



GHI Health Plan

1999

A Prepaid Comprehensive Medical Plan with a Point of Service Product



Serving:

Enrollment in this Plan is limited; see page 8 for requirements.

Enrollment code:

801 Self Only

802 Self and Family

**Visit the OPM website at <http://www.opm.gov/insure>
and
this Plan's website at <http://www.ghi.com>**

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**United States
Office of
Personnel
Management**



**Federal Employees
Health Benefits Program**

GHI Health Plan

Group Health Incorporated, 441 Ninth Ave., New York, NY 10001, has entered into a contract (CS 1056) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called the Plan, GHI Health Plan, or GHI.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on the inside back cover of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claim statements carefully. If you find that a provider, such as a doctor, hospital, or pharmacy charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation — sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-888/456-3728 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

Inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education. As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by doctors, hospitals, facilities, and other providers as defined on page 6-7.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See If you are hospitalized on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in the plan under the FEHB.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earlier of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance 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.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" on page 3. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including the determination of whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

- You may also remain enrolled in this Plan when you join a Medicare prepaid plan. Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program, nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member also may be eligible for one of the following:

Former spouse coverage

When the spouse of a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about this Plan.

Temporary continuation of coverage

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which discusses TCC, and for RI-70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months' coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to non-group coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premiums plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to non-group coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee will be responsible for premium payments retroactive to the effective date, and coverage may not exceed the 18 or 36-month period noted above.

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within

60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled. The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events; the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation for nonpayment of premium), you may be eligible to convert to an individual, non-group contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB program.

Certificate of Creditable Coverage

Under federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically you must be given one on request.

Facts about GHI Health Plan

This Plan is a prepaid medical plan that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are encouraged to select a personal doctor who will provide or arrange your care and you will pay minimal amounts for comprehensive benefits. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges and the benefits available may be less comprehensive.

Because the Plan emphasizes care through participating providers and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a more comprehensive range of benefits than many insurance plans. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at first sign of illness.

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 212/501-4444 or you may write the Carrier at GHI, P.O. Box 1701 New York, NY 10023-1701. You may also contact the Carrier by fax at 212/501-7585, at its website at <http://www.ghi.com> or by e-mail at fed@ghi.com.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If non-compliant, the reason for non-compliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care to plan members?

A **"provider"** as used in this brochure includes any duly-licensed doctor, dentist, podiatrist, qualified clinical psychologist, optometrist, chiropractor, nurse, certified midwife, nurse practitioner/clinical specialist, or qualified clinical social worker any other duly licensed, registered or certified practitioner or privately operated facility permitted to perform or render care or service described in this brochure.

Facts about GHI Health Plan *continued*

A medical/surgical provider who participates has agreed to limit fees to the GHI allowances and to await payment from GHI. Such a provider must be notified by the subscriber before service is rendered that GHI is the insurer.

A medical/surgical provider who does not participate has no agreement with GHI and does not have to accept GHI payments as payment in full. **Only 50% of the scheduled benefits will be paid to you if you use the services of a non-participating medical/surgical provider.** Services of non-participating diagnostic laboratory facilities, x-ray facilities, and anesthesia are covered at the plan's full medical/surgical fee schedule. Payment may be less than actual charges. In addition, you can not transfer your right to collect payment from GHI to another person, corporation or other organization. Any assignment by you will be void.

If you are newly enrolling in this Plan, you will be given a GHI medical/surgical/hospital identification card, and a GHI prescription drug card. The medical/surgical/hospital card is to be used for all services except drug benefits. The medical/surgical/hospital card contains telephone numbers which you are required to call before nonemergency hospital confinement or surgery of the type referred to on page 13.

