Group Health Cooperative

www.ghc.org/fehb

Customer Service 888-901-4636

GroupHealth.

2017

A Health Maintenance Organization (high and standard option) and a high deductible health plan

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details.

Serving: Most of Washington State and Northern Idaho

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 16 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2017: Page 18
- Summary of benefits: Page 128

Enrollment codes for this Plan:

541 High Option Self Only
543 High Option Self Plus One
542 High Option Self and Family

544 Standard Option Self Only
546 Standard Option Self Plus One
545 Standard Option Self and Family

PT1 High Deductible Health Plan (HDHP) Self Only
PT3 High Deductible Health Plan (HDHP) Self Plus One
PT2 High Deductible Health Plan (HDHP) Self and Family

HEALTH PLAN NCQA ACCREDITATION COMMENDABLE

Group Health Standard Option

Group Health High Option

Group Health High Deductible Health Plan

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 73-012

Important Notice from Group Health Cooperative About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Group Health Cooperative's Plan 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 Group Health Cooperative 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 each month 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 also have to wait until the next Annual Coordinated Election Period (October 15 through 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 provided by Group Health Cooperative under our contract (CS 1043) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 888-901-4636 or through our website: www.ghc.org. The address for Group Health Cooperative's administrative office is:

Group Health Cooperative
320 Westlake North, Suite 100
Seattle, WA 98109-5233

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 also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2017, and changes are summarized on page 18. Rates are shown at the end of this brochure.

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.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value 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 Group Health Cooperative.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- 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 to your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services 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 888-901-4636 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 was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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

The Group Health Cooperative plan complies with all applicable Federal Civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557 the Group Health Cooperative plan 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 death 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 ant 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 to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- 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 tests 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 reaction 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 makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer 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 Events")

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, patients do suffer from injuries or illnesses that could have been prevented if doctors or 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 your FEHB plan nor you will incur costs to correct the medical error.

If a Never Event occurs, the health care facility is required to report the event to the Washington State Department of Health in accordance with RCW 70.56.020. The health care facility should apologize to the patient, report the event, investigate the event, report its underlying cause, take corrective action to prevent similar events and waive costs directly related to the event.

In the instance of a Never Event, the health care facility agrees that it will not charge the patient or Group Health for any and all care associated with the event, including complications which are the result of the event.

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 specific out-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/healthcare-insurance 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
  - What happens when your enrollment ends
  - 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 member. 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 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/life-events. 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 children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one 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 your 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 children.

  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, as appropriate, coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
  - If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self 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 for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **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 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 26, etc.

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 FEHBP coverage.

- **Finding replacement 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.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, 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 888-901-4636 or visit our website at www.ghc.org.

- **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 is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option or a Standard Option Plan.

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

When you receive covered services from Plan providers, you generally will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

General features of our High and Standard Options

On our High Option Plan, when you receive covered services, you will be responsible for a copayment or a coinsurance unless the service is covered in full. This Plan also covers dental care. See Section 5 for Plan specifics.

Our Standard Option Plan is an annual deductible plan. Most services are subject to the annual deductible, coinsurance, and copayments. There is no dental coverage on this Plan.

How we pay providers

We contract with individual providers, 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.

Who provides my health care?

Group Health Cooperative is a Mixed Model Prepayment (MMP) Plan. The Plan provides medical care by doctors, nurse practitioners, and other skilled Medical personnel working as medical teams. Specialists are available as part of the medical teams for consultation and treatment.

In some of the Group Health Cooperative Service areas, participating providers are practitioners who provide routine care within their private office settings in the community.

The first and most important decision each member must make is the selection of a primary care provider. The decision is important since it is usually through this provider that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care provider to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a Plan approved written referral by the member's primary care provider, with the following exception: a woman may see a participating General and Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Doctor of Osteopathy, Obstetrician or Advanced Registered Nurse Practitioner who provide women's health care services directly, without a referral from her primary care provider, for medically appropriate maternity care, reproductive health services, preventive care and general examination, gynecological care and medically appropriate follow-up visits for the above services. If your chosen provider diagnoses a condition that requires referral to other specialists or hospitalization, you or your chosen provider must obtain preauthorization and care coordination in accordance with applicable Plan requirements.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

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

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

Health Savings Account (HSA):

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA or Indian Health Services (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

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

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

Catastrophic protection: We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $3,500 for Self Only enrollment, and $7,000 for a Self Plus One or Self and Family enrollment.

Health education resources and accounts management tools:

Your Rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You can also find out about Care Management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. 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.

- Years in existence
- Profit status

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Group Health Cooperative at www.ghc.org/fehb. You can also contact us to request that we mail a copy to you.

If you would like more information about us, call 888-901-4636, or write to Group Health Cooperative, Customer Service, P. O. Box 34590, Seattle WA 98124-1590. You may also visit our website at www.ghc.org/fehb to get information about us, our networks, providers and facilities.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.ghc.org/fehb. 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 in this Plan, you must live or work in our service area. Group Health Cooperative providers practice in the following areas. Our service area is:

Western Washington (entire counties):

- Island
- King
- Kitsap
- Lewis
- Mason
- Pierce
- San Juan
- Skagit
- Snohomish
- Thurston
- Whatcom

In Grays Harbor County, the following cities, by Zip Code:

- Elma (98541)
- Malone (98559)
- McCleary (98557)
- Oakville (98568)

In Jefferson County, the following cities, by Zip Code:

- Brinnon (98320)
- Chimacum (98325)
- Gardner (98334)
- Hadlock (98339)
- Nordland (98358)
- Port Ludlow (98365)
- Port Townsend (98368)
- Quilcene (98376)

Central and Eastern Washington (entire counties):

- Benton
- Columbia
- Franklin
- Kittitas
- Spokane
- Walla Walla
- Whitman
- Yakima

Northern Idaho (entire counties):

- Kootenai
- Latah

If you receive care outside the service area described above, we will pay for covered services described under the “Travel Benefit” pages 63 and 104 or for emergency services as described on pages 53 and 97. We will not pay for any other health care services.

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

Plan members who are temporarily outside the service area of this Plan have access to care with Kaiser Permanente Plans. If you need services when out of the area, and are in the service area of a Kaiser Permanente Plan, you may obtain care from any Kaiser Permanente Provider, medical office, or medical center. If you plan to travel and wish to obtain more information about the benefits available to you, please call Customer Service at 888-901-4636.

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.

Program wide changes

Changes to this Plan

- We have expanded the benefit for enteral nutritional therapy. See pages 34 and 82.
- We have removed the Wellness Incentive.
- We have added a virtual care benefit. See pages 29 and 79.
- We have added an incentive to choose a generic drug over a brand name drug when a generic is available. See pages 58 and 101.
- We have revised the circumcision benefit for newborns. See pages 32 and 77.
- We have updated the preventive care benefit per USPSTF requirements. See pages 30 and 76.

Changes to High Option only:

- Your share of the non-Postal premium will increase for Self Only, Self Plus One or Self and Family. See page 134.
- Your share of the Postal Category 1 premium will increase for Self Only, Self Plus One, or Self and Family. See page 134.
- Your share of the Postal Category 2 premium will increase for Self Only and Self Plus One and decrease for Self and Family. See page 134.

