GHI Health Plan

http://www.EMBLEMHEALTH.com

GHI
an EmblemHealth company

2017

A Prepaid Comprehensive Medical Plan.

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 4 for details.

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

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

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2017: Page 17
- Summary of benefits: Page 88

Enrollment codes for this Plan:

801 High Option – Self Only
802 High Option – Self and Family
803 High Option - Self Plus One
804 Standard Option – Self Only
805 Standard Option – Self and Family
806 Standard Option - Self Plus One

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ACCREDITED
Health Utilization Management
Expires 07/01/2018

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-007

Important Notice from the GHI Health Plan About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D 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 will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 thru December 7) 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 800-772-1213 (TTY 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 800-MEDICARE (800-633-4227),; (TTY 877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of Group Health Incorporated (GHI) under our contract (CS 1056) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 212-501-4GHI (4444) or through our website: www.emblemhealth.com. The address for GHI administrative offices is:

Group Health Incorporated
441 Ninth Avenue
New York, NY 10001

This brochure is the official statement of benefits. No verbal 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. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2017, unless those benefits are shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2017, and changes are summarized beginning on page 16. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essentail coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual share responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the ivdividual requirement for MEC.

The ACA establishes a minimum value for the stanadard of benefits of a health plan. The minimum standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive
- 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 212-501-4444 and explain the situation.
- If we do not resolve the issue

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also 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)

  - Your child age 26 or over (unless he/she is 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.

- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have 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 by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

GHI complies with applicable Federal civil rights, laws to include both Title VII and Section 1557 of the ACA. Pursuant to Section1557 GHI does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age disability, or sex (including pregnancy and gender identity).

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. 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 take notes, 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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what you doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you don't receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of test or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?

- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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

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

Patient Safety Links

For more information on patient safety, please visit:

- http://www.jointcommission.org/speakup.aspx. The Joint Commission's Speak UP patient safety program.
- http://www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/ The Agency for Healthcare Research and Quality provides information about patient safety, choosing quality health care providers, and improving the quality of care you receive.
- www.npsf.org . The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Event")

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. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specificout-of-pocket costs are determined as explained in this brochure.

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

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

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

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

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family members. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. 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 or Self Plus One 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 60 days is established by 5 CFR 890.301(e)(1)

The Self Plus One or 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 Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance//lifeevents. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage and same sex domestic partners) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact you human resources office or retirement system for additional information.
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.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **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 Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, 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. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 2017 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 2016 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

When FEHB coverage ends

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

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn age 26, regardless of marital status.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

We also want to inform you that The Patient protection and Afordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

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 or Tribal 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.

We will assist you in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at (212) 501-4444 or visit our website at **www.emblemhealth.com.** .

Health Insurance Marketplace

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace,please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

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

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

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

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

General Features of our High Option with POS coverage

The enrollment codes for the High Option with POS are 801 (Self only) and 802 (Self and Family) and 803 (Self Plus One). If you are enrolled in our High Option with POS coverage, you have access to in-network covered care from participating providers under our Preferred Provider Option (PPO) or you may obtain covered care for certain services from non-network providers under POS benefits. Please refer to Section 5(i) High Option Point of Service Benefits for specific information on the POS coverage. Our High Option coverage offers a PPO network(s) of participating providers and uses provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long term cost savings. Your out-of-pocket costs are lower when you seek covered care from within our PPO network because participating providers have agreed to accept GHI's schedule of allowances or negotiated rate as payment in full for a covered service. You will only owe your deductible, copayment and/or coinsurance for covered services.

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

General Features of our Standard Option coverage

The enrollment codes for the Standard Option coverage are 804 (Self only) and 805 (Self and Family) and 806 (Self Plus One). If you are enrolled in our Standard Option coverage, you have access to covered care only from within our network participating providers under our Exclusive Provider Option (EPO). We will not cover care that you receive from non-network (non-participating) providers. Contracted providers within our EPO network have agreed to accept our schedule of allowances or negotiated rate as payment in full for a covered service. Our EPO offers a network(s) of participating providers and uses provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long term cost savings. Since you must seek care from within the EPO network, you will only owe your deductible, copayment and/or coinsurance for covered services. You are not responsible for balances that exceed our payment for covered services from EPO network providers.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments,deductibles or annual limits when received from a network provider.

How we pay providers

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

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

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services obtained from participating providers, including deductibles and copayments, cannot exceed $6,850 for Self-Only enrollment, or $13,700 for a Self Plus One or Self and Family enrollment.

Your annual out-of-pocket expenses for covered services obtained from non-participating providers, including deductibles and copayments, cannot exceed $15,000 per person.

Your rights and responsibilities

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

- GHI has been in continuous existence for over seventy (70) years.
- GHI is a Not for Profit New York company.

You are also entitled to a wide range of consumer protection and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting the EmblemHealth website, www.emblemhealth.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 212 501-4GHI (4444), or write to GHI, PO Box 1701, New York, NY 10023-9476. You may also visit our website at www.emblemhealth.com.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit the EmblemHealth website at www.emblemhealth.com. You can also contact us to request that we mail a copy regarding access to PHI.

Your medical and claims records are confidential

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

Service area

To enroll with us in the High Option you must live or work in our service area. Our service area is: all of New York and the New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union.

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

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

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

Section 2. Changes for 2017

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

Changes to Standard Option:

- Increase Prescription Drug copays to: Retail $15 generic, $50 brand formulary, $100 brand non-formulary. Mail Order $40 generic, $125 brand formulary, $170 brand non-formulary. Express Advantage Network $10 generic, $45 brand, $95 brand non-formulary.
- Removal of coverage for Invitro Fertilization.

Changes to both High and Standard Options:

- Your share of the non-Postal premium will increase for Self Only, Self Plus One and for Self and Family. See the rates that appear on the back cover of this brochure.
- Add coverage for Applied Behavior Analyses (ABA) for dependent children diagnosed with autism spectrum disorder
- External hearing aid prosthetic device limited to every 2 years.

Section 3. How you get care

Identification cards

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

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

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

- **Covered Providers**

We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act (PHSA). Coverage of practitioners is not determined by your state's designation as a medically underserved area (MUA).

Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

What you must do to get covered care

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

- **Primary care**

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

- **Specialty care**

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

  Here are other things you should know about specialty care:

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

  You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

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

  We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 212/501-4GHI (4444). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

You must get prior approval for certain services. Failure to do so will result in a $125 per day up $250 penalty for hospital admissions. Members that do not receive prior approval for certain medical services will be responsible for all charges.
The pre-service claim approval processes for inpatient hospital admissions (called precertifcation) and for other services are detailed in this section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval, or referral.

- **Inpatient hospital admission**

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

Your physician must obtain precertification for the following services:

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

You do not need precertification in the following situations:

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

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

- **Other services**

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

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

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

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

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

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (212) 501-4444. You may also call OPM's Health Insurance x at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at (212) 501-4444. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim.)

- **Concurrent care claims**

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 before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. 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.

- **Emergency inpatient admission**

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

- **Maternity care**

We do not require precertification of hospital admissions for delivery.

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

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

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

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

If you disagree with our pre-service claim decision

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

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

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

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

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

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM** — After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

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

Cost-sharing

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of $20 per office visit under the High Option and $40 per office visit, and $10 per office visit for dependent children to age 26, under the Standard Option.

Deductible

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

The calendar year deductible for certain services is:

- For **out of network services** under the High Option the deductible is $500 for Self Only, or $1000 for Self Plus One, or $1000 for Self and Family. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered out of network expenses applied to the calendar year deductible for your enrollment reach $500 under High Option.
- For orthopedic and prosthetic devices, oxygen and other covered durable medical equipment you pay $100 deductible per individual.

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: For orthopedic and prosthetic devises, after the applicable deductible is met you pay 20% of the Plan's fee schedule for a participating provider and 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider

Differences between our Plan allowance and the bill

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

Your catastrophic protection out-of-pocket maximum

After your (copayments deductibles and coinsurance) total $6,850 for Self Only or $13,700 for Self Plus One, or $13,700 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments, deductibles and coinsurance 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:

- Routine foot care
- Alternative treatments
- Educational classes, not mandated by State or Federal law
- Adult dental care services
- Vision care services
- Non-FEHB benefits

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

Carryover

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

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

When Government facilities bill Us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 16 for how our benefits changed this year and pages 86 and 87 for a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

We offer two different benefits packages. We offer High Option with POS and Standard Option. We describe the available benefits under each package in Section 5 of this brochure. Make sure that you review the benefits that are available under the option in which you are enrolled. The enrollment codes for the High Option with POS are 801 Self Only and 803 Self Plus One and 802 for Self and Family. The enrollment codes for Standard Option are 804 Self Only and 806 Self Plus One and 805 Self and Family.

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

High Option with POS features:

- Access to GHI's network of participating Preferred Provider Option (PPO)
- $20 copayment per office visit to participating network doctors
- $0 copayment for United States Preventive Task Force (USPSTF) recommended preventive care services
- $200 per day up to a maximum of $600 per admission for covered inpatient hospital admissions
- $0 copayment for up to 30 days of GHI approved skilled nursing facility benefits
- POS benefits for certain services from non-network providers (See Section 5(i) for specific information)

Standard Option features:

- Access to GHI's Exclusive Provider Option (EPO) network
- $40 copayment per office visit to participating network doctors
- $0 copayment for United States Preventive Task Force (USPSTF) recommended preventive care services
- $10 copayment for dependent children who are under the age of 26 as long as the services are performed by a participating network provider.
- $250 per day up to a maximum of $750 per admission for covered inpatient hospital admissions
- $0 copayment for up to 30 days of GHI approved skilled nursing facility benefits

Both Options offer the following unique features:

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- POS (out of network) benefits apply only if you are enrolled in the High Option coverage.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The High Option has a $500 Self Only, or $1000 Self Plus One, $1000 Self and Family out-of-network calendar year deductible.
- **Invitro fertilization benefits apply only if you are enrolled in the High Option coverage.**

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per office visit for participating providers $10 per office visit for children (under age 26) for participating providers All charges for non-participating providers
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion • Routine physical examination every year • Advance care planning	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per office visit for participating providers $10 per office visit for children (under age 26) for participating providers All charges for non-participating providers
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for participating providers All charges for non-participating providers
• At home	$20 per visit for participating providers	$40 per office visit for participating providers $10 per office visit for children (under age 26) for participating providers

Diagnostic and treatment services - continued on next page

Benefit Description	You pay	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
	POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	All charges for non-participating providers
Telehealth Services	**High Option**	**Standard Option**
If your provider offers covered services using Telehealth: • Covered services will include the use of electronic information and communication technologies by a provider to deliver covered services to you while your location is different than your providers location.	$10 for consultations from physicians providing Telehealth services $5 for consultations from Dietitians/Nutritionists providing Telehealth services	$10 for consultations from physicians providing Telehealth services $5 for consultations from Dietitians/Nutritionists providing Telehealth services
Note: Covered services are subject to the same utilization review and quality assurance requirements and other terms and conditions of this plan.	*All charges*	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	$20 per each diagnostic x-ray + laboratory test performed by a participating provider (a maximum of two diagnostic copays will apply per date of service) POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per each diagnostic x-ray + laboratory test performed by a participating provider (a maximum of two diagnostic copays will apply per date of service) $10 copayment per each diagnostic x-ray + laboratory test for children (under age 26) when performed by a participating provider (a maximum of two diagnostic copays will apply per date of service) All charges for non-participating providers.
Preventive care, adult	**High Option**	**Standard Option**
Routine screenings, such as: • Total Blood Cholesterol • Chlamydial infection • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - every five (5) years starting at age fifty (50) - Colonoscopy screening - every ten (10) years starting at age fifty (50)	Nothing for preventive services performed by a participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for preventive care performed by a participating provider All charges for non-participating providers

