GlobalHealth

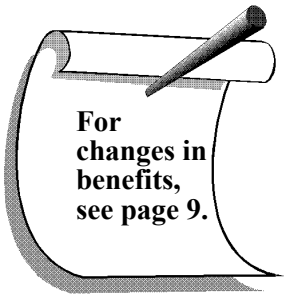
http://www.globalhealth.com

2011

A Health Maintenance Organization

Serving: *Oklahoma City and Tulsa Metropolitan areas and beyond*

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



Enrollment code for this Plan:
IM (1) for High Option Self

IM (2) for High Option Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-834

Important Notice from GlobalHealth About

Our Prescription Drug Coverage and Medicare

OPM has determined that the GlobalHealth prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY 1-877-486-2048.

Table of Contents

Introduction 3
Plain Language 3
Stop Health Care Fraud! 3
Preventing Medical Mistakes 4
Section 1 Facts about this HMO plan 7
Section 2 How we change for 2011 9
- How we pay providers 6
- Your Rights 6
- Service Area 6

Section 3. How you get care 10
- Identification cards 10
- Where you get covered care 10
- What you must do to get covered care 10
- Circumstances beyond our control 11
- Services requiring our prior approval 11

Section 4 Your costs for covered services 13
- Copayments 13
- Deductible 13
- Coinsurance 13
- Your catastrophic protection Out-of-Pocket Maximum 13

Section 5 benefits 14
Non-FEHB benefits available to Plan Members 43
Section 6 General exclusions – things we don't cover 44
Section 7 Filing a claim for covered services 45
Section 8 The disputed claims process 48
Section 9 Coordinating benefits with other coverage 50
- When you have other health coverage 50
- What is Medicare? 50
  - Should I enroll in Medicare? 50
  - The Original Medicare Plan (Part A or Part B) 51
  - Medicare Advantage (Part C) 52
  - Medicare prescription drug coverage (Part D) 52
- TRICARE and CHAMPVA 54
- Workers' Compensation 54
- Medicaid 54
- When other Government agencies are responsible for your care 54
- When others are responsible for injuries 54
- When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage 55
- Clinical trials 55

Section 10 Definitions of terms we use in this brochure 56
Section 11 FEHB Facts 58
- Coverage information 59
  - No pre-existing condition limitation 58
  - Where you can get information about enrolling in the FEHB Program 58
  - Types of coverage available for you and your family 58
  - Children's Equity Act 59

- When benefits and premiums start 60
- When you retire 60

When you lose benefits 61

- When FEHB coverage ends 60
- Upon divorce 61
- Temporary Continuation of Coverage (TCC) 61
- Converting to individual coverage 61
- Getting a Certificate of Group Health Plan Coverage 61

Section 12 Three Federal Programs complement FEHB benefits 62

The Federal Long Term Care Insurance Program 63

The Federal Flexible Spending Account Program - FSAFEDS 63

The Federal Employees Dental and Vision Insurance Program – FEDVIP 64

Summary of benefits for the GlobalHealth Plan - 2011 65

2011 Rate Information for GlobalHealth 66

Introduction

This brochure describes the benefits of *GlobalHealth* under our contract (CS 2893) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for *GlobalHealth* administrative offices is:

GlobalHealth

P.O. Box 2328

Oklahoma City, OK 73101-2328

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, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized Plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care Providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.

- 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 1-877-280-5600 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, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or if you are no longer enrolled in the Plan.
- 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.

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 healthcare, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

"Exactly what will you be doing?"

"About how long will it take?"

"What will happen after surgery"

"How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

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 healthcare Providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. 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.
- www.quic.gov/report/toc.htm. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's healthcare delivery system.

Never Events

When a Never Event occurs:

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 GlobalHealth preferred Providers. This new policy will help 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 will encourage 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 you nor your FEHB Plan will incur cost to correct the medical error.

Section 1 Facts about this HMO plan

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

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

When you receive services from Plan Providers, you will not have to submit claim forms or pay bills. You pay only the Copayments, Coinsurance, and Deductibles described in this brochure. When you receive emergency services from non-Plan Providers, you may have to submit claim forms.

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

This plan is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

Questions regarding what protections apply may be directed to us at 1-877-280-5600. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

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.

Your Rights

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

- **GlobalHealth is a Health Maintenance Organization (HMO) operating since 2003.**
- **GlobalHealth is a for profit organization.**

If you want more information about us, call 1-877-280-5600, or write to P.O. Box 2328, Oklahoma City, OK 73101-2328. You may also contact us by visiting our Web site at www.globalhealth.com.