Changes to Standard Option only:

- Your share of the non-Postal premium will increase for Self Only, Self Plus One or Self and Family. See page 134.
- Your share of the Postal Category 1 premium will increase for Self Only, Self Plus One or Self and Family. See page 134.
- Your share of the Postal Category 2 premium will decrease for Self Only, Self Plus One or Self and Family. See page 134.

Changes to our High Deductible Health Plan:

- Your share of the non-Postal premium will increase for Self Only, Self Plus One or Self and Family. See page 134.
- Your share of the Postal Category 1 premium will increase for Self Only, Self Plus One or Self and Family. See page 134.
- Your share of the Postal Category 2 premium will decrease for Self Only, Self Plus One or Self and Family. See page 134.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, please call our Customer Service at 888-901-4636 or write to us at Group Health Cooperative, Customer Service, P.O. Box 34590, Seattle WA 98124-1590. You may also request replacement cards through our website, www.ghc.org

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. You may call Customer Service at 888-901-4636. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directories. The list is also on our website.

What you must do to get covered care

You and each family member should choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. There are several ways to select a physician; you may contact Customer Service 888-901-4636 or your chosen Plan facility for assistance.

- **Primary care**

Your primary care physician (such as family practitioner or pediatrician) will arrange for most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call Customer Service at 888-901-4636 or contact your chosen Plan facility. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care, but you may also self-refer to many specialists at Group Health Cooperative facilities. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. However, you may see a woman’s health care specialist or a mental health provider without a referral. A woman may see a participating General or Family Practitioner, Physician’s Assistant, Gynecologist, Certified Nurse Midwife, Doctor of Osteopathy, Obstetrician or Advanced Registered Nurse Practitioner who provide women’s health care services directly, without a referral from her primary care provider, for medically appropriate maternity care, reproductive health services, preventive care and general examination, gynecological care, and medically appropriate follow-up visits for the above services. If the chosen provider diagnoses a condition that requires a referral to other specialists or hospitalization, you or your chosen provider must obtain preauthorization and care coordination in accordance with applicable Plan requirements.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan;
  - 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 our Customer Service Department at 888-901-4636 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 888-901-4636. 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;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

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

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other Services.*

- **Inpatient hospital admissions**

Precertification 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.

- **Other Services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Specialty care
- Surgical treatment of morbid obesity
- Non-emergency ambulance
- Durable Medical Equipment
- Transgender surgery

How to request Precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 888-901-4636 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent 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 judgment of a prudent layperson who possess 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 888-901-4636. You may also call OPM's Health Insurance 3 at (202) 606-0737 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, call us at 888-901-4636. 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.

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

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.

What happens when you do not follow the Precertification rules when using non-Plan facilities

We will not cover any care you receive from a non-Plan facility without following the Precertification rules.

Circumstances beyond our control

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

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 on 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 request for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious 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 provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician, you pay a copayment of $25 per office visit if you are on the High Option Plan. On the Standard Option Plan you pay a copayment of $25 for primary care services and $35 for a specialist per office visit. Example: When you are admitted to the hospital, you pay $350 per person per hospitalization under the High Option Plan; under the Standard Option Plan you pay $500 per person per hospitalization after the annual deductible is met.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. The calendar year deductible is $350 per person under the Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $350. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $700. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $700 under the Standard Option. There is no calendar year deductible for the High Option Plan. **Annual Deductible Carryover:** Under the Standard Option, charges from the last 3 months of the prior year which were applied toward the individual annual deductible will also apply to the current year individual annual deductible. The individual annual deductible carryover will apply only when expenses incurred have been paid in full. The Family deductible does not carry over into the next year. **The High Deductible Health Plan (HDHP)** calendar year deductible is $1,500 for Self Only enrollment and $3,000 for Self Plus One or Self and Family enrollment. 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.
Coinsurance	We have different coinsurance percentages for some benefits, and in those cases, we specify the percentage that you must pay. For example, there is a 50% coinsurance for certain types of infertility services. Durable medical equipment and ambulance services are other services that require you to pay a coinsurance.
Your catastrophic protection out-of-pocket maximum	**For High Option:** After your out-of-pocket expenses, including any copayments, and coinsurance total $3,000 for Self Only or $6,000 for Self Plus One or Self and Family enrollment in any calendar year for the High Option Plan, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $3,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $3,000 Self Only maximum out-of-pocket limit and a $6,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $3,000 for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self Plus One or Self and Family enrollment out-of-pocket maximum of $6,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $3,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

For Standard Option: After your out-of-pocket expenses, including any deductibles, copayments, and coinsurance total $5,000 for Self Only or $5,000 for Self Plus One or Self and Family enrollment in any calendar year for the Standard Option Plan, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $5,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $5,000 Self Only maximum out-of-pocket limit and a $5,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $5,000 for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self Plus One or Self and Family enrollment out-of-pocket maximum of $5,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $5,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

For HDHP: After your out-of-pocket expenses, including deductibles, copayments, and coinsurance total $3,500 for Self Only or $7,000 for Self Plus One or Self and Family enrollment in any calendar year for the HDHP, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $3,500 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $3,500 Self Only maximum out-of-pocket limit and a $7,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $3,500 for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self Plus One or Self and Family enrollment out-of-pocket maximum of $7,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $3,500 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

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 or 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.

High and Standard Option Benefits

See page 18 for how our benefits changed this year. Page 128 and page 129 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-888-901-4636 or on our website at www.ghc.org/fehb.

Each option offers unique features.

- **High Option**

The High Option Plan covers most outpatient services subject to a copayment. Select services are covered subject either to a copayment or to a coinsurance and some services are covered in full. This Plan also covers dental care. See Section 5 for Plan specifics.

- **Standard Option**

The Standard Option Plan is an annual deductible plan, with most services covered subject to the annual deductible and a copayment. See Section 5 for Plan specifics. Dental care is not covered on this Plan.

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.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option –We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In provider's office	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
At home	Nothing	Nothing
Professional services of physicians • In an urgent care center • Office medical consultation • Second surgical opinion	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Virtual care: healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (ex. home) with an in-network provider that is diagnostic and treatment focused. The Member is NOT located at a healthcare site.	Nothing	Nothing (no deductible)
Not covered: • *Audio-only, telephone, fax and e-mail communications*	All Charges	All Charges

Benefit Description	You pay After the calendar year deductible…	
Telehealth services	**High Option**	**Standard Option**
Telemedicine services provided by the use of real time interactive audio and video communication or time delayed transmission of medical information between the patient at the originating site and a provider at another location for diagnosis, consultation, or treatment. Services must be provided by a Washington state licensed physician.	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: • *Audio-only, telephone, fax and e-mail communications*	*All charges*	*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	Nothing	Nothing after deductible
Preventive care, adult	**High Option**	**Standard Option**
Routine physical according to the Plan's well adult schedule, which includes: Routine screenings, such as: • Total blood cholesterol - once every five years • Colorectal cancer screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Diabetic Retinal Screening • Obesity screening/counseling • Healthy diet • Physical activity counseling Well woman care; including, but not limited to:	Nothing	Nothing (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Routine Pap test • Human papillomavirus testing for women age 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. • Breast Related Cancer Risk Assessment, Genetic counseling, and Genetic testing (BRCA)	Nothing	Nothing (No deductible)
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	Nothing (No deductible)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing (No deductible)
Note: 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/ HHS: https://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 and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction once every 12 months - Hearing exams through age 17 to determine the need for hearing correction	Nothing	Nothing (No deductible)

