefits for minor restorative or major restorative dental services, prosthodontics, endodontics, orthodontics, etc.**
- 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. The need for these services must result from an accidental injury caused by external means and services must be completed within one year.	Any difference between our fee schedule and the actual charges.	Any difference between our fee schedule and the actual charges.
Not covered: • *Therapeutic service* • *Other dental services not shown as covered* • *Charges which exceed the Plan's fee schedule*	*All charges*	*All charges*
Routine Dental Services	**High Option**	**Standard Option**
Examinations (maximum 2 per calendar year)	Nothing for a participating provider POS: All charges in excess of $10.00	Nothing for a participating provider All charges for non-participating providers.
Prophylaxes (under age 12 - maximum 2 per calendar year)	Nothing for a participating provider POS: All charges in excess of $7.00	Nothing for a participating provider All charges for non-participating providers
Prophylaxes (over age 12 - maximum 2 per calendar year)	Nothing for a participating provider	Nothing for a participating provider

Routine Dental Services - continued on next page

Benefit Desription	You Pay	
Routine Dental Services (cont.)	**High Option**	**Standard Option**
	POS: All charges in excess of $10.00	All charges for non-participating providers
Emergency visits for relief of pain (1 per calendar year)	Nothing for a participating provider POS: All charges in excess of $10.00	Nothing for a participating provider All charges for non-participating provider
X-rays (Full-mouth series, 1 every 3 years)	Nothing for a participating provider POS: All charges in excess of $20.00	Nothing for a participating provider All charges for non-participating providers
Bitewings (4 per calendar year)	Nothing for a participating provider POS: All charges in excess of $2.50 per each bitewing	Nothing for a participating provider All charges for non-participating providers
Space maintainers	Nothing for a participating provider POS: All charges in excess of $65.00	Nothing for a participating provider All charges for non-participating providers
Fluoride Treatments – dependent children to age 26	Nothing for a participating provider POS: All charges in excess of $5.00	Nothing for a participating provider All charges for non-par provider

Section 5(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 regular contract benefits as a less costly alternative • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we do not 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. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, than you may dispute our regular contract benefits decision under the OPM disputed claim process (see section 8).
Large Case Management	The Plan provides a large case management program that seeks to provide alternatives for improving the quality and cost effectiveness of care. The large case management program focuses on catastrophic illnesses — for example, major head injury, high-risk infancy, stroke and severe amputations. The large case management process begins when we are notified that you or covered family member has experienced a specific illness or injury with potential long-term effects or changes in lifestyle. Case Managers evaluate individual needs, and the full range of treatment and financial exposures, from the onset of a condition or illness to recovery or stabilization. They review the efforts of the health care team and family with the goal of helping the patient return to pre-illness/injury functioning or of lessening the burden of a chronic or terminal condition. Case Managers provide the family with support and advice ranging from referral to family counseling. If it is determined that involvement of a Case Manager would be both care- and cost-effective, we will obtain the necessary authorization from the patient to proceed. Throughout the process, we will maintain strict confidentiality.
Customer Service AnswerLine	For information and assistance 24 hours a day, 7 days a week, access our automated telephone AnswerLine at 212/501-4GHI (4444).
Services for deaf and hearing impaired	If you have a question concerning Plan benefits or how to arrange for care, contact (212) 721-4962 (Hearing impaired — TDD) or you may write to us at Post Office Box 1701, New York, NY 10023-9476 or contact our office nearest you. You may also contact the Plan at its website at http://www.emblemhealth.com.
High risk pregnancies	The Plan provides an intensive large case management program as described above.
Centers of Excellence	We have a special network of hospitals that perform a broad range of cardiac care and organ transplants. These centers are recognized leaders in their respective specialties and their services are available to you at no out-of-pocket expense. Call GHI Managed Care at least 10 days before the hospital admission to pre-certify coverage and for details on how to use this program.
Travel benefit/ services overseas	As a GHI subscriber under the High Option Plan benefit package, you are not restricted to just using members of our provider network. However, if you go outside the network, your out-of-pocket expenses will increase significantly. You will receive 50% of our fee schedule if you use a non-participating provider — you are responsible for the balance of the provider's charge. Also, unlike when you use a network provider, you are responsible for paying the non-participating provider up front and filing a claim form with us for reimbursement.