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our Providers practice. Our Service Area is the following counties in their entireties: **Blaine, Caddo, Canadian, Carter, Cherokee, Cleveland, Comanche, Creek, Custer, Garfield, Garvin, Grady, Harmon, Hughes, Jackson, Johnston, Kingfisher, Kiowa, Lincoln, Logan, Love, Major, Mayes, McClain, McIntosh, Murray, Muskogee, Noble, Nowata, Okfuskee, Oklahoma, Okmulgee, Osage, Pawnee, Payne, Pontotoc, Pottawatomie, Rogers, Seminole, Sequoyah, Stephens, Tulsa, Wagoner, and Washington counties**.

Ordinarily, you must get your care from Providers who contract with us. If you receive care outside our Service Area, we will pay only for Emergency Care benefits. We will not pay for any other healthcare services out of our Service Area unless the services have prior Plan approval.

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

Section 2 How we change for 2011

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

Program-wide changes

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarify coverage.
- We have reorganized mental health and substance abuse benefits to clarify coverage.

Changes to this Plan

- You share of the non-Postal premium will increase for self only and for self and family. See page 70.
- Removed associated office visit Copayment for routine screenings, routine physical exams, routine immunizations for adults and children, and routine exams for children up to age 21.
- Change donor testing from actual donor (1) to up to 4 donors.
- Added new benefit for smoking cessation to include up to 2 quit attempts with up to 4 counseling sessions each, both RX and OTC medications (see prescription benefit), and no lifetime limit.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan Provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (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 1-877-280-5600 or write to us at*: P.O.Box 2328, Oklahoma City, OK 73101-2328*. Y ou may also request replacement cards through our Web site: *www.globalhealth.com*.

Where you get covered care

You get care from "Plan Providers" and "Plan Facilities." You will only pay Copayments, Deductibles, and/or Coinsurance.

- **Plan Providers**

Plan Providers are physicians and other healthcare professionals in our Service Area that we contract with to provide covered services to our Members. We credential Plan Providers according to national standards.

We list Plan Providers in the Provider Directory, which we update periodically. The list is also on our Web site.

- **Plan Facilities**

Plan Facilities are Hospitals and other Facilities in our Service Area that we contract with to provide covered services to our Members. We list these in the Provider Directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a Primary Care Physician. This decision is important since your Primary Care Physician provides or arranges for most of your healthcare. *You may choose a Primary Care Physician by completing the Primary Care Physician Selection form inside your enrollment packet, or call Customer Service at 1-877-280-5600.*

- **Primary care**

Your Primary Care Physician can be a a *family practitioner, internist, a pediatrician for Members under the age of 18, or a general practitioner.* Your Primary Care Physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change Primary Care Physicians or if your Primary Care Physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your Primary Care Physician will refer you to a specialist for needed care. When you receive a referral from your Primary Care Physician, you must return to the Primary Care Physician after the consultation, unless your Primary Care Physician authorized a certain number of visits without additional referrals. The Primary Care Physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your Primary Care Physician gives you a referral.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your Primary Care Physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your Primary Care Physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your Primary Care Physician. Your Primary Care Physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your Primary Care Physician, who will arrange for you to see another specialist. Y ou may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we: 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.
  - Terminate our contract with your specialist for other than cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - Reduce our service area and you enroll in another FEHB Plan,

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**

If you are in the Hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-877-280-5600. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the Hospital beginning on the effective date of your coverage.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

Your Primary Care Physician is the person you will see first for your medical care. He/she is responsible for coordinating all of your medical care. In most cases, your doctor will be able to take care of your medical problem. But if your Primary Care Physician believes a specialist is needed to treat your medical condition, he or she will make the referral request to GlobalHealth on your behalf.

Sometimes, your Primary Care Physician may consult with other physicians who are members of a patient care team. This team allows Primary Care Physicians to discuss special medical situations with colleagues. The team shares knowledge and experiences to recommend the course of care appropriate for you.

When you select a Primary Care Physician, it is important to remember this limits you to the network of specialists who are affiliated with your PCP's network. Certain Primary Care Providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations, or IPA's, and physician-Hospital organizations, etc.), and Members who select these Providers will generally be referred to specialists and Hospitals within those systems or groups. However, if a system or group does not include a Provider qualified to meet your medical needs, you may request to have services provided by non-system or non-group Providers. Your request will require prior authorization

With your Primary Care Physician's referral, you can see a specialist. After your Primary Care Physician makes the referral, you are responsible for making the actual appointment with the designated specialist.

The following services require approval. They include but are not limited to:

- Hospital stays
- All surgery
- Any non-emergent care
- Growth Hormone Therapy (GHT)

Section 4 Your costs for covered services

This is what you will pay Out-of-Pocket for covered care.

Copayments

A Copayment is a fixed amount of money you pay to the Provider, Facility, pharmacy, etc., when you receive certain services.

Example: When you see your Primary Care Physician, you pay a Copayment of $15 per office visit, and when you go in the Hospital, you pay $250 per day with a maximum of $750 per admission.