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing for preventive services performed by a participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for preventive services performed by a participating provider All charges for non-participating providers
Well woman care - including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age thirty (30) and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing for preventive services performed by a participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for preventive services performed by a participating provider All charges for non-participating providers
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing for preventive services performed by a participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for preventive services performed by a participating provider All charges for non-participating providers.
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) such as: • Tetanus-diptheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine annually • Pneumococcal vaccine, age 65 and over • Varicella (Chickenpox) – for all persons aged 19-49 • Tetanus, Diptheria and Pertussis (TDAP) – for persons aged 19-64, with a booster every 10 years • Shingles vaccine, age 50 and over	Nothing for preventive services performed by a participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for preventive services performed by a participating provider All charges for non-participating providers
Note:		

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS: www.healthcare.gov/preventive-care-benefits/ CDC:http://www.cdc.gov/vaccines/schedules/index.html **Women's preventive services:** https://www.healthcare.gov/preventive-care-women/		
Not covered: *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations • ACIP's recommendation for the vaccine to prevent Rotavirus for infants between 8 and 32 weeks of age.	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for participating providers All charges for non-participating providers
• Well-child care charges for routine examinations, immunizations and care (up to age 26)	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for participating providers All charges for non- participating providers
Examinations, limited to: • Examinations for amblyopia and strabismus - limited to one screening examination (ages 3 through 5) • Ear exams to determine the need for hearing correction • Examinations done on the day of immunizations (ages 3 up to age 26)	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for participating providers All charges for non-participating providers
Note:		

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS: www.healthcare.gov/preventive-care-benefits/ CDC:http://www.cdc.gov/vaccines/schedules/index.html **Women's preventive services:** https://www.healthcare.gov/preventive-care-women/		
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not have to precertify your vaginal delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or Self and Family enrollment. Surgical Benefits, not maternity benefits, apply to circumcision if this is the case. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits (Section 5b). •	A single $20 copay for all prenatal and postnatal care from a participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	A single $40 copay for all prenatal and postnatal care from a participating provider All charges for non-participating providers
• Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk.	Nothing	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**
Contraceptive counseling on an annual basis	Nothing	Nothing
A range of voluntary family planning services for women, limited to: • Voluntary sterilization (See Surgical procedures Section 5b) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Nothing for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for participating providers All charges for non-participating providers
Voluntary family planning services for men, limited to: • Voluntary sterilization (See Surgical procedures Section 5b)	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per visit for participating providers All charges for non-participating providers
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility, such as**:** • Artificial insemination (AI) - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterinal insemination (IUI) • Invitro fertilization - limited to three transfers per lifetime (covered under the **High Option plan ONLY)** • Fertility drugs	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per visit for participating providers All charges for non-participating providers **Note**: Invitro fertilization (IVF) is **NOT** covered under Standard Option

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per visit for participating providers All charges for non-participating providers **Note**: Invitro fertilization (IVF) is **NOT** covered under Standard Option
Not covered: • Cost of donor egg • Cost of donor sperm	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections • Treatment materials (such as allergy serum)	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per office visit for participating providers $10 per office visit for children (under age 26) for participating providers All charges for non-participating providers
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 43. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing in a participating provider doctor's office POS: In a doctors office, 50% of the Plan's fee schedule, for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing in a participating provider doctor's office Note: Subject to prior approval, we will provide up to ten out of area hemodialysis treatments performed by a non participating provider. You are responsible for all charges that exceed our allowable charges
• High-tech nursing and infusion therapy - IV infusion therapy - Parenteral and enteral therapy - Other home IV therapies Note: Contact us at (800) 223-9870 prior to receiving services to ensure coverage.	Nothing for a participating provider POS: All charges for non-participating providers	Nothing for a participating provider All charges for non-participating providers

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
• Intermittent home nursing service - Provided by a Registered Nurse or Licensed Practitioner - Authorized and supervised by a doctor - Intermittent visits less than 2 hours per day	Nothing for a participating provider POS: All charges for non-participating providers	Nothing for a participating provider All charges for non-participating providers
• Growth hormone therapy (GHT). Note: This benefit is provided under our Prescription Drug Benefits. Please see Section 5(f) Prescription Drug benefits for information on growth hormone. Note: We only cover GHT when we preauthorize the treatment before you begin treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under You need prior to Plan approval for certain services on page .	Applicable prescription drug copay Note: Please see Section 5(f) Prescription Drug Benefits.	Applicable prescription drug copay Note: Please see Section 5(f) Prescription Drug Benefits.
Not covered: • *Treatment for experimental or investigational procedures*	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**
• Note: We only cover therapy when ordered by a provider. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 32 sessions.	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per visit for participating providers $10 per visit for children (under age 26) for participating providers All charges for non-participating providers
Not covered: • *Long-term rehabilitative and habilitation therapy* • *Exercise programs*	*All charges*	*All charges*

Benefit Description	You pay	
Speech therapy	**High Option**	**Standard Option**
Rehabilitation Up to 60 visits of speech therapy each calendar year for services from the following: • Licensed or certified speech therapists **Habilitation** Up to 60 visits of speech therapy each calendar year for services for: • Speech therapy services that help a person keep, learn or improve skills and functioning for daily living. including: • the management of limitations and disabilities • services or programs that help maintain or prevent deterioration in cognitive function. Note: We Cover Habilitation Services in the outpatient department of a Facility or in a Health Care Professional's office.	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per visit for participating providers $10 per visit for children (under age 26) for participating providers All charges for non-participating providers
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Diagnostic and treatment services for disease or medical conditions affecting hearing • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • External hearing aids (See "Orthopedic and Prosthetic devices")	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per visit for participating providers $10 per visit for children (under age 26) for participating providers All charges for non-participating providers
Not covered: Hearing services that are not listed as covered	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Medical and surgical benefits for diagnosis and treatment of diseases of the eye	$20 per visit for participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per visit for participating provider $10 per visit for children (under age 26) for participating providers All charges for non-participating providers
• Examination of the eyes to determine if glasses are required: once each calendar year • One set of single vision or bifocal lenses (toric kryptok or flat top 22mm): once each calendar year	Nothing for services provided by participating opticians, optometrists and vision centers POS: All charges for non-participating providers	Nothing for services provided by participating opticians, optometrists and vision centers All charges for non-participating providers