Section 5(i). High Option Point of Service benefits

High Option Point of Service (POS) Benefits

Facts about this Plan's High Option POS benefits

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

What is covered

All services are covered under our POS except:

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

Remember, only participating providers have agreed to accept the Plan's allowance, except for any applicable copayments, as payment in full. If you choose to receive covered services from non-participating or out-of-network providers, you will be reimbursed at the POS level that in most cases is 50% of the Plan's allowance.

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

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

There is a $150 annual deductible for nursing services and a $100 annual deductible for appliances, oxygen and equipment. There is also a $25 deductible, per referral, for ambulatory laboratory test and diagnostic X-rays performed at outpatient hospital or ambulatory surgical center.

In most cases, the POS coinsurance is any amount in excess of 50% of the Plan's fee schedule. The Plan's fee schedule is set at approximately 45% of the New York State 2009 Fair Health mean. Members, when receiving POS services, will be responsible for 50% of the Plan's fee schedule plus any difference between our fee schedule and the billed amount.

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

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

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

Emergencies within the service area:

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

The Plan pays the emergency allowance for emergency care services to the extent the services would have been covered if received from Plan providers.

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

Emergencies outside the service area:

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

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

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

What is covered

- Emergency care at a doctor's office or an urgent care center.
- Ambulance service (see page 43).
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.

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

Non-FEHB benefits available to Plan members

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

You have access to specific dental services as indicated on the table below and pay the reduced fee for the dental service directly to the participating provider. You must verify that your provider is participating in this dental program.

Dental Service	High Option	Standard Option
Restorative (Fillings)		
Amalgam 1 Surface	$81.00	$67.00
Resin (anterior) 1 surface	$90.00	$83.00
Resin (anterior) 2 surface	$112.00	$99.00
Resin (anterior) 3 surface	$132.00	$117.00
Prosthodontics Removable		
Complete denture (upper)	$840.00	$782.00
Upper partial denture, resin base	$857.00	$840.00
Lower partial denture, resin base	$857.00	$840.00
Prosthodontics Fixed		
Bridge pontic (resin with high noble metal)	$811.00	$726.00
Abutment crown (porcelin fused to high noble metal)	$838.00	$751.00
Oral Surgery		
Removal of impacted tooth - complete bone	$351.00	$319.00
Removal of impacted teeth - soft tissue	$207.00	$179.00
Surgical removal of erupted tooth	$170.00	$146.00
Periodontics (Gum Treatment)		
Gingivectomy (per quadrant)	$308.00	$303.00
Osseous surgery (per quadrant)	$748.00	$661.00
Perio-scaling/planing (per quadrant)	$121.00	$110.00
Endodontics (Root Canal)		
Root Canal Therapy - 1 canal	$416.00	$374.00
Root Canal Therapy - 2 canals	$503.00	$443.00
Root Canal Therapy - 3 canals	$765.00	$668.00
Orthodontics (Braces)		
Full course of treatment	$4,300.00	$4,300.00

* Downstate includes Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Putnam, Orange, Rockland and Westchester and New Jersey

** Upstate includes Eastern, Central, and Western New York Counties.

Benefits on this page are not part of the FEHB contract.

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 it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition. For information on obtaning prior approval for specfic services, such as transplants, see Section 3 When you need prior approval for certain services.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received. See section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file the form CMS-1500, Health Insurance Claim Form. Facilities will file the UB-04 form. For claims questions and assistance, contact us at (212) 501-4GHI (4444) or at our Web site at www.emblemhealth.com.

When you must file a claim, - such as for services you received outside the Plan's service area- submit it on the CMS-1500 or a claim form that includes all the following shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number 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 payor -- such as the Medicare Summary Notice (MSN), and
- Receipts, if you paid for your services.

Note: Canceled checks, cash register receipts or balance due statemates are not acceptable substitute for itemized bills.