Choosing your doctor

The Plan's provider directory lists participating generalists, specialists, laboratories, and radiologists with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at 212/501-4444; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she participates with the Plan and is accepting new patients. **Important note: The continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.**

You may choose any licensed provider you wish. When you use the services of participating providers, show your identification card to receive paid-in-full benefits, except applicable copayments. These providers have agreed to limit their fees to GHI allowances and to wait for payment from GHI. ***If you use a medical/surgical provider who does not participate, you will receive only 50% of GHI's scheduled allowance.***

Referrals for specialty consultations

Upon referral from your attending doctor, one consultation in each specialty field is covered per member per hospital admission. On an outpatient basis, this benefit is applied per illness per calendar year. A written report must be sent to the referring doctor by the specialist.

Hospital care

If you require hospitalization, your doctor will make the necessary arrangements and continue to supervise your care. A "hospital," as used in this brochure, means a general hospital that is licensed and accredited and that has medical and surgical facilities for the care and treatment of the sick. The hospital must provide 24-hour nursing service by registered graduate nurses who are present and on duty. The hospital must be supervised by a staff of doctors.

Out-of-pocket maximum

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated payments which are required for a few benefits; to the difference between the Plan's payment for non-participating providers and the provider's charges; and charges for any services or equipment in excess of the maximum benefits listed on Pages 11 and 12. Please note that there are reductions in benefits due to non-compliance with the precertification requirements shown on Page 13.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than June 30 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

Experimental/ Investigational determinations

The Plan considers factors which it determines to be most relevant under the circumstances, such as: published reports and articles in the authoritative medical, scientific, and peer review literature; or written protocols used by the treating facility or being used by another facility studying substantially the same drug, device, or medical treatment. The Plan also considers Federal and other government agency approval as essential to the treatment of an injury or illness by, but not limited to, the following: American Medical Association, U.S. Surgeon General U.S. Department of Public Health, the Food and Drug Administration, or the National Institutes of Health.

Facts about GHI Health Plan *continued*

The Plan's Service Areas

The service area is the area within which the Plan's providers are most accessible. For this Plan, the service area is all of New York and the New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union. You must live or work in the service area to enroll in the Plan.

If you or a covered family member move outside the Service Area, or farther away from the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Parts B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits as a result of, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury

General Limitations *continued*

DVA facilities, DoD facilities, and Indian Health Service

settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the definitions, limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless the Plan itself determines it is medically necessary to prevent, diagnose or treat your illness or condition. The following are excluded:**

- Expenses incurred while not covered by this Plan.
- Services furnished or billed by a provider or facility barred from the FEHB Program.
- Services not required according to accepted standards of medical, dental, or psychiatric practice.
- Procedures, treatments, drugs or devices that are experimental or investigational. Subscribers are not covered for expenses that GHI determines to be related to:
 - (a) experimental treatment; or
 - (b) investigational treatment; or
 - (c) clinical trials.

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

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

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

- Procedures, services, drugs and supplies related to sex transformations.
- Procedures, services, drugs and 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.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by doctors and other providers. This includes all necessary office visits; **you pay** a \$10 office visit copay, but no additional copay for laboratory tests and X-rays by **Participating providers**. Within the Service Area, house calls will be provided if in the judgment of the Plan such care is necessary and appropriate; **You pay** a \$10 house call copay for a participating doctor's visit; nothing for visits by nurses. **Participating doctors** also provide all necessary medical or surgical care in a hospital **at no additional cost to you**.

The following services are included:

- Preventive care, including well-baby care (no copay applies) and periodic check-ups.
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters (The cost of the immunizing agent is covered for children to age 22).
- Consultations by specialists, upon referral from attending doctors (one inpatient per confinement and one outpatient per illness).
- Diagnostic procedures, such as laboratory tests and X-rays.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a **participating doctor**. The mother, at her option, may remain in the the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Routine nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services.
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment, which includes the cost of the test and treatment materials (such as allergy serum).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Non-experimental transplants, including cornea, human heart, heart/lung, lung, pancreas, kidney and liver transplants. Allogenic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for acute lymphocytic leukemia or non-lymphatic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Additionally, autologous bone marrow transplants (autologous stem and peripheral stem cell support) and high dose chemotherapy for the following conditions: breast cancer, multiple myeloma and epithelia ovarian cancer. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis.
- Chemotherapy and radiation therapy.
- Inhalation therapy.
- Surgical treatment of morbid obesity.