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

Benefit Description	You pay	
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• 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 This benefit is administered by EyeMed -www.eyemed.com	Nothing for services provided by participating opticians, optometrists and vision centers POS: All charges for non-participating providers	Nothing for services provided by participating opticians, optometrists and vision centers All charges for non-participating providers
Not covered: • *Frames at any time unless lenses are also provided* • *Replacement or repair of frames* • *Certain bifocals and trifocals, tinted, plastic and oversized lenses and sunglasses and frames other than basic frames; contact lenses for cosmetic purposes* • *Charges in excess of the maximum GHI allowance*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes, including the routine treatment of corns, calluses, and bunions, and the partial removal of toenails Note: There is a limit of 4 visits per calendar year.	$20 per visit for participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per visit for participating provider All charges for non-participating providers
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) • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Orthotics devices for the feet*	*All charges*	*All charges*

Benefit Description	You pay	
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • External hearing aids **(Once every two years)** • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Orthopedic devices, such as braces • Ostomy supplies • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% of the Plan's fee schedule for a participating provider POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies) Note: $100 annual deductible applies per individual.	20% of the Plan's fee schedule for a participating provider All charges for non-participating providers Note: $100 annual deductible applies per individual.
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Corrective appliances for treatment of tempormandibular joint (TMJ) pain dysfunction syndrome*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment at our option, including repair and adjustment. Covered items include: • oxygen • dialysis equipment • hospital beds • wheelchairs • crutches • walkers • blood glucose monitors	20% of the Plan's fee scheduled for a participating provider POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider Note: $100 annual deductible applies per individual.	20% of the Plan's fee scheduled for a participating provider All charges for non-participating providers Note: $100 annual deductible applies per individual.

Durable medical equipment (DME) - continued on next page

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

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**High Option**	**Standard Option**
• *Services and supplies related to normal maternity care* • *Services and supplies provided following a noncovered hospital admission or admission to a facility that is not a participating facility* • *Services and supplies provided when the subscriber would not have required continued inpatient care* • *Services and supplies provided by a non-participating facility for home health care* • *High-tech nursing and infusion therapy* • *Nursing care requested by or for the convenience of the patient's family and/or private duty nursing*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• Manipulation of the spine and extremities • Adjustment procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$20 per visit for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per visit for participating providers $10 per visit for children (under age 26) for participating providers All charges for non-participating providers
Not covered: • *chiropractic services not shown as covered*	All charges	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Acupuncture – unlimited visits; no utilization management under the Standard Option only Services obtained through American Specialty Health at www.choosehealthy.com 1 (877) 327-2746 • anesthesia • pain relief Note: We do not cover acupuncture treatment under the High Option coverage	All charges	$40 per visit for participating providers $10 per visit for children (under age 26) for participating providers All charges for non-participating providers
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges*	*All charges*

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The High Option out of network calendar year deductible is: $500 for Self Only, or $1000 for Self Plus One or $1000 for Self and Family.
- POS (out of network) benefits and deductibles apply only if you are enrolled in the High Option coverage. If you are enrolled in the Standard Option EPO, you must use participating providers within the EPO network.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery)– see Services requiring our prior approval on page 18. • Insertion of internal prostethic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns	$20 per office based surgical procedure for a participating provider Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies) See Section 5(c) for outpatient hospital or ambulatory surgical center copayments.	$40 per office based surgical procedure for a participating provider All charges for non-participating providers See Section 5(c) for outpatient hospital or ambulatory surgical center copayments
Not covered:	*All charges*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• *Reversal of voluntary sterilization* • *Stand-by services* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and; - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • Gender Reassignment Surgery (GRS) when all Plan criteria are met. Pre-authorization is required for all services.	$20 per office based procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per office based procedure for participating providers All charges for non-participating providers
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; or - breast prostheses and surgical bras and replacements (see Prosthetic devices). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$20 per office based procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per office based procedure for participating providers All charges for non-participating providers
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*	*All charges*