Submit your claimsto:

Group Health Inc.
P.O. Box 3000
New York, New York 10116-3000

Prescription drugs

For drugs obtained at a non-participating pharmacy in an emergency call GHI Pharmacy Services at 1-877-444-3614 to obtain a claim form.

Deadline for filing your claim

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

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.emblemhealth.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post service claim (a claim where services, drugs or supplies have already been provided). In Section 3 If you disagree with our pre-service claim decision, we described the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

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: GHI Customer Service Department, 441 Ninth Avenue, New York, NY 10001; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a resonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision or reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. 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.
3	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 Operations, Health Insurance II, 1900 E Street, NW, Washington, D.C. 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; • Your daytime phone number and the best time to call; and • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. 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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	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 you did not indicate that your claim was a claim for urgent care, then call us at (800) 223-9870. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

When we are the secondary payor, 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 and 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 (1-800-633-4227), (TTY 1-877-486-2048) 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 helping 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 1-800-722-1213 (TTY 1-877-486-2048). 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 (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

Claims process when you have The Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, Medicare processes your claim first.

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

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

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

Under the Standard Option benefit package, care by non-participating providers for routine care is not covered even if Medicare is primary. To get full maximum use of your Standard Option package you must use GHI's participating provider network for services.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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 (1-800-632-4227), (TTY 1-877-486-2048) or at www.medicare.gov

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

  This plan and GHI's Medicare Advantage Plan or 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, but we will not waive any of our copayments, coinsurance, or deductibles.

  Under the Standard Option benefit package, care by non-participating providers for routine care is not covered even if Medicare Advantage is primary. To get full maximum use of your Standard Option package you must use GHI's participating provider network for services.

  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 you FEHB coverage to enroll in a Medicare Advantage plan, eliminating you 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 our of the Medicare Advantage plan's service area.

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

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF 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 (or a covered family member) 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

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

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB Plans already cover 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.

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs.

Clinical Trials

- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. We do not cover these costs.

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.

Clinical Trials Cost Categories

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 14.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 14.

Covered services

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

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 14.

Exclusive Provider Option (EPO)

Coverage that utilizes a network(s) of providers and uses provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long-term health care costs savings.

Experimental or investigational service

Experimental treatment is a treatment that has not been tested in human beings; or that is being tested but has not yet been approved for general use; or that is subject to review or approval by an Institutional Review Board.

Investigational treatment includes, but is not limited to, services or supplies which are under study or in a clinical trial to evaluate their toxicity, safety and efficiency for a particular diagnosis or set of indications.

Clinical trials include, but are not limited to, controlled experiments having a clinical event as an outcome measurement involving persons having a specific disease or health condition; or involving the administration of different study treatments in a parallel treatment design done to evaluate the efficacy and safety of a test measurement. Clinical trials include Phase I, Phase II, and Phase III studies. Clinical trials also include randomized trials or studies.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Medically necessary services are services; supplies or equipment provided by a hospital or covered provider of the health care services that the carrier determines:

- are appropriate to diagnose or treat the patient's condition, illness, or injury;
- are consistent with standards of good medical practice in the United States;
- are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- are not part of or associated with scholastic education or vocational training of the patient; and
- in case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply or equipment does not, in itself, make it medically necessary.

Network Provider

A network provider is a participating provider who has a contract with GHI and has agreed to accept GHI's schedule of allowances or negotiated rate(s) as payment in full for covered services and who participates in the GHI network that applies to your coverage.

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:

For participating providers, the Plan allowance is the fee schedule or negotiated rate that GHI uses as payment in full for covered services rendered by participating providers. For non-participating providers, the allowance is the amount that we determine based on certain data.

Precertification

Certain covered services must be precertified by contacting GHI for approval prior to treatment. GHI's advance approval for these services may result in a reduction of benefits and/or payments.

Preferred Provider Option (PPO)

Coverage that offers a network(s) of providers and uses provider selection standards, utilization management, and quality assessment techniques to complete negotiated fee reductions as an effective strategy for long-term health care cost savings. Enrollees retain the freedom of choice of providers but have financial incentives (i.e., lower out-of-pocket costs) to use the PPO network.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at **212/501-4GHI (4444)**. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Group Health Incorporated

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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.