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Preventive care, children (cont.)	**High Option**	**Standard Option**
• Diabetic Retinal Screening • Childhood immunizations recommended by CDC: http://www.cdc.gov/vaccines/schedules/index.html • Routine circumcision	Nothing	Nothing (No deductible)
Note: 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/ HHS: https://www.healthcare.gov/preventive-care-benefits/		
Maternity care	**High Option**	**Standard Option**
Routine maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care	Nothing for routine prenatal and postpartum care Non-routine care: $25 copayment per office visit	Nothing for routine prenatal and postpartum care Non-routine care: $25 copayment for primary care services or $35 copayment for specialty care services per office visit
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing
Note: Here are some things to keep in mind: • You do not need to have "prior approval" for your vaginal delivery; see below 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 medically necessary circumcision. We cover routine circumcision under Preventive care, children. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgery benefits Section 5(b).		

Benefit Description	You pay After the calendar year deductible…	
Family planning	**High Option**	**Standard Option**
Contraceptive counseling	Nothing	Nothing (No deductible)
A range of voluntary family planning services, limited to: • Voluntary sterilization - vasectomy (See Surgical procedures Section 5b)	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Voluntary sterilization - tubal ligation (See Surgical procedures Section 5b) • Intrauterine devices (IUDs) - insertion • Injectable contraceptive drugs • Diaphragms - fittings • Oral contraceptives • Implantable contraceptives	Nothing	Nothing (No deductible)
Not covered: Reversal of voluntary or involuntary surgical sterilization	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
• Nonexperimental infertility services limited to general diagnostic services.	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Specific diagnosis and treatment of infertility, such as: - Artificial insemination (AI): - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	50% of all charges	50% of all charges (No deductible)
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Allergy injections • Allergy Serum	Nothing	Nothing
Not covered: any testing or treatment that does not meet Plan protocols	*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 are limited to those transplants listed under Organ/Tissue Transplants Section 5(b). • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy	Nothing when administered at home	Nothing when administered at home
• Growth hormone therapy (GHT)	Covered under prescription drug benefit	Covered under prescription drug benefit
• Dietary formula for the treatment of Phenylketonuria (PKU)	Nothing	Nothing
• Enteral nutritional therapy when necessary due to malabsorption and an eosinophilic gastrointestinal disorder, including equipment and supplies	20% of charges for enteral nutritional therapy. Equipment and supplies are covered under Durable medical equipment (DME)	20% of charges for enteral nutritional therapy. Equipment and supplies are covered under Durable medical equipment (DME) (No deductible)
• Total parenteral nutritional therapy and supplies necessary for its administration	Nothing for formula. Equipment and supplies are covered under Durable medical equipment (DME)	Nothing for formula. Equipment and supplies are covered under Durable medical equipment (DME)
• Routine nutritional counseling	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Applied Behavioral Analysis (ABA) therapy	Covered under Mental health and substance abuse benefits Section 5(e)	Covered under Mental health and substance abuse benefits Section 5(e)
Not covered: over the counter formulas	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Physical and occupational therapies	**High Option**	**Standard Option**
The following therapies are covered for rehabilitative or habilitative care. Physical therapy, occupational therapy, massage therapy and speech therapy are subject to a combined limit of 60 visits per condition per calendar year. Speech therapy benefit is described in the next section. The following physical and occupational therapy benefits are covered: • Qualified physical therapists • Qualified occupational therapists • Qualified massage therapists • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction when provided at a Plan facility	$25 copayment per office visit See Section 5(c) for Hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit See Section 5(c) for Hospital charges
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Speech therapy, physical therapy and occupation therapy are subject to a combined limit of 60 visits per condition per calendar year. The physical and occupational therapy benefits are described under "Physical and Occupational therapies." Speech therapy is covered: • Qualified speech therapists	$25 copayment per office visit See Section 5(c) for Hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit See Section 5(c) for Hospital charges
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
Hearing testing to determine hearing loss. Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children* • Implanted hearing-related devices, such as bone anchor hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *orthopedic and prosthetic devices*	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: Hearing aids, testing and examinations for them	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• When dispensed through a Plan facility contact lenses are covered when medically necessary for eye pathology, including following cataract surgery. Replacement lenses for eye pathology, including following cataract surgery will be provided only when needed due to change in your medical condition and will be replaced only one time within any 12 month period. • Eye exam to determine the need for vision correction • Annual eye exams or refractions Note: See *Preventive care, children* for eye exams for children.	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: • *Eyeglasses* • *Contacts lenses and related supplies including examinations and fittings for them, except as provided above* • *Eye exercises and orthoptics* • *Evaluations and surgical procedures to correct refractions which are not related to eye pathology including complications*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
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 • Ostomy supplies necessary for the removal of bodily secretions or waste through an artificial opening • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, auditory osseointegrated implants/bone anchored health assistance (BAHA), intraocular lenses, and surgically implanted breast implant following mastectomy Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device. • Occlusal splints (including fittings) for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Therapeutic shoe inserts for severe diabetic foot disease • Braces, such as back, knee, and leg braces, but not dental braces	20% of all charges	20% of all charges (No deductible)
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* • *cost of artificial or mechanical hearts* • *cost of penile implanted device* • *orthopedic and prosthetic replacements provided except when medically necessary* • *replacement of devices, equipment and supplies due to loss, breakage or damage*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Durable medical equipment (DME)	**High Option**	**Standard Option**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Under this benefit, we cover: • hospital beds • standard wheelchairs • crutches • walkers • speech generating devices • canes • oxygen and oxygen equipment for home use • nasal CPAP device • blood glucose monitors • external insulin pumps • medically necessary replacement of supplies	20% of our allowance	20% of our allowance (No deductible)
Not covered: • *Motorized wheelchairs except when approved by the medical director as medically necessary* • *Replacement of devices, equipment and supplies due to loss, breakage or damage* • *Wigs/hair prosthesis*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), physical therapist, occupational therapist or speech therapist. Home health services require the skill of one of the listed providers based on the complexity of the service and the condition of the patient. • Services may include oxygen therapy, intravenous therapy or services provided by a Social Worker, licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide, when provided in connection with the skilled services described above	Nothing 20% for oxygen therapy	$25 copayment per visit 20% for oxygen therapy
Not covered: • *Nursing care requested by, or for the convenience of the patient or the patient's family* • *Home care primarily for personal assistance, custodial care or maintenance care that is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Chiropractic	**High Option**	**Standard Option**
Manipulative therapy services— for manipulation of the spine and extremities when treatment is received from a Plan provider and meets Plan protocols up to a maximum of 20 visits per Member per calendar year	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: • *Maintenance therapy* • *Care given on a non-acute asymptomatic basis* • *Services provided for the convenience of the member*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Acupuncture services – Self referral to a Plan provider for up to 8 visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan. • anesthesia • pain relief • substance abuse - unlimited	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Naturopathic services – Self referral to a Plan provider for up to 3 visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan.	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: • *Maintenance therapy* • *Vitamins* • *Food supplements* • *Care given on a non-acute asymptomatic basics* • *Services provided for the convenience of the member* • *Hypnotherapy* • *Biofeedback* • *Botanical and herbal medicines*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: • Tobacco cessation - Participation in an individual or group program, including educational materials and approved pharmacy products, provided you are actively participating in a Group Health Cooperative -designated tobacco cessation program.	Nothing	Nothing (No deductible)