Medical and Surgical Benefits *continued*

- High-tech nursing and infusion therapy through GHI's participating provider network for services of I.V. infusion therapy, parenteral and enteral therapy, and other home I.V. therapy. Participating providers must be used for these services. Contact GHI at 212/615-4662 prior to receiving services to ensure coverage.
- Intermittent home nursing service — The Plan pays full charges when billed by a home nursing service for services of a Registered Nurse or, if not available, a Licensed Practical Nurse *provided that* the service is authorized and supervised by a doctor, subject to the same limitations as those imposed for other providers rendering the same type of covered service. The Plan covers only intermittent visits, generally for less than two (2) hours per day.

Plan provides payment in full for medical-surgical benefits shown above by Participating Providers. Only 50% of the Plan's fee schedule will be paid, unless otherwise stated, for services of a nonparticipating medical-surgical provider. Failure to precertify nonemergency hospital confinements and certain surgical procedures will result in benefit reductions. (See Page 13.)

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, the removal of impacted teeth, the treatment of fractures and the excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Chiropractic services are limited to 15 visits per calendar year, plus two (2) related X-rays.

Podiatric services, including the routine treatment of corns, calluses, and bunions and the partial removal of toenails, are limited to 4 visits per calendar year.

Diagnosis and treatment of infertility is covered (as well as associated prescription drugs which are covered under the Prescription Drug Benefits). The cost of donor sperm is not covered. **Other assistive reproductive technology (ART) procedures** that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization (limited to three transfers per lifetime) and embryo transfer and artificial insemination are covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided; you pay a \$10 copay per session.

Reconstructive surgery will be provided to correct a condition resulting from a functional defector from an injury or surgery which has resulted from accidental injury or from surgery if the accident or injury has produced a major effect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery.

Multiple surgery — The allowances for multiple surgery when one incision is made are limited to the highest payment for a single procedure involved. When two or more surgical procedures requiring more than one incision are performed at the same time, the allowance is limited to the highest payment, plus one-half of each of the lesser payments.

Short-term rehabilitative therapy (physical, speech and occupational) in a general hospital or approved facility is provided on an inpatient or outpatient basis for up to 60 visits per condition if significant improvement can be expected within two months; **you pay** a \$10 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Medical and Surgical Benefits *continued*

Nursing, appliances, oxygen and equipment: For nursing services, **you pay** the annual deductible of \$150 per individual or family. When you use a GHI participating provider for nursing services, no further out-of-pocket expenses would be incurred by you. When you use a non-participating provider, you are responsible for 50% of the Plan's fee schedule after you have satisfied your deductible, plus any charges that exceed the fee schedule. For appliances, oxygen and equipment, you pay the annual deductible of \$100 per individual or family. When you use a GHI participating provider for appliances, oxygen and equipment, you are responsible for 20% of the Plan's fee schedule after you have satisfied your deductible. When you use a non-participating provider, you are responsible for 50% of the Plan's fee schedule after you have satisfied your deductible, plus any charges that exceed the fee schedule. There is a maximum Plan payment for these combined benefits of \$25,000 per member per calendar year. **The following services are covered when prescribed by a medical doctor:**

- Active private duty nursing service rendered at home or in the hospital by a registered nurse (R.N.) or, when an R.N. is not available, by a licensed practical nurse (L.P.N.)
- Durable medical equipment (as defined by Medicare), such as wheelchairs, hospital beds, and oxygen for home use.
- Artificial eyes, limbs, lenses following cataract removal or prosthetic appliances to replace internal body organs.
- Orthopedic devices, such as braces.
- Ostomy supplies.
- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel, or governmental licensing.
- Elective cosmetic surgery.
- Cost of donor sperm.
- Reversal of voluntary, surgically-induced sterility.
- Custodial care.
- Hearing aids.
- Homemaker services.
- Services furnished or billed for by an extended care facility, nursing home, or other non-covered facility.
- Blood and blood derivatives received on an outpatient basis (no charge if replacement is arranged by member.)
- Air purifying devices.
- Long-term rehabilitative therapy.
- Orthotic devices for the feet.
- Stand-by services.
- Alarm and Alert services.