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent-child relationship to be eligible for coverage up to age 26.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Foster Children	Foster children are eligible for coverage up to age 26.

You can find additional information at www.opm.gov/insure.

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 2012 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 2011 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.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

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

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26.

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

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

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, 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 eligible dependents.

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **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)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter medications, 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)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

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 provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- 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 for dependent children up to age 19.

Vision Insurance

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

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide 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 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help 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, such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U. S. Postal Service employees and annuitants, active and retired members of the Uniformed Services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indianna, Kentucky, Lousianna, Massachusettes, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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Summary of benefits for the High Option of the GHI Health Plan - 2012

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$15 per visit for a Participating Provider. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for a non-participating provider.	19-20
Services provided by a hospital:		
• **Inpatient**	$100 per inpatient admission up to a maximum of $200 per year.	39-40
• **Outpatient**	Nothing for a plan facility and $25 copayment for diagnostic labs, x-rays, and pathology	40
Emergency benefits:		
• **In-area**	$75 per hospital emergency room visit or urgent care center visit plus charges that exceed the Plan's emergency fee schedule.	42-43
• **Out-of-area**	$75 plus charges per hospital emergency room visit or urgent care center visit for non-participating facilities plus charges that exceed our allowance.	43
Mental health and substance abuse treatment:	Regular cost-sharing	44-45
Prescription drugs:		
• Retail Pharmacy - Up to a 30-day supply per prescription unit or refill (limit of two refills per prescription at a participating pharmacy.	$15 copay for generic drugs; $25 copay Name brand preferred drugs; and $50 copay for non-preferred drugs	46-48
• Mail Order – Up to a 90-day supply of maintenance medication	$35 copay for generic drugs, $60 copay for name brand preferred; and $75 copay for non-preferred prescription drugs	46-48
Dental care: Routine preventive care	Nothing to participating providers.	49-50
Vision care: Limited to one annual eye refraction	Nothing to Participating providers.	25-26
Special features: Large Case Management , High Risk Pregnancies, Centers of Excellence for organ/tissue transplants, Heart Surgery, etc.	Copays or coinsurance as indicated	51

Summary of benefits for the Standard Option of the GHI Health Plan - 2012

- **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.
- You must use participating providers under the Standard Option coverage. We do not cover services from non-participating providers.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$25 per visit for a Participating Provider. All charges for non-participating providers. Copayment for pediatric visits waived.	19-20
Services provided by a hospital:		
• Inpatient	$250 per day inpatient admission up to a maximum of $750 per admission (waived for maternity care)	39-40
• Outpatient	Nothing for a plan facility and $25 copayment for diagnostic labs, x-rays, and pathology	40
Emergency benefits:		
• In-area	$75 per hospital emergency room visit or urgent care center visit and charges that exceed the Plan's emergency fee schedule.	42-43
• Out-of-area	$75 per hospital emergency room visit or urgent care center visit for non-participating facilities plus charges that exceed our allowance.	43
Mental health and substance abuse treatment:	Regular cost-sharing	44-45
Prescription drugs:		
• Retail pharmacy - Up to a 30-day supply per prescription unit or refill (limit of two refills per prescription at a participating pharmacy)	$5 copay for generic drugs; $25 copay Name brand preferred drugs; and $50 copay for non-preferred drugs	46-48
• Mail order - Up to a 90-day supply of maintenance medication	$12.50 copay for generic drugs, $50 copay for name brand preferred; and $80 copay for non-preferred prescription drugs	46-48
Dental care: Routine preventive care	Nothing to participating providers	49-50
Vision care: Limited to one annual eye refraction	Nothing to participating providers	25-26
Special features: Large Case Management , High Risk Pregnancies, Centers of Excellence for organ/tissue transplants, Heart Surgery, etc.	Copays or coinsurance as indicated	51

2012 Rate Information

For 2012 health premium information, please see http://www.opm.gov/insure/health/tribes/rates/ or contact your tribe's Human Resources department.