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Diabetes self-management	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit

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.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option –We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The services listed below are for 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 PLAN DOCTOR MUST GET "PRIOR APPROVAL" FOR SOME SURGICAL PROCEDURES. Please refer to the "prior approval" information shown in Section 3 to be sure which services require "prior approval" and identify which surgeries require "prior approval."

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
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), subject to the following criteria: • You must be at least 20 years of age • Your BMI (Body Mass Index) must be 40 or greater (or between 35 and 39, with medical record documentation of one or more complicating medical conditions) • You must have failed all non-surgical methods of weight loss	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Your medical record must show the absence of medical contraindications for the procedure **Note:** You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the Group Health clinical review physician. • Insertion of internal prosthetic devices. See Section 5(a) – "Orthopedic and prosthetic devices" for device coverage information. **Note:** Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Non-routine Circumcision	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Cost of penile implanted device* • *Cost of an artificial or mechanical heart* • *Weight loss programs* • *Adjustable gastric banding, Laparoscopic or Open* • *Bilio-pancreatic bypass* • *Distal gastric bypass* • *Duodenal Switch* • *Mini-gastric bypass*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect Surgery to correct a condition caused by injury or illness if: • the condition produced a major effect on the member's appearance; and • the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and webbed toes. All stages of breast reconstruction surgery following a mastectomy, such as: • surgery to produce a symmetrical appearance of breasts • treatment of any physical complications, such as lymphedemas • compression garments to treat lymphedemas (see Durable Medical Equipment) • 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. • Surgery for gender reassignment. Services must meet Plan protocols and be authorized in advance by your Plan and are limited to the following: - Skin tissue rearrangement - Formation of direct or tubed pedicle - Excision, excessive skin and subcutaneous tissue - abdomen - Electrolysis, when required for covered surgeries - Prophylactic mastectomy - Nipple/areola reconstruction - Urethroplasty 1- stage reconstruction - Repair procedure on urethra - Urethroplasty - 2 stage reconstruction - Excision procedures on penis - Orchiectomy	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
- Insertion of testicular prosthesis - Scrotoplasty - Repair procedures on scrotum - Laparoscopic radical prostatectomy - Intersex surgery - male to female - Intersex surgery - female to male - Clitoroplasty for intersex state - Vaginectomy, Salpingo -Oophorectomy - Hysterectomy	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
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 gender reassignment surgeries not listed above or as covered*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip or cleft palate • Removal of stones from salivary ducts • Excision of malignancies • Excision of non-dental cysts and incision of non-dental abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures • TMJ related services (non-dental)	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
Not covered: • *Oral implants including preparation for implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Surgical correction of malocclusion done solely to improve appearance*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. • **Autologous tandem transplants** for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplant for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Epithelial ovarian cancer - Neuroblastoma - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
Mini-transplants performed in a clinical trial setting (non myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma Tandem transplants for covered transplants: Subject to medical necessity.	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
These blood or marrow stem cell transplants are 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: • National Transplant Program (NTP) • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Childhood rhabdomyosarcoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Aggressive non-Hodgkin's lymphomas (Mantel Cell lymphoma, adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Group Health Cooperative contracts with transplant centers who deal directly with a National Organ Transplant Clearinghouse	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges.
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.		
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Skilled nursing facility	Nothing	$35 copayment per office visit or on an inpatient basis.
Professional services provided in – • Hospital outpatient department • Ambulatory surgical center • Provider's office	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option - We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- 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).

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Semiprivate room accommodations • Special care units such as intensive care or cardiac units • General nursing care • 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.	$350 inpatient copayment per person per hospitalization	$500 inpatient copayment per person per hospitalization
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 and blood derivatives • Dressing, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	$350 inpatient copayment per person per hospitalization	$500 inpatient copayment per person per hospitalization

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing home, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines administered at the facility • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood derivatives • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Telehealth (audio and video communication) services between a consulting distant site provider and the originating site provider, where the member is located. The originating site is in a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing See section 5(b) for professional services	Nothing See section 5(b) for professional services
Not covered: • *Telehealth services when the originating site is not a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services* • *The site fee from the originating location*	*All Charges*	*All Charges*

Benefit Description	You pay After the calendar year deductible...	
Rehabilitative therapies	**High Option**	**Standard Option**
Physical therapy, occupational therapy, speech therapy- 2 months per condition per calendar year for the services of each of the following in a certified rehabilitation facility: • Qualified physical therapist • Qualified speech therapists; and • Qualified occupational therapists	$350 inpatient copayment per person per hospitalization	$500 inpatient copayment per person per hospitalization
Not covered: Long-term rehabilitative therapy	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF) benefit: When full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and authorized by the Plan, you will receive up to 60 days per calendar year.	Nothing	Nothing
Not covered: • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care* • *Personal comfort items such as telephone or television*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services could include: • Inpatient and outpatient care • Drugs • Biologicals • Medical appliances and supplies that are used primarily for the relief of pain and symptom management • Family counseling These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Ambulance	**High Option**	**Standard Option**
Ground and air ambulance transportation to a Plan facility, Plan designated facility, or non-Plan designated facility, when medically appropriate and ordered or authorized by a Plan doctor.	20% of charges	20% of charges (No deductible)

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.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option –We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, go to the nearest hospital emergency room. In extreme emergencies, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Remember, it is your responsibility to notify the Plan.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 24 hours by calling the Plan notification line at 888-457-9516, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full. If you have questions about acute illnesses other than emergencies, you should call your primary care physician.

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

If you are admitted to an in-Plan hospital or designated facility directly from the emergency room, we will waive the Emergency Room copayment. An observation bed is an extension of the emergency room and is not considered an inpatient admission.