Benefit Description	You pay	
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures, and • Removal of impacted teeth • Other surgical procedures that do not involve the teeth or their supporting structures.	$20 per office based procedure for participating providers POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per office based procedure for participating providers All charges for non-participating providers
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of teporomandibular joint (TMJ) pain dysfunction syndrome.*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Lung: single/bilateral/lobar • Liver • Kidney • Pancreas • Kidney/Pancreas • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	$20 per office based procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per office based procedure for participating providers $10 per office procedure for children (under age 26) for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants. The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Acute lymphocyic or non- lymphocyic (i.e. myelogenous) leukemia - Chronic Lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma with recurrence - Advanced non-Hodgkin's lymphoma with recurrence - Acute Myeloid Leukemia - Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Chronic myelogenous leukemia - Hemoglobinapathy - Myelodysplasia/Mylodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous leukemia) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for: - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - Denovo myeloma	$20 per office based procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 peroffice based procedure for participating providers $10 per office procedure for children (under age 26) for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Blood or marrow stem cell transplants for Allogeneic transplants for • Phagocytic/Hemophagocytic deficiency diseases(e.g., Wiskott-Aldrich syndrome) • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies	$20 per office based procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center	$40 per office based procedure for participating providers $10 per office procedure for children (under age 26) for participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Myelodysplasia/Myelodysplastic Syndromes • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Waldenstrom's macroglobulinemia	$20 per office based procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per office based procedure for participating providers $10 per office procedure for children (under age 26) for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity Tandem transplants for covered transplants: Subject to medical necessity	$20 per office based procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 peroffice based procedure for participating providers $10 per office procedure for children (under age 26) for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for Allogeneic transplants for • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)	$20 per office based procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center	$40 peroffice based procedure for participating providers $10 per office procedure for children (under age 26) for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Hemoglobinopathies • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Myelodysplasia/Myelodysplastic syndromes • Multiple myeloma • Multiple sclerosis Non-myeloablative allogeneic transplants or Reduced intensity conditioning (RIC) for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Myelodysplasia/myelodysplastic syndromes • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell disease Autologous transplants for • Chronic myelogenous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Small cell lung cancer • Multiple sclerosis • Systemic lupus erythematosus	$20 per office based procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers	$40 peroffice based procedure for participating providers $10 per office procedure for children (under age 26) for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for: • Allogeneic transplants for - Breast cancer - Epithelial ovarian cancer National Transplant Program (NTP)- We will cover transplants approved as safe and effective for a specific disease by the Federal Drug Administration (FDA) or National Institute of Health, or which our Medical Director determines is medically necessary, appropriate and advisable on a case-by-case basis. We will cover the medical and hospital services, and related organ acquisition costs. Eligibility for transplants will be determined and approved in advance solely by our Medical Director upon recommendation of your PCP. Additionally, all transplants must be performed at hospitals specifically approved and designated by us to perform these procedures. Specialty physician experts from our designated centers of excellence will provide clinical review and support to the Medical Director's decision. **Limited Benefits** – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.	$20 per office procedure for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	$40 per office procedure for participating providers $10 per office procedure for children (under age 26) for participating providers Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Note: • We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in additiona to the testing of family members. Donor coverage is provided up to a maximum of $10,000 per transplant.		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Travel expenses up to a maximum of $150 per person per day and $10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center. This includes food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place. Note: The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery.		
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient)	Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Professional services provided in – • Hospital (outpatient) • Skilled nursing facility • Ambulatory surgical center • Office	Nothing for a participating provider in the hospital or a participating ambulatory surgery center POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount (deductible applies)	Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Not covered: • *Services administered by the same practitioner performing surgery*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 per day up to a maximum of $600 per inpatient admission Note: Except for medically necessary emergency admissions you pay all charges for an inpatient admission at a non-particating facility.	$250 per day up to a maximum of $750 per inpatient admission Note: Except for medically necessary emergency admissions you pay all charges for an inpatient admission at a non-particating facility.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing (included in the inpatient hospital cost sharing) Note: Except for medically necessary emergency admissions you pay all charges for an inpatient admission at a non-particating facility	Nothing (included in the inpatient hospital copay) Note: Except for medically necessary emergency admissions you pay all charges for an inpatient admission at a non-particating facility
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Non-covered facilities, such as nursing homes and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Long term rehabilitation*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition. For approved inpatient admissions, you are responsible for the applicable hospital admission copay (see inpatient hospital benefits).	$150 copayment POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount	$150 copayment All charges for a non-participating provider
• Diagnostic laboratory tests, X-rays, and pathology services	$20 copayment POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers (deductible applies)	$40 copayment All charges for non-participating providers
• Chemotherapy and radiation	Nothing for chemotherapy and radiation provided in a participating facility POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers (deductible applies).	Nothing for chemotherapy and radiation provided in a participating facility All charges for non-participating providers
Not covered: Blood and blood derivatives replaced by the member	*All charges*	*All charges*

Benefit Description	You pay	
Skilled nursing facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF) care is limited to 30 days per calendar year and includes the following: • Bed, board and general nursing care • Drugs, biologicals, supplied and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your doctor as governed by Medicare guidelines.	Nothing for a participating provider POS: All charges for a non-participating provider	Nothing for a participating provider All charges for a non-participating provider
Not Covered: • *Custodial care*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include: • inpatient/outpatient care; and • family counseling under the direction of a doctor. Note: Your provider must certify that you are in the terminal stages of illness, with a life expectancy of approximately six months or less. The hospice must have an agreement with us or recognized by Medicare as a hospice.	Nothing for a participating provider	Nothing for a participating provider
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
End of life care	**High Option**	**Standard Option**
Acute care provided in a licensed Article 28 facility or acute care facility that specializes in terminally ill patients, for members diagnosed with advanced cancer with less than sixty (60) days to live.	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Ambulance services for each trip to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility.	All charges in excess of $100. Note: We will not pay more than $100 for covered ambulance services.	All charges in excess of $100. Note: We will not pay more than $100 for covered ambulance services.
Not covered: • *Air ambulance* • *Ambullette services*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- GHI will determine reimbursement for emergency services from non-participating providers based on a lesser of 100% of the 90th percentile of FAIR Health Prevailing Healthcare Charges System for Emergency Professional charges and Emergency Admission Professional Charges or the provider's billed charge.

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

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

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

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

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

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

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

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency medical/surgical care at a doctor's office • • Emergency medical/surgical care at an urgent care center	$20 per office visit for a participating provider. $20 per office visit for a participating provider. POS: Any difference between our allowance and the billed amount for a non-participating provider.	$40 per office visit for a participating provider. $40 per office visit for a participating provider. Any difference between our allowance and the billed amount for a non-participating provider.
• Emergency care as an outpatient Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.	$175 copay per hospital emergency room visit. POS: Any difference between our allowance and the billed amount for a non-participating provider	$175 copay per hospital emergency room visit plus all charges that exceed the emergency allowance for non-participating hospitals.
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency medical/surgical care at a doctors' office • Emergency medical/surgical care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services	$20 per office visit for a participating provider. POS: Any difference between our allowance and the billed amount for a non-participating provider	$40 per office visit for a participating provider. Any difference between our allowance and the billed amount for a non-participating provider.
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility. See 5(c) for non-emergency service.	All charges in excess of $100 Note: We do not pay more than $100 for covered ambulance services.	All charges in excess of $100 Note: We do not pay more than $100 for covered ambulance services.
Not covered: air ambulance and ambullette services	*All charges*	*All charges*

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Under the Standard Option, you must obtain care from within the participating provider network.
- Mental Health and Substance Abuse benefits are eligible for POS benefits under the High Option. However, you are responsible for all balances that exceed our payment.

Benefit Description	You pay	
Mental health and substance abuse benefits	**High Option**	**Standard Option**
All diagnostic and treatment services obtained from a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	Nothing for outpatient mental health care.	Nothing for outpatient mental health care.
• Diagnostic tests	Nothing	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing	Nothing
• Facility charges of a non-participating general hospital or facility • Treatment by a non-participating professional provider Note: See Section 5(d) Emergency Benefits for information on emergency services. *Not Covered* • Services we have not approved	POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount. All Charges	*All charges* All Charges

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	**High Option**	**Standard Option**
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	All Charges	All Charges
Autism Spectrum Disorders	**High Option**	**Standard Option**
Inpatient and Outpatient Coverage for the Treatment of Autism Spectrum Disorder Coverage is provided for medically necessary and appropriate services associated with the screening, diagnosis and treatment of Autism Spectrum Disorder. Services must be provided by an in-network provider through Beacon Health Options. There are no age, visit or annual benefit limits. Treatment includes the following care and assistive communication devices prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist: • Behavioral Health Treatment; • Psychiatric Care; • Psychological Care; • Medical care provided by a licensed health provider; • Therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative; • Assistive Communication Devices; • Applied Behavioral Analysis	Nothing	Nothing
Not covered: • *Services we have not approved.* • *Services received from out-of-network providers*	*All Charges*	*All Charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- We will send each new enrollee a description of the prescription drug program and a mail order form/patient profile and a preaddressed reply envelope. You may use your Plan identification card to access the prescription drug benefits.
- 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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.