What is not covered

TO RECEIVE FULL BENEFITS CARE MUST BE OBTAINED FROM PLAN DOCTORS

Hospital/Home Health Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a doctor. You pay nothing for services billed by the admitting hospital. All necessary services are covered, including:

- Semiprivate room accommodations; when medically necessary, the doctor may prescribe private accommodations.
- Specialized care units, such as intensive care or cardiac care units.
- Facility charges for the following outpatient services:
 - Ambulatory surgery.
 - Pre-admission testing (Surgery must actually take place within 7 days after tests are performed.)
 - Renal dialysis.
 - Mammography and pap smear screenings. subject to a \$25 deductible per referral.
 - Chemotherapy and radiation therapy.
 - Emergency room treatment (\$25 co-payment per emergency room visit.)
 - Ambulatory laboratory test and diagnostic X-rays, when referred and rendered,

Precertification of hospital confinements

Nonemergency admissions must be precertified prior to admission. All inpatient hospital admission for maternity care and skilled nursing facility must be approved by the Plan whether or not the case is an emergency. Maternity admissions should be precertified no later than the second trimester. In case of emergency, GHI should be notified within 48 hours (72 hours if confined on a weekend). Responsibility for informing GHI rests with you, the subscriber. Urge your doctor to contact GHI as soon as possible. You or your doctor must call the Plan at 212/615-4662 in New York City or 1/800/223-9870 outside New York City. If precertification is not obtained, benefits will be reduced by \$125 per day to a maximum \$250.

Large case management

The Plan provides a large case management program which seeks to provide alternatives for improving the quality and cost effectiveness of care. The large case management program focuses on catastrophic illnesses — for example, major head injury, high-risk infancy, stroke and severe amputations. The large case management process begins when GHI is notified that an enrollee or covered family member has experienced a specific illness or injury with potential long-term effects or changes in lifestyle. Case managers assess individual needs and the full range of treatment and financial exposures from the onset of a condition or illness to recovery or stabilization. They review the efforts of the health care team and family with the goal of helping the patient return to pre-illness/injury functioning or of lessening the burden of a chronic or terminal condition. Case managers provide the family with support and advice ranging from referral to family counseling.

If it is determined that involvement of a case manager would be both care- and cost-effective, GHI will obtain the necessary authorization from the patient to proceed. Throughout the process, GHI will maintain strict confidentiality.

Skilled nursing care facility

Within 14 days following discharge from a hospital after a covered admission of at least 3 days, the Plan will cover up to 30 days per calendar year of full-time skilled nursing care for confinements in a participating skilled nursing facility, which are in lieu of hospitalization. Participating providers must be used for these services. Contact GHI at 212/615-4662 prior to receiving services to ensure coverage. The following services are covered:

- Bed, board and general nursing services in a semi-private room.
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility as governed by Medicare guidelines.

Your condition must require skilled nursing that can only be provided in a skilled nursing facility, and the skilled care must be based on a doctor's order.

Home health care benefits

Following discharge from a hospital after a covered admission, benefits are provided for the covered home health care service stated below if (1) services rendered are billed by a certified home health agency which has an agreement with GHI to provide home health care services "and" (2) the subscriber remains under the care of a medical doctor "and" (3) the services are provided according to a plan of treatment approved by the attending medical doctor "and" (4) medical evidence substantiates that the subscriber would have required further inpatient care had the home health care not been available "and" (5) the home health care begins within 5 days after the discharge from the hospital. Participating providers must be used for these services. Contact GHI at 212/615-4662 to pre-certify and ensure coverage.

What is covered

- Part-time or intermittent nursing care by a registered professional nurse (R.N.) or a home health aide under the supervision of a registered professional nurse
- Physical therapy.
- Respiration or inhalation therapy.
- Prescription drugs.