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

If you need to be hospitalized, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Emergency within our service area	**High Option**	**Standard Option**
• Emergency or urgent care at a Plan doctor's office • Emergency or urgent care at a Plan urgent care center	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Emergency care at a Plan or Plan designated emergency department • Emergency care at a non-Plan facility, including doctors' services Note: We waive the ER copayment if you are admitted as an inpatient to the hospital.	$100 copayment per member per visit $100 copayment per member per visit	$150 copayment per member per visit $150 copayment per member per visit
Not covered: Elective care or non-emergency care	*All charges except at Plan doctor's office or Plan urgent care center*	*All charges except at Plan doctor's office or Plan urgent care center*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency or urgent care at a doctor's office • Emergency or urgent care at an urgent care center	$25 copayment per member per visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Emergency care at a hospital, including doctors' services Note: We waive the ER copayment if you are admitted as an inpatient to the hospital.	$100 copayment per member per visit	$150 copayment per member per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service which include both ground and air ambulance transportation, when medically appropriate and approved by the Plan. See Section 5(c) for non-emergency service.	20% of charges	20% of charges (No deductible)
Not covered: Cabulance	*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.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option –We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional Services	**High Option**	**Standard Option**
We cover all diagnostic and treatment services for the treatment of mental health and substance abuse conditions that are clinically necessary and recommended by the member's primary physician and approved by the Plan Medical Director or designee.	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.
Diagnostic and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Consultation services • Psychiatric treatment (individual, family and group therapy) by providers such as psychiatrists, psychologists, or clinical social workers • Diagnosis, treatment and counseling for alcoholism and drug addiction • Medication management visits • Alcohol and drug education • Diagnostic tests • Applied Behavioral Analysis (ABA) therapy - limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnostic assessments, individualized treatment plans and progress evaluations are required.	$25 copayment per office visit Nothing for diagnostic tests See Section 5(f) for mental health prescription drug coverage.	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Nothing for diagnostic tests See Section 5(f) for mental health prescription drug coverage.

Benefit Description	You pay After the calendar year deductible…	
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	Nothing	Nothing
Inpatient diagnostic tests provided and billed by a hospital or other covered facility.	$350 inpatient copayment per person per hospitalization.	$500 inpatient copayment per person per hospitalization.
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
• Hospitalization (including inpatient professional services) • Detoxification • Diagnostic tests • Diagnostic evaluation • Consultation services • Residential treatment	$350 inpatient copayment per person per hospitalization	$500 inpatient copayment per person per hospitalization
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization	$25 copayment per office visit. $25 copayment per day for partial hospitalization; no day limit.	$25 copayment for primary care services or $35 copayment for specialty care services per office visit. $25 copayment per day for partial hospitalization; no day limit.
Not Covered	**High Option**	**Standard Option**
Not covered: *Mental health inpatient and outpatient treatment that the Plan excludes are:* • *Psychiatric evaluation or therapy that is court ordered as a condition of parole or probation unless determined by a Plan provider to be necessary and appropriate* • *Psychological testing that is not medically necessary* • *Services that are custodial in nature* • *Assessment and treatment services that are primarily vocational and academic in nature (i.e., educational testing)* • *Services provided under a Federal, state, or local government* • *Services rendered or billed by a school or a member of its staff*	*All charges*	*All charges*

Not Covered - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Not Covered (cont.)	**High Option**	**Standard Option**
• *Continued services if you do not substantially follow your treatment plan* • *Treatment not authorized by a Plan provider, provided by the Plan, or specifically contracted for by the Plan*	*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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Under Standard Option –We have no calendar year deductible under the prescription drug benefits.
- Under High Option –We have no calendar year deductible under 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, *Coordinating benefits with Medicare and other coverage*.

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 Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy**.**
- **We use a formulary.** Prescriptions written by Plan physicians are dispensed in accordance with the Plan's drug formulary. A drug formulary is a list of preferred pharmaceutical products that our pharmacists and physicians have developed to assure that you receive quality prescription drugs at a reasonable price. Non-formulary drugs will be covered only if based on medical necessity and if prescribed by a Plan doctor. For information about specific formulary drugs, please call Customer Service at 888-901-4636.
- A generic equivalent to a brand name drug will be dispensed if it is available. If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. You pay a higher copayment when a brand name drug is prescribed. If you elect to purchase a brand name drug instead of the generic equivalent (if available), you will be responsible for paying the difference in cost in addition to the prescription drug cost share.
- **These are the dispensing limitations.** Prescription drugs prescribed by Plan doctors and filled at Plan pharmacies will be dispensed for up to a 30-day supply. You will be required to pay a copayment for each 30-day supply. If your prescription is written for more than a 30-day supply, such as a 90-day supply, you are responsible for three copayments, one for each 30-day supply. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Customer Service at 888-901-4636.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells that drug. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a name-brand drug.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs (including injectable)s for which a prescription is required by Federal law • Insulin • Diabetic supplies limited to: - Disposable needles, syringes, lancets, urine and blood glucose testing reagents; a copayment charge applies per item per each 30-day supply • Compound dermatological preparations • Disposable needles and syringes for the administration of covered prescribed medications • Allergy serum Intravenous fluids and medication for home use are covered under (Section 5(a) for Treatment therapies)	$20 copayment for generic formulary drugs or $40 copayment for brand name formulary drugs (including insulin and diabetic supplies), per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). $60 copayment for non-formulary drugs when prescribed by a Plan doctor. 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs when prescribed by a Plan doctor. Nothing for allergy serum.	$20 copayment for generic formulary drugs or $40 copayment for brand name formulary drugs (including insulin and diabetic supplies), per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). $60 copayment for non-formulary drugs when prescribed by a Plan doctor. 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs when prescribed by a Plan doctor. Nothing for allergy serum.
Women's contraceptive drugs and devices, including over-the-counter emergency contraceptives, such as the morning after pill.	Nothing	Nothing
Mail Order Drug Program • Prescription medications mailed to your home by the Group Health mail order pharmacy. (Mail order issues up to a 90-day supply)	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.
Limited benefits: • Drugs to aid in tobacco cessation when prescribed and dispensed as part of the GHC-designated tobacco cessation program.	Nothing	Nothing
• Sexual dysfunction drugs; dosage limits set by the Plan. Contact Customer Service toll-free at 888-901-4636 for details.	50% coinsurance	50% coinsurance
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except when due to an out-of-area emergency*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Vitamins and nutritional substances not listed as a covered benefit even if a physician prescribes or administers them, including dietary formulas and special diets, except for the treatment of phenylketonuria (PKU); total parenteral; and enteral nutrition therapy* • *Oral nutritional supplements* • *Medical supplies such as dressings, antiseptics, etc.* • *Experimental drugs, devices and biological products* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Replacement of lost or stolen drugs, medicines or devices* • *Weight loss medications* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See Section 5(a))*	*All charges*	*All charges*
Preventive care medications	**High Option**	**Standard Option**
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 • Liquid iron supplements for children age 6 months -1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for childrenage 0-6 Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.	Nothing	Nothing

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 payment and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*.
- You are not required to receive your care from specified dental providers, although your out-of-pocket costs will be less if you obtain services from providers in the PPO network.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The following is a summary of the Plan's dental benefits. Please call the Plan's member Services Department at 1-206-522-2300 or 1-800-554-1907 or you may visit our website at www.deltadentalwa.com for a listing of preferred providers or more information on additional exclusions and limitations.