Deductible

A Deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a Deductible.

Coinsurance

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

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

Your catastrophic protection Out-of-Pocket Maximum

After your Copayments and/or Coinsurance total $1,500 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, Copayments for the following services do not count toward your catastrophic protection Out-of-Pocket Maximum, and you must continue to pay Copayments for these services:

- Prescription Drugs
- Durable Medical Equipment

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

Carryover

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

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

Section 5 Benefits Overview....16
Section 5(a) Medical services and supplies provided by physicians and other health care professionals....17
- Diagnostic and treatment services....17
- Lab, X-ray and other diagnostic tests....17
- Preventive care, adult....18
- Preventive care, children....18
- Maternity care....19
- Family planning....19
- Infertility services....20
- Allergy care....20
- Treatment therapies....20
- Physical and occupational therapies....21
- Speech therapy....21
- Hearing services (testing, treatment, and supplies)....21
- Vision services (testing, treatment, and supplies)....22
- Foot care....22
- Orthopedic and prosthetic devices....22
- Durable medical equipment (DME)....23
- Home health services....24
- Chiropractic....24
- Alternative treatments....24
- Educational classes and programs....24

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals....25
- Surgical procedures....25
- Reconstructive surgery....26
- Oral and maxillofacial surgery....26
- Organ/tissue transplants....27
- Anesthesia....31

Section 5(c) Services provided by a hospital or other facility, and ambulance services....32
- Inpatient hospital....32
- Outpatient hospital or ambulatory surgical center....33
- Extended care benefits/Skilled nursing care facility benefits....33
- Hospice care....33
- Ambulance....33

Section 5(d) Emergency services/accidents....34
- Emergency within our service area....35
- Emergency outside our service area....35
- Accidental injury....35
- Ambulance....35

Section 5(e) Mental health and substance abuse benefits....36
- Professional services....36
- Diagnostics....37
- Inpatient hospital or other covered facility....37
- Outpatient hospital or other covered facility....37
- Not covered....38

Section 5(f) Prescription drug benefits....39

Covered medications and supplies 40
Section 5(h) Special features 42
Services for deaf & hearing impaired 42
Hearing aids for children 42
Non-FEHB benefits available to Plan Members 43
Summary of benefits for the GlobalHealth Plan - 2011 65

Section 5 Benefits Overview

See page 9 for how our benefits changed this year. Page 67 is a benefit summary of our Plan. Make sure that you review the benefits that are available under GlobalHealth's HMO plan. To obtain more information about our benefits, contact us at 1-877-280-5600 or at our Web site at www.globalhealth.com.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- Plan physicians must provide or arrange your care.
- A Facility Copayment 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**
Professional services of physicians • In physician's office	$15 Copayment per PCP visit $35 Copayment per Specialist visit
Professional services of physicians • In an urgent care center • In a Skilled Nursing Facility • Office medical consultation • Second surgical opinion	$15 Copayment per PCP visit $35 Copayment per specialist visit Nothing for inpatient services
At home	$15 Copayment per PCP visit $35 Copayment per specialist visit
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing
Specialized scanning diagnostic exams	**High Option**
Specialty Scans and Imaging • CT scans • PET scans • SPECT scans • MRI scans • Nuclear scans	$100 Copayment per scan *per body part scanned

Benefit Description	You pay
Preventive care, adult	**High Option**
Routine physical (one per year) which includes: Routine screenings, such as: • Total blood cholesterol • Colorectal cancer screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Routine Pap test	Nothing
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
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams up to age 22 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing

Benefit Description	You pay
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 33 for other circumstances, such as extended stays for you or your baby. • You may remain in the Hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if Medically Necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	Nothing for prenatal care or the first postpartum care visit. $35 Copayment per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services.
Family planning	**High Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$15 Copayment per PCP office visit $35 Copayment per specialist office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*

Benefit Description	You pay
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$15 Copayment per PCP office visit $35 Copayment per specialist office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Reversal of voluntary,surgically induced sterility* • *Treatment for infertility after a reversal of surgically induced sterility*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	$15 Copayment per PCP office visit $35 Copayment per specialist office visit
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Allergy serum	Nothing
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	$15 Copayment per PCP office visit $35 Copayment per specialist office visit Infusion, drug only, $25 if administered in physician's office