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

- **Who can write your prescription**.A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant,Nurse Practitionerand Psychologist must prescribe your medication.
- **Where you can obtain them**. You may fill the prescription at a participating pharmacy by presenting your Plan Identification Card. You must obtain certain generic maintenance drugs or name brand formulary drugs by mail order.
- **We use a formulary.** Our formulary is a list of effective medications and other items that we have approved for our members' use. A special committee of medical and pharmacy professionals reviews the formulary annually. We add or delete items on the list based on their findings. We have found that the drugs on our formulary are safe, effective, and therapeutic in the treatment of disease or illness. Please call GHI Pharmacy Services 877-444-3614 for a copy of our formulary.
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription. Under the High Option Plan you will pay $20 for generic formulary drugs, $45 for name brand formulary drugs, $85 for non-formulary drugs or 25% coinsurance up to maximum of $200 per prescription for speciality drugs. Under the Standard Option Plan you pay $15 for generic formulary drugs $50 for name brand formulary drugs, $100 non-formulary drugs or 25% coinsurance up to a maximum of $200 per script for speciality drugs
- **Maintenance Medication by mail-order**. Your prescription coverage includes a mail order program for all maintenance medications. You must obtain a new prescription from your provider for a 90 day supply, to be sent to GHI Pharmacy Services. Please call GHI Pharmacy Services at 877-444-3614. Specialty drugs and Sexual dysfunction drugs are not available by mail-order and require prior approval.
- **Step Therapy Prior Authorization Program.** For prior authorization, your physician or you should call GHI Pharmacy Services at 877-444-3614. Step Therapy programs apply edits to drugs in specific therapeutic classes at the point of service. Coverage for second-line therapies is determined at the member level based on the presence or absence of first-line drugs in the member’s claims history. Step Therapy coverage criteria are automated whenever possible so that rejects are further reduced. Only claims for members whose histories do not show use of first-line drugs are rejected for payment at the point of service and online messaging is sent to the pharmacy indicating that prior authorization is required for coverage of the second-line therapy.
- **Drug Quantity Management Program.** The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copayment is consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Clinicians maintain a list of quantity limit drugs, which is based upon FDA-approved dosing guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per copayment and per days’ supply.

- **Diabetic Supplies Close Category Program.** The Diabetic Supplies Category Program refers only to prescriptions for test strips and meters. You will be granted authorization for test strips and meters when you present a prescription for a covered diabetic supply product (Roche and J&J products are covered).
- **A generic equivalent will be dispensed if it is available,unless your physician specifically requires a name brand.** If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- You will be able to choose from pharmacies in the Express Advantage Network (EAN), provided by Express Scripts. This is a smaller network that is available in addition to the larger ESI network of pharmacies you can choose from that are included in your GHI FEHB plan. By choosing an EAN pharmacy, you could see smaller copays.

Why use a generic drug?

- Generic drugs may have unfamiliar names, but they are safe and effective.
- Generic drugs contain the same active ingredients, in the same dosage form as their brand name counterparts, and are manufactured according to the same strict federal regulations.
- Generic drugs may differ in color, size, or shape, but they have the same strength, purity, and quality as the brand-name alternatives.
- Prescriptions filled with generic drugs often have lower co-payments. Therefore, you may be able to get the same health benefits at a lower cost. You should ask your physician or pharmacist whether a generic version of your medications is available. By using a generic drug, you may be able to receive the same high-quality medication but reduce your expenses.

When you have to file a claim. Please call GHI Pharmacy Services 1-877-444-3614 and we will send you a claim form. Under normal circumstances, you do not have to file prescription drug claims. You simply present your GHI card to the participating pharmacy and pay the appropriate copay.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from either a Plan pharmacy or through our mail order program: • Drugs for which a prescription is required by Federal law of the United States • FDA approved prescription drugs and devices for birth control • Fertility drugs (oral and injectable) • Insulin • Drugs to treat sexual dysfunction (with Prior authorization) • Disposable needles and syringes needed for the administration of covered medication • Smoking cessation drugs and medication, including nicotine patches (up to 90-day supply) • Intravenous fluids and medications for home use through our Participating Provider network for home infusion therapy • Nutritional supplements for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria	**Network Retail:** $20 generic $45 brand name listed on the preferred prescription drug formulary $85 brand name drug not listed on the preferred prescription drug formulary 25% coinsurance up to a maximum of $200 per prescription for specialty drugs **Network Mail Order: 90 day supply** $40 generic $90 brand name listed on the preferred prescription drug formulary $125 brand name drug not listed on the preferred prescription drug formulary. **Express Advantage Network (EAN)** $15 generic $40 brand name listed on the preferred prescription drug formulary $80 brand name drug not listed on the preferred prescription drug formulary	**Network Retail:** $15 generic $50 brand name listed on the preferred prescription drug formulary $100 brand name drug not listed on the preferred prescription drug formulary. 25% coinsurance up to a maximum of $200 per prescription for specialty drugs **Network Mail Order: 90 day supply** $40 generic $125 brand name listed on the preferred prescription drug formulary $170 brand name drug not listed on the preferred prescription drug formulary **Express Advantage Network (EAN)** $10 generic $45 brand name listed on the preferred prescription drug formulary $95 brand name drug not listed on the preferred prescription drug formulary
• Physician prescribed over-the-counter and prescription smoking cessation medication approved by the FDA to treat tobacco dependence • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Vitamin D supplements for adults 65 years of age and older	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Women's contraceptive medications and devices, including the "morning after pill" as an over-the-counter (OTC) emergency contraceptive drug.	Nothing	Nothing
Preventive Care medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age (400 & 800 mcg) • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 **Note:** To receive this benefit a prescription from a doctor must be presented to pharmacy.	Nothing	Nothing
Not covered: • *Nonprescription medications* • *Drugs obtained at a non-participating pharmacy, except for emergencies.* • *Vitamins, nutrients and food supplements not listed a a covered benefit, even if a physician prescribes or administers them* • *Medical supplies* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Network Mail Order for Specialty Drugs*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We will cover dental care for accidental injury only as indicated within the benefits description.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- **This Plan provides routine preventive dental coverage only.** The emphasis is on prevention, with preventive and minor diagnostic dental services covered with no copayments through Participating Plan Dentists. Services by non-participating dentists are covered in accordance with the fees listed below. **This Plan does not provide benefits for minor restorative or major restorative dental services, prosthodontics, endodontics, orthodontics, etc.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury caused by external means and services must be completed within one year.	Any difference between our fee schedule and the actual charges.	Any difference between our fee schedule and the actual charges.
Not covered: • *Therapeutic service* • *Other dental services not shown as covered* • *Charges which exceed the Plan's fee schedule*	*All charges*	*All charges*
Routine Dental Services	**High Option**	**Standard Option**
Examinations (maximum 2 per calendar year)	Nothing for a participating provider POS: All charges in excess of $10.00	Nothing for a participating provider All charges for non-participating providers.
Prophylaxes (under age 12 - maximum 2 per calendar year)	Nothing for a participating provider POS: All charges in excess of $7.00	Nothing for a participating provider All charges for non-participating providers
Prophylaxes (over age 12 - maximum 2 per calendar year)	Nothing for a participating provider	Nothing for a participating provider