The Dental program will pay a percentage of the reasonable and customary charge for dental services listed below and will reimburse any dentist, dental hygienist (under the supervision of a dentist), or denturist, that you select. You pay an annual deductible of $50 per member and $150 per family, per year up to $750 maximum benefit, per member per year as well as any amounts over Plan payment. You are not required to receive your care from specified dental providers, although your out-of-pocket costs will be less if you obtain services from providers in the PPO network.

Important: Benefits are provided only for services included in the list of covered dental services and no charge will be paid in excess of the reasonable and customary charge. No dental benefit will be paid for any dental services or supply which is incomplete or temporary.

Dental Benefits	You Pay	
Service	**High Option**	**Standard Option**
Preventive Care services include: • Prophylaxis (cleaning and polishing of teeth) not more than two (2) procedures in a calendar year • Routine oral examinations, except for orthodontics • Fluoride treatment • Fissure sealants once every two years • Dental X-rays, except for orthodontics • Bacteriologic cultures and biopsies of tissue • Emergency palliative treatment for relief of dental pain • Space maintainers, except for orthodontics • Prescription-strength anti-microbial mouth rinse or toothpaste for patients who have undergone periodontal surgery	Nothing after the deductible	Not covered

Service - continued on next page

Dental Benefits	You Pay	
Service (cont.)	**High Option**	**Standard Option**
• Anti-microbial mouth rinse for pregnant women without regard to prior receipt of periodontal procedures	Nothing after the deductible	Not covered
Restorative Care includes: • Basic periodontal services, limited to occlusal adjustment when performed with a covered root scaling • Major periodontal treatment of the gums and supporting structure of the teeth	PPO Network - 50% of reasonable and customary charges after the deductible Non PPO Network - 70% of reasonable and customary charges after the deductible	Not covered
Not covered: other dental services not shown as covered	*All charges*	*All charges*

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. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Consulting Nurse Service	For urgent care information and after hours care 24 hours a day, 7 days a week, call toll-free 800-297-6877.
Services for deaf and hearing impaired	Members who are hearing or speech-impaired may use the following number to access a Group Health Facility, staff member, or Group Health provider. Washington: 711 or 800-833-6388 Idaho: 711 or 800-377-3529
Reciprocity benefit	Plan members who temporarily reside or are traveling outside the service area of this Plan may have access to care with Kaiser Permanente Plans. If you need services when out of the area, and are in the service area of a Kaiser Permanente Plan, you may obtain care from any Kaiser Permanente provider, medical office, or medical center. Applicable cost - shares will apply. If you plan to travel and wish to obtain more information about the benefits available to you, please call our Customer Service Center at 888-901-4636.
Travel benefit	If you are traveling, and are outside the Plan's service area by more than 100 miles, certain health services are covered. You pay the applicable copayment per visit for services. Services are covered up to a Plan maximum of $2,000 per person per calendar year. You must pay the provider at the time you receive the services. If the services are covered under this benefit, you will be reimbursed the reasonable charges for the care, up to a maximum of $2,000 per person per calendar year, and the copayment per visit will be deducted from the payment you receive from the Plan. Submit a claim to the Plan for the services on a CMS-1500 form, with necessary supporting documentation, i.e., itemized bills and receipts, along with an explanation of the services, and the identification information from your ID card. Send the claims to Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585.

High Deductible Health Plan Benefits

See page 18 for how our benefits changed this year and page 131 for a benefits summary.

Section 5. High Deductible Health Plan Benefits Overview

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

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 888-901-4636 or on our website at www.ghc.org/fehb.

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

Based on your eligibility, when you enroll in this HDHP, you can have either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) account. We automatically pass through a portion of your total health Plan premium to your HSA each month or credit an equal amount to your HRA.

The first year you enroll in this HDHP, funds will be prorated based on your enrollment effective date. If your enrollment is effective other than the first day of a month, your HSA funds (or HRA credit) will be prorated based on the first of the following month. **Before funding for either an HSA or HRA can occur, Group Health must receive an HSA Eligibility Worksheet from you** (the worksheet is sent to you with your new member materials or is available on our website at www.ghc.org/fehb). If you are eligible for an HSA, in addition to the worksheet, you must complete the HSA enrollment process with HealthEquity®.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on pages 78 - 101. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

- **Preventive care**

  The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms) well-child care, and child and adult immunizations. These services, except for preventive dental, are covered at 100% if you use a network provider and the services are described in Section 5, page 76, *Preventive care.* ***you do not have to meet the deductible before using these services.***

  The Plan covers the tobacco cessation program, obesity weight loss programs, and nutritional guidance under Educational classes and programs. Please Section 5(a), page 86, for benefit details.

- **Traditional medical coverage**

  After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 80% for in-network care.

  Covered services include:

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

- **Savings**

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay for out-of-pocket expense (see page 71 for more details.)

Health Savings Accounts (HSAs)

By law, HSAs are available to members who:

- Are not enrolled in Medicare;
- Cannot be claimed as a dependent on someone else's tax return;
- Have not received VA (except for service connected disability) and/or Indian Health Services (IHS) benefits within the last three months; or
- Do not have other health insurance coverage other than another high deductible health plan.

In 2017, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $62.50 per month for a Self Only enrollment or $125 per month for a Self Plus One or Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $3,400 for an individual and $6,750 for a family. See maximum contribution information on page 70. You can use funds in your HSA to help pay your health Plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

NOTE: When you enroll in this HDHP, Group Health will send you an HSA Eligibility Worksheet and instructions on how to enroll in an HSA with HealthEquity®. The worksheet is sent to you with your new member materials or is available on our website at www.ghc.org/fehb. The first year you enroll in this HDHP, funds will be prorated based on your enrollment effective date. If your enrollment is effective other than the first day of a month, your HSA funds will be prorated based on the first of the following month. Before funding for an HSA can occur, Group Health must receive the HSA Eligibility Worksheet. In addition to the worksheet, you must complete the HSA enrollment process with HealthEquity®.

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

HSA features include:

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

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA (such as FSAFEDS offers – see *Section 11, Other Federal Programs*), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish a Health Reimbursement Arrangement (HRA) account for you.

Health Reimbursement Arrangements (HRA)

If you aren't eligible for an HSA, for example you are enrolled in Medicare or are covered on another health plan, we will establish an HRA for you instead. You must notify us that you are ineligible for an HSA by returning the HSA Eligibility Worksheet from your new member materials; the worksheet also is available on our website at www.ghc.org/fehb.

In 2017, we will give you an HRA credit of $750 per year for a Self Only enrollment and $1,500 per year for a Self Plus One or Self and Family enrollment (these amounts may be prorated the first year you are enrolled in this HDHP). You can use funds in your HRA to help pay your Plan deductible and/or for certain expenses that do not count toward the deductible.

HRA features include:

- Your HRA is administered by HealthEquity®.
- When you need them, your funds are available up to the actual HRA balance.
- The tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year to year.
- The HRA credit does not earn interest.
- The HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

Catastrophic protection for out-of-pocket expenses

Your annual maximum for out-of-pocket expenses (deductibles, coinsurance, and copayments) for covered services is limited to $3,500 for Self Only enrollment or $3,500 per person for Self Plus One or Self and Family enrollment not to exceed a total out-of-pocket maximum of $7,000. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4, *Your catastrophic protection out-of-pocket maximum* and HDHP Section 5. *Traditional medical coverage subject to the deductible*, for more details.