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is Medically Necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not Medically Necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$15 Copayment per PCP office visit $35 Copayment per specialist office visit Infusion, drug only, $25 if administered in physician's office
Physical and occupational therapies	**High Option**
60 visits for the services of each of the following: • qualified physical therapists and • occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction is provided for up to 3 visits per week for 12 weeks.	$35 Copayment per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**High Option**
60 visits	$35 Copayment per office/outpatient visit Nothing per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	**High Option**
• Hearing testing, examinations, and necessary hearing aids for children up to age 22 (see *Preventive care, children)* • Hearing aid benefits and limits (see *Orthopedic and prosthetic devices*) • Audible prescription reading and speech generating device benefits and limit (see *Durable medical equipment*) Note: Hearing aids for children up to age of 22 are limited to one (1) hearing aid per ear every forty-eight (48) months, unless Medically Necessary. For Member up to age two (2), four additional ear molds may be obtained per year.	$35 Copayment per office visit Nothing for hearing aids determined to be covered for children up to age 22

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**
Not covered: • *All other hearing testing* • *Hearing aids, testing, and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions • Eye exam to determine the need for vision correction for children through age 17. Note: See *Preventive care, children* for eye exams for children.	$35 Copayment per visit
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$15 Copayment per PCP office visit $35 Copayment per Specialist office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet, or bunions or spurs; and of any instability, imbalance, or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Hearing aids and testing to fit them • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	Nothing
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	**High 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; • Audible prescription reading devices • Speech generating devices • Blood glucose monitors; and • Insulin pumps. Note: Call us at 1-877-280-5600 as soon as your Plan physician prescribes this equipment. We cover DME only when you use a preferred DME Provider. We will arrange the rental or purchase of DME with an appropriate Provider, and will tell you more about this service when you call.	20% Coinsurance
Not covered: • *Bathroom equipment such as tub seats, benches, rails, and lifts* • *Home modifications such as elevators or wheelchair ramps*	*All charges*

Benefit Description	You pay
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy, and medications.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	**High Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: Chiropractic services limited to 20 visits per Member per calendar year	$35 Copayment per office visit
Not covered: Any services not specifically listed as covered	*All charges*
Alternative treatments	**High Option**
No benefit.	All charges
Educational classes and programs	**High Option**
Coverage is provided for: · Diabetes *Nutritional Training for Diabetics* · Smoking cessation programs, including individual group/telephone counseling, and for over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependece. · Congestive Heart Program Disease Management *Learn skills to help manage Diabetes, Congestive Heart Failure, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease.*	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Childhood obesity education	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.
- 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**
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) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$15 Copayment per PCP office visit $35 Copayment per specialist office visit Nothing for procedures done in a Facility setting
Not covered: • *Reversal of voluntary sterilization*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High 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; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the Hospital up to 48 hours after the procedure.	$15 Copayment per PCP office visit $35 Copayment per specialist visit Nothing if you receive these services in a Facility setting
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*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$15 Copayment per PCP office visit $35 Copayment per specialist office visit Nothing if you receive these services in a Facility setting

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	**High Option**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas These **tandem blood** or **marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authroization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular caner)	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Physicians consider many features to determine how disease will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases will respond to treatment without transplant and which diesases may respond to transplant. Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) • Chronic myleogenous leukemia • Hemogloblinopathies • Myelodysplasia/Myelodysplastic syndromes • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Amyloidosis • Paroxysmal Nocturnal Hemoglobinuria • Advanced Neuroblastoma • 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) • Mucopolysaccaridosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Sickle cell anemia • X-linked lymphoproliferative syndrome	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Amyloidosis • Breast Cancer • Epithelial ovarian cancer • Multiple myeloma • Testicular mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Waldonstrom's macroglobulinemia Autologous tandem transplants for • Recurrent germ cell tumors (including testicular cancer) • Multiple myeloma • De-novo myeloma	Nothing
Mini-transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for Members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurence (relapsed) - Advanced non-Hodgkin's lumphoma with reoccurence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Chronic Lumphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lumphocytic or nonlumphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lumphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lumphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma These blood or marrow stem cell transplants are 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. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is Medically Necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional infromation on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Tandem transplants for covered transplants: Subject to medical necessity	Nothing
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Benefit Description	You pay
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled Nursing Facility • Ambulatory Surgical Center • Office	Nothing Note: When the anesthesiologist is the only Provider of services, such as for pain management, the specialist Copayment applies.

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**
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.	$150 Copayment per day with a maximum of $750 per 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 • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Inpatient physician services and visits	Nothing
• 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
Not covered: • *Custodial care* • *Non-covered Facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Physician surgical services Note: We cover Hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$150 Copayment per visit
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care benefit:	Nothing
Skilled Nursing Facility (SNF):	Nothing
Not covered: Custodial care	*All charges*
Hospice care	**High Option**
Supportive and palliative care provided in the home or hospice Facility for a terminally ill Member is covered when directed by a Plan Provider who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	Nothing

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

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

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

What is a medical emergency?

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

What to do in case of emergency:

When It's an Emergency

If you or someone in your family needs Emergency Care,

1. Go to the nearest Hospital emergency room or call 911.

2. Identify yourself as a GlobalHealth Member by showing your ID card

3. Call your Primary Care Physician's office within 48 hours, unless it is not reasonably possible to do so. Let your doctor know you have been treated in an emergency room. Remember, the condition must be an emergency.