Hospital/Home Health Care Benefits *continued*

What is not covered	<ul style="list-style-type: none">• Medical supplies which serve a specific therapeutic or diagnostic purpose.• Other medically necessary services or supplies that would have been provided by a hospital if the subscriber were still hospitalized.• Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter.• Services and supplies related to normal maternity care.• Services and supplies provided following a noncovered hospital admission or admission to a facility that is not a participating facility.• Services and supplies provided when the subscriber would not have required continued inpatient care.• Services and supplies provided by a nonparticipating facility.• High-tech nursing and infusion therapy.
Hospice care	Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. An eligible hospice organization is one which has an agreement with GHI and/or is recognized as a hospice by Medicare.
Ambulance service	The Plan pays up to \$100 for an ambulance service for each trip to or from a hospital in connection with the types of services covered by the contract. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility. You pay all charges above Plan payment.
Organ transplants	Hospital benefits for the organ transplant procedures described on Page 10 will apply only to covered patients and will include: <ul style="list-style-type: none">• All medically necessary inpatient and outpatient hospital charges of the recipient patient.• All medically necessary medical, surgical and hospital costs of the donor patient, when the recipient is covered by the Plan, related to the donation of the organ used in the transplant procedure, such as the surgical procedure necessary to procure the organ, storage expenses, and organ transportation costs, up to a maximum of \$10,000 per transplant.• Travel expenses up to a maximum of \$150 per person per day and \$10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center, including food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place.• The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery. There is a separate lifetime maximum benefit up to \$1,000,000 per recipient for each type of covered transplant.
Limited benefits	Hospitalization for certain dental procedures is covered when a doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition.
Inpatient dental procedures	
Acute inpatient detoxification	Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for nonmedical Substance Abuse Benefits.
	<i>To avoid possible reduction in benefits, you must precertify all nonemergency hospital confinements. See Page 13.</i>
What is not covered	<ul style="list-style-type: none">• Personal comfort items, such as telephone and television.• Custodial care, rest cures, domiciliary or convalescent care.• Extended care.• Blood and blood derivatives received on an outpatient basis (no charge if replacement is arranged by member).• Long-term rehabilitation.• Air ambulance and Ambulette service.• Transplants not listed as covered.

Emergency Benefits

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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the service area

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

Benefits within the Service Area

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

Plan pays . . .

Emergency fee schedule for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay . . .

\$25 per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of this Plan, and charges which exceed the Plan's emergency fee schedule. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

Emergencies outside the service area

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

Plan pays . . .

Full emergency fee schedule for emergency care services to the extent the services would have been covered if received from Plan providers; 80% of charges from a nonparticipating hospital.

You pay . . .

\$25 plus 20% of charges per hospital emergency room visit or urgent care center visit for non-participating facilities and nothing for emergency services billed for by a doctor, except charges which exceed the Plan's emergency fee schedule, for services which are covered benefits of this Plan. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

What is covered

- Emergency care at a doctor's office or an urgent care center.
- Ambulance service (see page 14).
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.

If the medical/surgical care received from nonparticipating providers is not due to a medical emergency as defined above, the Plan will pay 50% of its fee schedule.

Follow-up care after an emergency is covered in full only if received from participating providers.

Mental Conditions/Substance Abuse Benefits

Mental Conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including treatment of mental illness or disorders. Only services rendered by a participating provider are covered. You must pre-certify before you receive benefits by calling GHI at 1-800/692-7311.

- Diagnostic evaluation.
- Psychological testing.
- Psychiatric treatment (including individual and group therapy.)
- Hospitalization (including inpatient professional services.)
- Life Management Services - telephone consultation services for a) finance & credit, b) childcare, c) eldercare, d) legal problem, e) organizing life's affairs, f) taxes, and pre-retirement questions. (These services are not subject to the outpatient and inpatient limits.)