Health education resources and account management tools

HDHP Section 5(i), page 105, describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings - HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA with HealthEquity®, This HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	The Plan will establish an HRA with HealthEquity®, This HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)
Fees	Monthly administration fee charged by the fiduciary is paid by the Plan.	Monthly administration fee charged by the fiduciary is paid by the Plan.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision, or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA and/or Indian Health Services (IHS) benefits in the last three months • Complete and return the HSA Eligibility Worksheet to the Plan	You must: • Enroll in this HDHP • Complete and return the HSA Eligibility Worksheet to the Plan
Funding	If you are eligible for HSA contributions, a portion of your monthly health Plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	HRA contributions are a portion of your monthly health plan premium which is credited to your HRA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
• **Funding (cont.)**	**NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, you will be eligible to receive the premium pass through contribution beginning the first of the following month. If you don't complete and return the Eligibility Worksheet within 3 months of your effective date, you will be enrolled in the HRA. Please notify us if your eligibility changes, enrollment in the HSA banding arrangement can only be made during the annual open enrollment period.**	**NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, funding for your HRA will be prorated based on the first of the following month. If you don't complete and return the Eligibility Worksheet within 3 months of your effective date, you will be enrolled in the HRA.**
• **Self Only enrollment**	For 2017, a monthly premium pass through of $62.50 will be made by the HDHP directly into your HSA each month.	For 2017, your monthly premium pass through of $62.50 will be credited to your HRA each month.
• **Self Plus One enrollment**	For 2017, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month.	For 2017, your monthly premium pass through of $125 will be credited to your HRA each month.
• **Self and Family enrollment**	For 2017, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month.	For 2017, your monthly premium pass through of $125 will be credited to your HRA each month.
Contributions/Credits	The maximum that can be contributed to your HSA is an annual combination of the HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,400 for an individual and $6,750 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.	Your monthly premium pass through will be credited to your HRA each month. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, funding for your HRA will be prorated based on the first of the following month.**

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
• **Contributions/ credits (cont.)**	If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (interest does not affect your annual maximum contribution). Catch-up contributions are discussed on page 74.	
• **Self Only enrollment**	You may make an annual maximum contribution of $2,650 if your enrollment effective date is January 1.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an annual maximum contribution of $5,250 if you enrollment effective date is January 1.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You make an annual maximum contribution of $5,250 if your enrollment effective date is January 1.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • HealthEquity® Visa® Health Account • Online portal • Withdrawal form	You can access your HRA by the following methods: • HealthEquity® Visa® Health Account • Online portal • Withdrawal form
Distributions/ withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse, or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses, including Part B premium, for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See Availability of funds, page 72 for information on when funds are available in the HRA.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
• **Medical (cont.)**		See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty; however, they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The Plan receives record of your enrollment. • The Plan sends you an HSA Eligibility Worksheet. • You return the HSA Eligibility Worksheet to the Plan, confirming you meet the HSA eligibility requirements. • The plan enrolls you in an HSA with HealthEquity®. • The Plan confirms your HSA enrollment with HealthEquity®. • The Plan initiates premium pass through contributions to your HSA. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, you will be eligible to receive funding for your HSA the first of the following month.**	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The Plan receives record of your enrollment. • The Plan sends you an HSA Eligibility Worksheet for you to complete. • You return the completed worksheet to the Plan, showing you are not eligible for an HSA. • The Plan forwards your enrollment information to HealthEquity® and establishes your HRA account. Your monthly premium pass through will be credited to your HRA each month, beginning the first of the month following the Plan's receipt of the HSA Eligibility Worksheet. Accumulated funds will be made available to you to pay for qualified medical expenses and Medicare Part B premium. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, funding for your HRA will be prorated based on the first of the following month.**

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate, or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 69 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement, subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

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

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

  Contact HealthEquity® toll-free at 866-346-5800 for more details.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.ustreas.gov/offices/public-affairs/hsa.

- **If you die**

  If you have not named beneficiary and you are married, your HSA becomes your spouse's, otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

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

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

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

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

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

- **Minimum reimbursements**

  You can request reimbursement in any amount.

If you have an HRA

- **Why an HRA is established**

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

- **How an HRA differs**

  Please review the chart on page 69, which details the differences between an HRA and an HSA. The major differences are:

  - you cannot make contributions to an HRA,
  - funds are forfeited if you leave the HDHP,
  - an HRA does not earn interest,
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

  Contact HealthEquity® toll-free at 800-503-9098 for more details.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- Preventive care serviceslisted in this Section are not subject to the deductible.
- Plan physicians must provide or arrange your care.
- For all other covered expenses, please see Section 5 - *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay
Preventive care, adult	
Routine physical according to the Plan's well adult schedule, which includes: Routine screenings, such as: • Total blood cholesterol - once every five years • Colorectal cancer screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Diabetic Retinal Screening • Obesity screening/counseling • Healthy diet • Physical activity counseling Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 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. • Breast Related Cancer Risk Assessment, Genetic counseling, and Genetic testing (BRCA)	Nothing
Routine mammogram — covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at:	

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: https://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 and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel	*All charges*
Preventive care, children	
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction once every 12 months - Hearing exams through age 17 to determine the need for hearing correction • Diabetic Retinal Screening • Childhood immunizations recommended by CDC: http://www.cdc.gov/vaccines/schedules/index.html • Routine circumcision	Nothing
Note: 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/ HHS: https://www.healthcare.gov/preventive-care-benefits/ ACIP recommendations on immunizations, please refer to the National Immunization Program website at: http://www.cdc.gov/vaccines/schedules/index.html	

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 76) and is not subject to the calendar year deductible.
- Plan physicians must provide or arrange your care.
- The deductible is $1,500 per person for Self Only ($1,500 per person for Self Plus One or Self and Family enrollment, not to exceed a total family deductible of $3,000). The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $3,500 per person for Self Only enrollment, $3,500 per person for Self Plus One enrollment or Self and Family enrollment, not to exceed an out-of-pocket maximum of $7,000, in any calendar year, you do not have to pay any more for covered services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One enrollment or Self and Family enrollment, not to exceed a total family deductible of $3,000, each calendar year. The deductible applies to most benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You pay After the calendar year deductible...
Note: The High Deductible Health Plan calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In provider's office	20% coinsurance
• At home	Nothing
Professional services of physicians • In an urgent care center • Office medical consultation • Second surgical opinion	20% coinsurance
Virtual Care: healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (ex. home) with an in-network provider that is diagnostic and treatment focused. The Member is NOT located at a healthcare site.	Nothing
Not covered: • *Audio-only, telephone, fax and e-mail communcations*	*All charges*
Telehealth services	
Telemedicine services provided by the use of real time interactive audio and video communication or time delayed transmission of medical information between the patient at the originating site and a provider at another location for diagnosis, consultation, or treatment. Services must be provided by a Washington state licensed physician.	20% coinsurance
Not covered: • *Audio-only, telephone, fax and e-mail communications*	*All Charges*

Benefit Description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% coinsurance
Maternity care	
Routine maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care	Nothing for routine prenatal and postpartum care (No deductible) Non-routine care: 20% coinsurance
Breastfeeding support, supplies and counseling for each birth	Nothing (No deductible)
Note: Here are some things to keep in mind: • You do not need to have "prior approval" for your vaginal delivery; see below 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 a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to medically necessary circumcision. We cover routine circumcision under Preventive care, children. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgery benefits Section 5(b).	