4. If you are admitted to the hospital, your Primary Care Physician may arrange to transfer you to a contracting hospital.

5. If you need preventive, routine, or follow-up care after being treated in an emergency room, the care must be arranged or provided by your Primary Care Physician.

If You're in an Accident

If you are in an accident and are outside the Service Area or have no control over where you are taken following the accident, you must notify your Primary Care Physician within 48 hours, unless it was not reasonably possible to do so. There is a physician on call 24 hours a day to take your call.

Emergencies within our Service Area

Urgent care is defined as Medically Necessary and immediately required as a result of an unforeseen illness, injury, or condition.

Urgent care is a covered benefit, subject to scheduled Copayments. *Use of the emergency room for urgent care services that are not pre-authorized by your Primary Care Physician will not be covered.*

2. If you need urgent medical care, call your Primary Care Physician's office and inform them that you are a GlobalHealth Member.

3. Inform your Primary Care Physician or office personnel that you have an urgent medical problem and need assistance and describe your condition or symptoms.

3. During office hours, your call will be given to your Primary Care Physician or a medical staff person who will give you instructions.

After office hours, your Primary Care Physician's answering service will take your name and phone number. Your Primary Care Physician or an on-call physician will call you back. You will be given medical direction at that time.

Emergencies outside our Service Area

Urgent care is a covered benefit, subject to scheduled copayments. *However, use of the emergency room for urgent care services that are not pre-authorized by your Primary Care Physician will not be covered.*

If you are traveling and require urgent care that cannot be delayed until you return to the GlobalHealth Service Area, contact your Primary Care Physician for prior authorization.

All follow-up care must be provided or arranged through your Primary Care Physician.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency Care at a doctor's office • Emergency Care at an urgent care center • Emergency Care as an outpatient at a Hospital, including doctors' services Note: We waive the ER Copayment if you are admitted to the Hospital.	$15 Copayment per PCP visit $35 Copayment per specialist visit $100 Copayment per visit in an urgent care center or emergency room Note: If admitted, the $100 ER Copayment is waived.
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**High Option**
• Emergency Care at a doctor's office • Emergency Care at an urgent care center • Emergency Care as an outpatient at a Hospital, including doctors' services Note: We waive the ER Copayment if you are admitted to the Hospital.	$35 Copayment per visit at a doctor's office $100 Copayment per visit in an urgent care center or emergency room Note: If admitted, the $100 ER Copayment is waived.
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan Providers that has not been approved by the Plan or provided by Plan Providers* • *Emergency Care provided outside the Service Area if the need for care could have been foreseen before leaving the Service Area* • *Medical and Hospital costs resulting from a normal full-term delivery of a baby outside the Service Area*	*All charges*
Ambulance	**High Option**
Professional ambulance service, including air ambulance when medically appropriate. Prior approval required. Note: See 5(c) for non-emergency service.	Nothing
Not covered: Air ambulance without prior approval	*All charges*

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

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

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:

We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

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.

Benefit Description	You pay
Mental health and substance abuse benefits	**High Option**
All diagnostic and treatment services recommended by a Plan Provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	$15 Copayment per visit
Not covered: Services that are not part of a preauthorized approved treatment plan	*All charges*
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation	$15 Copayment

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
• Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting Electroconvulsive therapy	$15 Copayment
Diagnostics	**High Option**
Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$150 Copayment per day up to a maximum of $750 per inpatient admission.
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$150 Copayment per day up to a maximum of $750 per inpatient admission.
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$10 Copayment per outpatient visit

Benefit Description	You pay
Not covered	**High Option**
Services that are not part of a preauthorized approved treatment plan	All charges

Preauthorization	To be eligible to receive these benefits, you must obtain a treatment plan and follow all of the following network authorization processes: Behavioral healthcare services (e.g., treatment or care for mental disease or illness, alcohol abuse and/or substance abuse) are managed by MHNet. MHNet makes initial coverage determinations and coordinates referrals; any behavioral healthcare referrals will be made to Providers affiliated with GlobalHealth/MHNet, unless your needs for covered services extend beyond the capability of the affiliated Providers. Emergency Care is covered. (See Section 5(d), Emergency services/accidents). You can receive information regarding the appropriate way to access the behavioral healthcare services that are covered under the Plan by calling Member Services at 1-877-280-5600. You may also access MHNet directly by calling 1-866-904-5234.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** Y ou must fill your prescriptions at certain pharmacies or through our own mail order pharmacy service. There is an exception for medical emergencies and urgently needed care. If it is a medical emergency or urgently needed care, we cover prescriptions you get from doctors who are not Plan Providers and prescriptions that are filled at non-Plan pharmacies.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan's formulary does not exclude medications from coverage, but requires a higher Copayment for non-formulary drugs. Certain drugs require your doctor to get precertification from the Plan before they can be prescribed under the Plan. Visit our Web site at www.globalhealth.com to review our Formulary Guide or call 1-877-280-5600.
- **These are the dispensing limitations.** Covered prescription drugs prescribed by a licensed physician obtained at a participating Plan retail pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31-day up to a 90-day supply of covered prescription medication through mail order. In no event will the Copayment exceed the cost of the prescription drug.
- **A generic equivalent will be dispensed if available**, unless your physician specifically requires a brand name. If you received a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