Routine Dental Services - continued on next page

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

Section 5(h). Special features

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

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

High Option Point of Service (POS) Benefits

Facts about this Plan's High Option POS benefits

Except for the benefits listed below, at your option, you may choose to obtain benefits covered by this Plan from non-participating doctors and hospitals whenever you need care. Benefits not covered under the Point of Service option must be obtained from participating providers.

The following benefits must be obtained from a participating provider.

- High-tech nursing and infusion therapy
- Skilled nursing care facility confinements
- Home health care services
- Prescription drugs
- Non-emergency inpatient hospital admissions

All other benefits covered by this Plan may be obtained from participating or non-participating providers.

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

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

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

For services received by non-participating or out of network providers there is a $500 Self Only, or $1000 Self Plus One; or $1000 Self and Family calendar year deductible.

There is a $100 annual deductible for appliances, oxygen and equipment and $150 annual deductible for nursing services. There is also a $20 copayment for ambulatory laboratory test and diagnostic X-rays performed at outpatient hospital or ambulatory surgical center.

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

After your out-of-pocket expenses total $15,000 per person in any calendar year for covered services provided by a non-participating provider, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services. Covered catastrophic services include: 1) surgery, 2) administration of anesthesia, 3) chemotherapy and radiation therapy, 4) covered in-hospital services and diagnostic services, and 5) maternity. However, expenses for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay coinsurance and deductibles for these services:

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

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

Emergencies within the service area:

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

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

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

Emergencies outside the service area:

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

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

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

What is covered

- Emergency care at a doctor's office or an urgent care center.
- Ambulance service (see page 52).
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.

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

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, all appeals must follow their guidelines. For additional information contact the Plan at 1-212-615-4GHI (1-212-615-4444) or visit their website at www.emblemhealth.com

Health Club Memberships - At some clubs, Plan members get the lowest publicly available rate. Others offer a 10% discount.

Weight Loss Services- Save on programs including Jenny Craig.

Vitamins and Natural Supplements - Order online and save 45%.

Registered Dietitians - Save 25% on nutrition counseling from credentialed dietitians.

Vision Affinity Discount Program - Receive discounts up to 20% at participating Davis Vision Centers.

Massage Therapy - Save up to 25% on therapeutic massage.

Acupuncture Therapy - Save up to 25% on acupuncture therapy.

Laser Vision Care- Save as much as 25% on laser vision correction.

Services included in EmblemHealth's Healthy Discounts program are available only through participating vendors. These discount programs are not health care benefits and we do not insure them.

For more about these services, visit www.emblemhealth.com/goodhealth.

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

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 When you need prior approval for certain services.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services 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.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

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

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

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

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

Submit your claimsto:

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

Prescription drugs

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a five year limitation on the re-issuance of uncashed checks.

Post-service claims procedures

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

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

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

Authorized Representative

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

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Group Health Incorporated, 441 Ninth Avenue, New York, NY 10001 or calling (212) 501-4GHI (4444).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgement (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: GHI Customer Service Department, 441 Ninth Avenue, New York, NY 10001; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision or reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to:

	a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at:United States Office of Personnel Management, Insurance Operations, Health Insurance II, 1900 E Street, NW, Washington, D.C. 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; • Your daytime phone number and the best time to call; and • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to file a lawsuit, 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 file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (800) 223-9870. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation Programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.emblemhealth.com.

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.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers’ Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers’ Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damaged claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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

Some FEHB Plans already cover dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 1-877-888-3337 (TTY 1-877-889-5680), 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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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 cancer, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care. We do not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. We do not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age and older;
- Some people with disabilities, under 65 years of age; and

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium free part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800-MEDICARE (800-633-4227), (TTY 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. 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. For people with limited income and resources, extra helping paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-722-1213 (TTY 877-486-2048).