Outpatient care

Up to 30 outpatient visits per calendar year maximum, subject to a \$10 copay when you use a participating provider, when the diagnosis is listed in the "Diagnostic and Statistical Manual, Fourth Edition" ("DSM IV Revised") as a mental disorder and there is impairment in one or more important areas of functioning. You pay a \$10 copay per outpatient visit for covered services rendered by a participating therapist for the first 30 outpatient visits — all charges thereafter.

Inpatient care

Up to 60 days of hospitalization each calendar year in a participating general hospital or participating private facility. All inpatient admissions for mental conditions must be precertified by the Plan prior to admission. You must contact GHI at 1-800-692-7311 for precertification prior to admission and to determine the hospital's current eligibility status or facility's current participating status in order to ensure coverage. In case of emergency, GHI should be notified within 48 hours (72 hours if confined on a weekend). You pay nothing for medically necessary covered services for the first 60 days — all charges thereafter.

What is not covered

- Care for psychiatric conditions that in the professional judgment of the Plan are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by the Plan to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.
- Benefits are payable only when personally rendered by doctors who confine their practices to psychiatry, by a licensed and registered psychologist, or a certified and qualified psychiatric social worker.
- The following diagnoses are not payable in that they are defined in the "DSM IV, Revised" Manual as conditions not attributable to a mental disorder: malingering; borderline intellectual functioning; adult antisocial behavior; childhood or adolescent antisocial behavior; academic problem; occupational problem; uncomplicated bereavement; noncompliance with medical treatment; phase of life problem or other life circumstance problem; marital problem; parent-child problem.
- Facility charges of a nonparticipating general hospital or facility.
- Treatment by a nonparticipating provider.

Substance Abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment. Only services rendered by a participating provider are covered. You must pre-certify before you receive benefits by calling GHI at 1-800-692-7311.

Outpatient care

Up to 60 outpatient visits to the outpatient department of a participating hospital or certified approved participating facility for follow-up care and counseling; You pay nothing for each covered visit — all charges thereafter.

Inpatient care

Up to a maximum of 30 days per calendar year for substance abuse rehabilitation (intermediate care) programs in a participating general hospital or participating private facility. All inpatient admissions for substance abuse must be precertified by the Plan prior to admission. You must contact GHI at 1-800-692-7311 for precertification prior to admission and to determine the hospital's current eligibility status or facility's current participation status in order to ensure coverage. In case of emergency, GHI should be notified within 48 hours (72 hours if confined on a weekend). You pay nothing for medically necessary covered services during the benefit period — all charges thereafter.

What is not covered

- Treatment that is not authorized by a doctor.
- Facility charges of a nonparticipating general hospital or facility.
- Treatment by a nonparticipating provider.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a doctor and obtained at a pharmacy that participates under the program through PAID Prescriptions, Inc. Coordinated Care Network III will be dispensed for up to a 31-day supply. Drugs are prescribed by doctors and dispensed in accordance with the Plan's drug formulary. You pay a \$5 co-pay for a generic drug, a \$10 copay per prescription unit or refill for a name brand.

Covered medications and accessories include:

- Drugs for which a prescription is required by law.
- Injectable and oral contraceptive drugs.
- Fertility Drugs.
- Drugs to treat sexual dysfunction (Viagra is limited to six tablets per every thirty-one days.)
- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape.
- Disposable needles and syringes needed for injection of covered prescribed medication
- Allergy serum.
- Smoking cessation drugs and medication, including nicotine patches (up to 90-day supply.)
- Intravenous fluids and medications for home use through GHI's participating provider network for home infusion therapy.

In addition to covered prescription drugs, you are covered for enteral formulas if each of the criteria set forth below are met:

- A covered Provider has given a written order and/or a prescription.
- It must be proven effective as a disease-specific treatment regimen for persons who are or will become malnourished or suffer from disorders which, if left untreated, cause chronic physical disability, mental retardation or death.

You are also covered for these modified food products that are low in protein or contain modified protein if each of the criteria set forth below are met:

- An authorized Provider has given a written order and/or a prescription.
- It must be for the treatment of certain inherited diseases of amino acid and organic acid metabolism.