Why use generic drugs? Generic drugs are produced and sold under their chemical names, rather than under the names of the companies that manufacture them. A generic drug is a lower cost version of a brand name drug. Some brand name drugs have a generic equivalent and others do not. Generic drugs cost less, but generic and brand name drugs are the same in terms of quality and how they work. The law requires that a generic drug must contain the same amount of the same active drug ingredient as the brand name drug. However, a generic drug may differ in certain other ways, such as its color or its flavor, the shape of the pill or tablet, and the inactive (non-drug) ingredients it contains. As we explain below, you pay less for formulary drugs if you get a generic drug rather than a brand name drug. The GlobalHealth formulary list includes most generic drugs. When there is a generic drug available, the formulary list usually includes only the generic drug. GlobalHealth's plan pharmacies and mail order service fill prescriptions using generic drugs rather than brand name drugs whenever possible**.**

When you do have to file a claim: Send your itemized bill to GlobalHealth, P.O. Box 2328, Oklahoma City, OK 73101-2328.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies limited to disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Contraceptive drugs and devices	Retail Pharmacy: For up to a 30-day supply per prescription or refill: $10 Copayment per covered generic formulary drug $30 Copayment per covered brand name formulary drug $50 Copayment per covered non-formulary (generic or brand name) drug. Mail Order Pharmacy: For a 31-day up to a 90-day supply per prescription or refill: $20 Copayment per covered generic formulary drug $60 Copayment per covered brand name formulary drug $100 Copayment per covered non-formulary (generic or brand name) drug.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Injectable Fertility drugs* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Vitamins, nutrients, and food supplements, even if a physician prescribes or administers them* • *Nonprescription medicines* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (See page 41)*	*All charges*

Section 5(h) Special features

Feature	Description
Feature	**High Option**
Services for deaf and hearing impaired	TTY/TDD/VOICE 1-800-522-8506
Hearing aids for children	Hearing aids for children up to age 22 are covered when Medically Necessary and hearing loss is documented.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Health improvement programs	• Nutritional Training for Diabetes • Medically managed Smoking Cessation and Freedom from Smoking Classes • Congestive Heart Program • Disease Management-Learn skills to help manage Diabetes, Congestive Heart Failure, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease
GlobalWellness discount card program	Your GlobalWellness discount card is provided at no additional cost to you. It is NOT insurance, but a discount program. You will be able to access discount plans for: • Dental services • Prescriptions • Eyeglasses, contacts, LASIK • Chiropractic visits • Fitness Clubs • Hearing aides • Vitamins

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
	Your membership booklet will tell you how to access savings for all of the above.

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.

Medicare Managed Care Plan

If you are Medicare eligible and are interest in enrolling in a Medicare HMO Plan sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-877-280-5600 for information.

Medicare Advantage HMO - As a member of Generations, you benefit from low or no plan Copayments, low or no Deductibles, and virtually no paperwork. Generations offers peace of mind for Medicare beneficiaries residing in Canadian, Cleveland, Creek, Grady, Lincoln, Logan, Mayes, McClain, Oklahoma, Osage, Pottawatomie, Rogers, Seminole, Tulsa, and Wagoner counties by offering more services than original Medicare for no additional cost. For more information, call toll-free 1-877-280-5600.

Section 6 General exclusions – things we don't cover

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

We do not cover the following:

- Care by non-Plan Providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not Medically Necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a Provider or Facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services, drugs, or supplies you would not be charged for if you had no health insurance;
- Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service;
- Services that you get without prior authorization, when prior authorization is required for getting that service;
- Emergency Facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency;
- Personal convenience items, such as a telephone or television in your room at a Hospital or Skilled Nursing Facility;
- Nursing care on a full-time basis in your home;
- Custodial care is not covered by GlobalHealth *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating, and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered;
- Homemaker services;
- Meals delivered to your home;
- Charges imposed by immediate relatives or members of your household;
- Elective or voluntary enhancement procedures, services, supplies, and medications including but not limited to: Hair growth, athletic performance, cosmetic purposes, anti-aging, and mental performance;
- Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
- Check your GlobalHealth *Member Handbook* for a comprehensive description of Exclusions and Limitations.