- **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 800-772-1213 (TTY 800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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

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

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

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

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

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

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

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

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

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

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

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost without Medicare	Member Cost with Medicare Part B	Member Cost with Medicare Part B
Benefit Description	**High Option**	**Standard Option**	**High Option**	**Standard Option**
Deductible	$0	$0	$0	$0
Out-of- Pocket Maximum	$6,850 Self Only/ $13,700 Self Plus One or Self and Family	$6,850 Self Only/ $13,700 Self Plus One or Self and Family	$6,850 Self Only/ $13,700 Self Plus One or Self and Family	$6,850 Self Only/ $13,700 Self Plus One or Self and Family
Primary Care Physician	$20	$40	$0	$0
Specialist	$20	$40	$0	$0
Inpatient Hospital	$200 copay per day for the first three days per admission	$250 copay per day for the first three days per admission	$0	$0
Outpatient Hospital	$175	$175	$0	$0
Rx	Level 1 -$20 Level 2 -$45 Level 3 - $85 Level 4 – 25% up to $200 per script Specialty (30 day supply)	Level 1 -$15 Level 2 -$50 Level 3 - $100 Level 4 – 25% up to $200 per script Specialty (30 day supply)	Level 1 -$20 Level 2 -$45 Level 3 - $85 Level 4 – 25% up to $200 per script Specialty (30 day supply)	Level 1 -$15 Level 2 -$50 Level 3 - $100 Level 4 – 25% up $200 per script Specialty (30 day supply)
Rx – Mail Order (90 day supply)	Level 1 -$40 Level 2 - $90 Level 3 - $125	Level 1 - $40 Level 2 - $125 Level 3 - $170	Level 1 - $40 Level 2 - $90 Level 3 - $125	Level 1 - $40 Level 2 - $125 Level 3 - $170

You can find more information about how our plan coordinates benefits with Medicare in (name of plan publication) at www.www.www

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800 632-4227), (TTY 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 or another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments, coinsurance, or deductibles.

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

If you enroll in a Medicare Advantage Plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend you FEHB coverage to enroll in a Medicare Advantage plan, eliminating 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 our of the Medicare Advantage plan's service area.

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

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

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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 cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

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

Copayment

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

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.

Exclusive Provider Option (EPO)

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

Experimental or investigational service

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

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

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

Health care professional

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

Medical necessity

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

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

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

Network Provider

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

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

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

Precertification/Prior approval

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

Preferred Provider Option (PPO)

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

Post-service claims

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

Pre-service claims

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

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a worker's compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as result of payment, to reimburse the carrier out of the payment to the extent of benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a worker's compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care claims

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

- Waiting could seriously jeopardize your life or health;

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

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

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

Us/We Us and We refer to Group Health Incorporated

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

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services thet routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100 and a maximum annual election of $2,550. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescription drugs, **physician prescribed** over-the-counter 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).
- FSAFEDS offer paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on claim information it receives from your plan.
- **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 out-of-pocket 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).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	• Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS (877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 866-353-8058

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

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. Most **FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All vision plans will provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision.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 877-888-3337 (TTY 877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment, such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U. S. Postal Service employees and annuitants, active and retired members of the Uniformed Services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 800-LTC-FEDS (800-582-3337), (TTY 800-843-3557) or visit www.ltcfeds.com.

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Summary of benefits for the High Option of the GHI Health Plan - 2017

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$20 per visit for a Participating Provider. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for a non-participating provider.	27,28
Services provided by a hospital:		
• **Inpatient**	$200 a day for a max of $600 per inpatient addmission.	50
• **Outpatient**	$150 copayment for outpatient hospital or ambulatory facility and $20 copayment for diagnostic labs, x-rays, and pathology	51
Emergency benefits:		
• **In-area**	$175 per hospital emergency room visit or urgent care center visit plus charges that exceed the Plan's emergency fee schedule.	53
• **Out-of-area**	$175 plus charges per hospital emergency room visit or urgent care center visit for non-participating facilities plus charges that exceed our allowance.	53
Mental health and substance abuse treatment:	Same cost-sharing as for other illnesses or conditions	55
Prescription drugs:		
• Retail Pharmacy - For up to a 30-day supply per prescription unit or refill (limit of two refills per prescription at a participating pharmacy.	$20 copay for generic drugs, $45 copay for brand preferred drugs, $85 copay for brand non-preferred drugs, 25% coinsurance up to $200 maximum per script for speciality drugs.	57
• Mail Order – For a 90-day supply of maintenance medication	$40 copay for generic drugs, $90 copay for name brand preferred; and $125 copay for non-preferred prescription drugs	59
Dental care: Routine preventive care	Nothing to participating providers.	60
Vision care: Limited to one annual eye refraction	Nothing to Participating providers.	35
Special features: Large Case Management , High Risk Pregnancies, Centers of Excellence for organ/tissue transplants, Heart Surgery, etc.	Copays or coinsurance as indicated	63

Summary of benefits for the Standard Option of the GHI Health Plan - 2017

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

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$40 per visit for a Participating Provider. $10 per visit for dependent children (under age 26) for a Participating Provider. All charges for non-participating providers.	27,28
Services provided by a hospital:		
• Inpatient	$250 per day inpatient admission up to a maximum of $750 per admission.	50
• Outpatient	$150 copayment for outpatient hospital or ambulatory facility and $40 copayment for diagnostic labs, x-rays, and pathology. $10 copayment for dependent children (under age 26) for diagnostic labs, x-rays and pathology.	51
Emergency benefits:		
• In-area	$175 per hospital emergency room visit or urgent care center visit and charges that exceed the Plan's emergency fee schedule.	53
• Out-of-area	$175 per hospital emergency room visit or urgent care center visit for non-participating facilities plus charges that exceed our allowance.	53
Mental health and substance abuse treatment:	Same cost-sharing as for other illnesses or conditions	55
Prescription drugs:		
• Retail pharmacy - Up to a 30-day supply per prescription unit or refill (limit of two refills per prescription at a participating pharmacy)	$15 copay for generic drugs, $50 copay for brand preferred drugs, $100 copay for brand non-preferred drugs, 25% coinsurance up to $200 maximum per script for speciality drugs.	57
• Mail order - For a 90-day supply of maintenance medication	$40 copay for generic drugs, $125 copay for brand preferred drugs or $170 copay for generic or brand non-preferred drugs	56-59
Dental care: Routine preventive care	Nothing to participating providers	61
Vision care: Limited to one annual eye refraction	Nothing to participating providers	36

Standard Option Benefits	You pay	Page
Special features: Large Case Management , High Risk Pregnancies, Centers of Excellence for organ/tissue transplants, Heart Surgery, etc.	Copays or coinsurance as indicated	63

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

For 2017 health premium information, please see: https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribe's Human Resources department.