You are covered for these modified food products up to a maximum of \$2,500 per calendar year or any continuous twelve (12) month period. You must submit your written order or prescription and store receipt for modified food products along with a completed claim form to: GHI, P.O. Box 2868, New York, New York 10116-2868

Maintenance Drug Program — The maintenance drug program permits long-term prescriptions to be filled for up to a 90-day supply. **You pay** a \$5 copay for a generic drug, a \$10 copay per prescription unit for a name brand.

Prescription Drug Benefits *continued*

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available.
- Drugs obtained at a nonparticipating pharmacy except for emergencies.
- Vitamins and nutritional substances that can be purchased without a prescription.
- Medical supplies such as dressings and antiseptics.
- Contraceptive devices, including diaphragms.
- Drugs for cosmetic purposes.
- Drugs to enhance athletic performance.
- Implanted time-release medication, such as Norplant.

Other Benefits

Dental Care

What is covered

This Plan provides the following program of dental coverage. The emphasis is on prevention, with preventive and diagnostic dental services covered with no copayments through participating Plan dentists. Services by nonparticipating dentists are covered in accordance with the **fees listed below**: This Plan provides the following program of dental coverage:

	Plan Pays
• Examinations — maximum 2 per calendar year	\$10.00 each
• Prophylaxes — under 12 years (maximum 2 per calendar year).....	\$ 7.00 each
• Prophylaxes — over 12 years (maximum 2 per calendar year)	\$10.00 each
• Emergency visits for relief of pain (1 per calendar year).....	\$10.00
• X-rays	
Full-mouth series, 1 every 3 years	\$20.00
Bitewings, (4 per calendar year)	\$ 2.50 each
• Space maintainers	\$65.00 maximum
• Fluoride treatments — dependent children to age 22	\$ 5.00

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury caused by external means and services must be completed within one year. It must occur while the member is covered under the FEHB Program. **You pay** the difference between the fee schedule and the actual charges.

What is not covered

- Therapeutic service.
- Other dental services not shown as covered.
- Charges which exceed the Plan's fee schedule.

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides certain vision care benefits; **You pay nothing for covered benefits provided by participating opticians, optometrists and vision centers.** Services by nonparticipating providers are paid in accordance with the Plan's fee schedule.

- Examination of the eyes to determine if glasses are required: once each calendar year.
- One set of single vision or bifocal lenses (toric kryptok or flat top 22mm): once each calendar year.
- One pair of basic frames from available styles: one every two years.
- Contact lenses for certain unusual medical conditions (such as post cataract surgery or keratoconus treatment.)
- Replacement of broken lenses with lenses of the same prescription and material originally supplied.
- Frames at any time unless lenses are also provided.
- Replacement or repair of frames.
- Certain bifocals and trifocals, tinted, plastic and oversized lenses and sunglasses and frames other than basic frames, contact lenses for cosmetic purposes.
- Charges in excess of the maximum GHI allowance.

What is not covered

Catastrophic medical coverage

What is covered

In the event you receive any of the covered services described below rendered by a nonparticipating provider and incur out-of-pocket expenses in a calendar year of more than a \$5,000 per person catastrophic deductible, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges, as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services.

Covered catastrophic services. Covered services under catastrophic coverage include:

- | | |
|--|--|
| (1) Surgery | (4) Covered in-hospital services and diagnostic services |
| (2) Administration of Anesthesia | (5) Maternity |
| (3) Chemotherapy and radiation therapy | |

What is not covered

Non-catastrophic services. The following services are not covered under catastrophic coverage:

- | | |
|--|------------------------|
| (1) Home and office visits and related diagnostic services | (3) Dental services |
| (2) Nursing, Appliance, Oxygen and Equipment | (4) Vision services |
| | (5) Prescription drugs |

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Subscriber Relations Department at 212/501-4GHI (4444), or 212/721-4962 (Hearing impaired — TDD) or you may write to them at Post Office Box 1701, New York, NY 10023-9476 or contact the GHI office nearest you. You may also contact the Plan at its website at <http://www.ghi.com>. If you have a question concerning a hospital claim, contact GHI's Hospital Service Department at 212/615-0500.