Section 7 Filing a claim for covered services

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

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 ID 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 on the form CMS-1500, Health Insurance Claim Form. Your Facility will file on the UB-04 form. For claims questions and assistance, call us at 1-877-280-5600.

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 the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to:

GlobalHealth

P.O. Box 2328

Oklahoma City, OK 73101-2328

1-877-280-5600

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.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at 1-877-280-5600. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) 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 a written or electronic notification within three days of oral notification.

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 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.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the 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 before the expiration 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.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we 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.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

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 healthcare 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

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.globalhealth.com. 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.

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 GlobalHealth, P.O. Box 2328, Oklahoma City, OK 73101-2328; 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 Member), 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.

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

a) Pay the claim (or, if applicable, arrange for the healthcare Provider to give you the care or precertify your Hospital stay or grant your request for prior approval for a service, drug, or supply); or

b) Write to you and maintain our denial - go to step 4; or

c) Ask you or your Provider for more information. If we ask your Provider, we will send you a copy of our request—go to step 3.

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

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

We will write to you with our decision.

In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 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 expeditious methods.

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

You must write to OPM within

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

Write to OPM at: United States Office of Personnel Management, Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;

- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email addess, 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.

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily function or death if not treated as soon as possible), and you did not indiate that your claim was a claim for urgent care, then call us at (405) 280-5600. 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 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays healthcare 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 or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (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 help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-877-486-2048). 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 panalty 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 coverd by the group plan.

If you are eligible for Medicare, you may have choices in how you get your healthcare. 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, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-877-280-5600 or see our Web site at www.globalhealth.com.

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

- Medical services and supplies provided by physicians and other healthcare professionals.

You can find more information about how our Plan coordinates benefits with Medicare in GlobalHealth's *Member Handbook* at www.globalhealth.com.

- **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 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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (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 our Medicare Advantage plan: You may enroll in our Medicare Advantage Plan, Generations Healthcare, and also remain enrolled in our FEHB Plan. In this case, we do not waive cost-sharing for your FEHB coverage. Some coordination of benefits will apply. For more information about our Medicare Advantage Plan please call 1-877-280-5600.

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

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's Service Area.

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

  When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB Plan.

- **Clinical Trials**

  If you are a participant in a clinical trial, this Health Plan will provide related care as follows, if it is not provided by the clinical trial:

  - 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 condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan only with prior-authorization and if services are received within the Plan's Provider Network. See General Exclusions for investigational procedures in Section 6 of this brochure.
  - 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. This Plan does not cover these costs.
  - 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. These costs are generally covered by the clinical trials, this Plan does not cover these costs.

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 healthcare 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 already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB Plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your Out-of-Pocket cost.

Clinical trials

If you are a participant in a clnical trial, this Health Plan will provide related care as follows, if it is not provided by the clinical trial:

- 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 condition, 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. This Plan does not cover these costs.
- 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. These costs are generally covered by the clinical trials. This Plan does 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 condition 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 13.

Copayment

A Copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Covered services

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

Deductible

A Deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.

Experimental or investigational service

Those procedures and/or items determined by GlobalHealth not to be generally accepted by the medical community.

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

Medical or hospital services we determine are appropriate for the treatment or diagnosis of an illness or injury.

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:

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.

Us/We

Us and We refer to *GlobalHealth.*

You

You refers to the enrollee and each covered family member.

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 could 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 1-877-280-5600. 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.

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens 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

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

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 spouses 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.

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 or stepchildren 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 when you add or remove family members from your coverage for any reason, including your marriage, divorce, annulment, or when your child under age 26 turns 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.

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 2011 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 2010 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.

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 for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Section 12 Three Federal Programs complement FEHB benefits

Important information

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

First, the **Federal 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 healthcare expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services 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. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified Dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** helps 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 reinbursed. 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 drugs and medications, vision and dental expenses, and much more) for you and your tax Dependents, including adult children (through the end of the calendar year in which they turn 26), which are not covered or reimbursed by FEHBP or FEDVIP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax Dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible Dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.
- 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 troll-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 Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

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

Dental Insurance

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

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

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

Vision Insurance

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

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

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/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 designed to help you receive help 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.