- GHI hospital payments will usually be made directly to the hospital.
- When a participating provider is used, you should not make payment for covered services except for the applicable copayment. GHI's check is sent to the provider.
- If a non-participating provider is used, you must file a claim. You pay the provider and GHI will reimburse you directly for the covered allowance for services rendered.

Timely submission of claims

In order to receive benefits you must promptly complete and file your claim form. All claims for services rendered in 1999 must be filed with GHI by June 30, 2000.

Albany office

GHI has a claims processing office in Albany, New York, to provide services for residents of Central New York State.

All claims for persons residing in that area should be forwarded to:

GHI Claims Department
Post Office Box 15030
Albany, NY 12212
518/446-8020

Regional office telephone numbers

GHI has offices throughout New York State and service in New Jersey and Florida. Our staff is ready to assist in answering any other questions you may have at the following numbers:

Albany	518/446-8020	New York City	212/501-4444
Buffalo	716/852-7711	Rochester	716/424-2467
Florida	1/800/358-5500	Syracuse	315/432-0826
New Jersey	973/623-6000		

Disputed Claims Review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing, and within six months of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (If the Plan failed to respond, provide instead (a) the date of your request to the Plan, or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How GHI Changes January 1999.

Program-wide Changes

Do not rely on this page; it is not an official statement of benefits.

- Several changes have been made to comply with the president's mandate to implement the recommendations of the Patient Bill of Rights.
- A medical emergency is defined as 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 (see page 15.)
- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits.

Changes to the Plan

- Under the Medical and Surgical section Chiropractic service have been increased from 8 visits per year to 15 visits per calendar year.
- Under the Prescription Drug Benefits section the cost of enteral formulas are covered up to a maximum of \$2,500 per calendar year or any continuous twelve (12) month period.

1999 Rate Information for GHI Health Plan

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

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	801	\$69.60	\$23.20	\$150.80	\$50.27	\$82.36	\$10.44
Self and Family	802	\$160.39	\$71.60	\$347.51	\$155.14	\$183.29	\$48.70

Summary of Benefits for GHI Health Plan — 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).

NOTE: If you use a medical-surgical provider who does not participate, you will receive only 50% of the GHI fee schedule.

BENEFITS	PLAN PAYS/PROVIDES	PAGE
Inpatient care	Hospital	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing.....13
	Extended Care	All necessary services for up to 30 days per year. You pay nothing ...13
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 60 days of inpatient care per calendar year. You pay nothing16
	Substance Abuse	Up to 30 days of substance abuse treatment per year. You pay nothing16
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay a \$10 copay per office visit or house call by a doctor (copay does not apply to well-baby care)13
	Home Health Care	All necessary visits by nurses and health aides. You pay nothing13
	Mental Conditions	Up to 30 visits for outpatient treatment per year. You pay a \$10 copayment per visit16
	Substance Abuse	Up to 60 visits per year. You pay nothing16
Emergency care		Services and supplies required because of a medical emergency (80% of charges from a nonparticipating hospital outside the Service Area). You pay a \$25 per emergency room visit and charges in excess of the Plan's emergency fee schedule and charges for services which are not covered benefits of this Plan and (20% of charges from a nonparticipating hospital outside the Service Area)...15
Prescription drugs		Drugs prescribed by a doctor and obtained at a participating pharmacy. You pay a \$5 copay for generic drugs, a \$10 copay per prescription unit or refill for name brand. For mail-order maintenance drugs, you pay a \$5 copay for generics, a \$10 copay for name brand17
Dental care		Accidental injury benefit. You pay in excess of fee schedule. Preventive and diagnostic dental care19
Vision care		One refraction annually. Lenses (annually) and frames (every two years). You pay nothing to participating vision centers19
Out-of-pocket limit		Your out-of-pocket expenses for benefits covered under this plan are limited to the stated payments which are required for a few benefits and/or to the difference between the Plan's payment for nonparticipating providers and the provider's charges7 & 10