Index

Accidental injury.....26,35,44
Allogeneic (donor) bone marrow transplant 28
Alternative treatments.....24
Ambulance.....32, 33, 35
Anesthesia.....5, 25, 31, 33
Associate.....66
Autologous bone marrow transplant...27, 29, 30
Biopsy.....25
Casts.....32, 33
Catastrophic protection (out-of-pocket maximum).....13, 43, 65
Changes for this plan.....9
Cholesterol tests.....18
Claims.....41, 45, 48, 51, 56, 60
Coinsurance.....13, 56
Colorectal cancer screening.....18
Congenital anomalies.....25, 26
Contraceptive drugs and devices.....19, 40
Covered charges.....51
Crutches.....23
Deductible.....10, 13, 56
Definitions.....56
Dental care.....33, 44, 54, 62, 63
Diagnostic services...17, 24, 33, 36, 37, 63, 65
Donor expenses.....9, 20, 30
Dressings.....32, 33
Durable medical equipment.....13, 21, 23
Effective date of enrollment...10, 11, 56, 60
Emergency.....7, 8, 33, 34, 39, 44, 45, 65
Experimental or investigational.....44, 56
Eyeglasses.....22, 41
Family planning.....19
Fecal occult blood test.....18
Fraud.....3, 60
General exclusions.....44
Home health services.....24, 63
Hospital...4-13, 19, 25, 26, 30-35, 37, 44, 45, 48, 50-52, 54, 56, 65
Immunizations.....9, 18
Infertility.....20
Inpatient hospital benefits.....32, 37
Insulin.....23, 40, 62
Licensed Practical Nurse (LPN).....24
Magnetic Resonance Imagings (MRIs) 17
Mammograms.....17, 18
Maternity benefits.....19, 32
Medicaid.....54
Medically necessary...11, 17, 19, 21, 25, 30, 32, 34, 38, 39, 41, 44
Medicare.....43, 45, 50-53
Members.....7, 10-12, 29, 39, 43, 51
Mental Health/Substance Abuse Benefits 9, 36, 65
Newborn care.....19
Non-FEHB benefits.....43
Nurse.....5, 24, 32, 52, 55, 56
Nurse Anesthetist (NA).....32
Occupational therapy.....21
Ocular injury.....22
Office visits.....7, 9, 19-22, 24-26, 65
Oral.....19, 20, 26, 63
Oral and maxillofacial surgical.....26
Original Medicare.....43, 51
Out-of-pocket expenses.....7, 13, 51, 54, 62
Outpatient.....33, 35, 37, 65
Oxygen.....23, 24, 32, 33
Pap test.....17, 18
Physician...7, 10-12, 17, 20, 21, 23-25, 28, 32-35, 39, 40, 45, 48, 49, 51, 55, 56, 62-65
Precertification.....25, 32, 39, 49, 56
Prescription drugs.....13, 24, 39, 40, 45, 65
Preventive care, adult.....18
Preventive care, children.....18, 21, 22
Preventive services.....18
Prior approval.....11, 21, 35, 48, 49, 56
Prosthetic devices.....21, 22, 25, 26
Psychologist.....36
Reconstructive.....25, 26
Room and board.....32, 37
Second surgical opinion.....17
Skilled nursing facility care...11, 17, 31, 33, 44
Social worker.....36
Speech therapy.....21
Splints.....32
Subrogation.....54
Substance abuse.....9, 36, 65
Surgery.....5, 12, 21-23, 25, 27, 32, 44, 63
Syringes.....40
Temporary Continuation of Coverage (TCC).....53, 60, 61
Transplants.....20, 27-30
Vision care.....18, 22, 59, 62, 63, 65
Vision services.....22, 54
Wheelchairs.....23
Workers' Compensation.....53, 54
X-rays.....17, 30, 32, 33, 52, 54, 56, 63

Summary of benefits for the GlobalHealth Plan - 2011

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

High Option Benefits	You pay	Page
Protection against catastrophic costs (Out-of-Pocket Maximum)**:**	Nothing after $1,500/Self only or $3,000/Family enrollment per year. Some costs do not count toward this protection.	13
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit Copayment: $15 primary care; $35 specialist	17
Vision care:	1 refraction annually - $35 Copayment	22
Services provided by a hospital:		
• **Inpatient**	$150 per day with a maximum of $750 per admission Copayment	32
• **Outpatient**	$150 Copayment per visit	33
Emergency benefits:		
• **In-area**	$100 Copayment per emergency room or urgent care visit	34
• **Out-of-area**	$100 Copayment per emergency room or urgent care visit	34
Mental health and substance abuse treatment:	Regular cost sharing	36
Prescription drugs:		39
• Retail pharmacy	$10 Copayment - covered generic formulary drug; $30 Copayment - covered brand name formulary drug; and $50 Copayment - covered non-formulary (generic or brand name) drug.	40
• Mail order	Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 Copayment - covered generic formulary drug; $60 Copayment - covered brand name formulary drug; and $100 Copayment - covered non-formulary (generic or generic brand name) drug.	40

2011 Rate Information for GlobalHealth

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

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

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

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-3273 Option 5

TTY: 1-866-260-7507

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	IM (1)	126.95	42.31	275.05	91.68	143.02	26.24
High Option Self and Family	IM (2)	305.89	101.96	662.76	220.92	344.63	63.22