Benefit Description	You pay After the calendar year deductible...
Family planning	
Contraceptive counseling	Nothing (No deductible)
A range of voluntary family planning services, limited to: • Voluntary sterilization - vasectomy (See Surgical procedures Section 5 (b))	20% coinsurance
• Voluntary sterilization - tubal ligation (See Surgical procedures Section 5(b) • Intrauterine devices (IUDs) - insertion • Injectable contraceptive drugs • Diaphragms - fittings • Oral contraceptives • Implantable contraceptives	Nothing (No deductible)
Not covered: Reversal of voluntary or involuntary surgical sterilization	*All charges*
Infertility services	
• Nonexperimental infertility services limited to general diagnostic services.	20% coinsurance
• Specific diagnosis and treatment of infertility, such as: - Artificial insemination (AI) - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	50% of all charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*
Allergy care	
• Testing and treatment	20% coinsurance
• Allergy injections • Allergy Serum	Nothing
Not covered: any testing or treatment that does not meet Plan protocols	*All charges*

Benefit Description	You pay After the calendar year deductible...
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/ Tissue Transplants in Section 5(b). • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	20% coinsurance
• Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy	Nothing when administered at home
• Growth hormone therapy (GHT)	Covered under prescription drug benefit
• Dietary formula for the treatment of Phenylketonuria (PKU)	Nothing
• Enteral nutritional therapy when necessary due to malabsorption and an eosinophilic gastrointestinal disorder, including equipment and supplies	20% of charges for enteral nutritional therapy. Equipment and supplies are covered under Durable medical equipment (DME)
• Total parenteral nutritional therapy and supplies necessary for its administration	Nothing for formula. Equipment and supplies are covered under Durable medical equipment (DME)
• Routine nutritional counseling	20% coinsurance
• Applied Behavior Analysis (ABA) Therapy	Covered under Mental health and substance abuse benefit Section 5(e)
Not covered: over the counter formulas	*All charges*
Physical and occupational therapies	
The following therapies are covered for rehabilitative or habilitative care. Physical therapy, occupational therapy, massage therapy and speech therapy are subject to a combined limit of 60 visits per condition per calendar year. Speech therapy benefit is described in the next section. The following physical and occupational therapy benefits are covered: • Qualified physical therapists • Qualified occupational therapists • Qualified massage therapists • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction when provided at a Plan facility	20% coinsurance See Section 5(c) for Hospital charges
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*

Benefit Description	You pay After the calendar year deductible...
Speech therapy	
Speech therapy, physical therapy and occupation therapy are subject to a combined limit of 60 visits per condition per calendar year. The physical and occupational therapy benefits are described under "Physical and Occupational therapies." Speech therapy is covered: • Qualified speech therapists	20% coinsurance See Section 5(c) for Hospital charges
Hearing services (testing, treatment, and supplies)	
Hearing testing to determine hearing loss. Note: For routine hearing screening performed during a child's preventive care visit, see Preventive care, children • Implanted hearing-related devices, such as bone anchor hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) orthopedic and prosthetic devices	20% coinsurance
Not covered: Hearing aids, testing and examinations for them	*All charges*
Vision services (testing, treatment, and supplies)	
• When dispensed through a Plan facility contact lenses are covered when medically necessary for eye pathology, including following cataract surgery. Replacement lenses for eye pathology, including following cataract surgery will be provided only when needed due to change in your medical condition and will be replaced only one time within any 12 month period. • Eye exam to determine the need for vision correction • Annual eye exams or refractions Note: See *Preventive care, children* for eye exams for children.	20% coinsurance
Not covered: • *Eyeglasses* • *Contacts lenses and related supplies including examinations and fittings for them, except as provided above* • *Eye exercises and orthoptics* • *Evaluations and surgical procedures to correct refractions which are not related to eye pathology including complications*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts	20% coinsurance
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges*

Foot care - continued on next page

Benefit Description	You pay After the calendar year deductible...
Foot care (cont.)	
• *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Ostomy supplies necessary for the removal of bodily secretions or waste through an artificial opening • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, auditory osseointegrated implants/bone anchored health assistance (BAHA), intraocular lenses, and surgically implanted breast implant following mastectomy Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device. • Occlusal splints (including fittings) for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Therapeutic shoe inserts for severe diabetic foot disease • Braces, such as back, knee, and leg braces, but not dental braces	20% of all charges
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* • *Cost of artificial or mechanical hearts* • *Cost of penile implanted device* • *Orthopedic and prosthetic replacements provided except when medically necessary* • *Replacement of devices, equipment and supplies due to loss, breakage or damage*	*All charges*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Under this benefit, we cover: • Hospital beds • Standard wheelchairs • Crutches • Walkers • Speech generating devices	20% of our allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	
• Canes • Oxygen and oxygen equipment for home use • Nasal CPAP device • Blood glucose monitors • External insulin pumps • Medically necessary replacement of supplies	20% of our allowance
Not covered: • *Motorized wheelchairs except when approved by the medical director as medically necessary* • *Replacement of devices, equipment and supplies due to loss, breakage or damage* • *Wigs/hair prosthesis*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), physical therapist, occupational therapist or speech therapist. Home health services require the skill of one of the listed providers based on the complexity of the service and the condition of the patient. • Services may include oxygen therapy, intravenous therapy or services provided by a Social Worker, licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide, when provided in connection with the skilled services described above	Nothing 20% for oxygen therapy
Chiropractic	
Manipulative therapy services— for manipulation of the spine and extremities when treatment is received from a Plan provider and meets Plan protocols up to a maximum of 20 visits per Member per calendar year.	20% coinsurance
Not covered: • *Maintenance therapy* • *Care given on a non-acute asymptomatic basis* • *Services provided for the convenience of the member*	*All charges*
Alternative treatments	
Acupuncture services – Self referral to a Plan provider for up to 8 visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan. • Anesthesia • Pain relief • Substance abuse - unlimited	20% coinsurance
Naturopathic services – Self referral to a Plan provider for up to 3 visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan.	20% coinsurance

Alternative treatments - continued on next page

Benefit Description	You pay After the calendar year deductible...
Alternative treatments (cont.)	
Not covered: • *Maintenance therapy* • *Vitamins* • *Food supplements* • *Care given on a non-acute asymptomatic basics* • *Services provided for the convenience of the member* • *Hypnotherapy* • *Biofeedback* • *Botanical and herbal medicines*	*All charges*
Educational classes and programs	
Coverage is provided for: • Tobacco cessation - Participation in an individual or group program, including educational materials and approved pharmacy products, provided you are actively participating in a Group Health Cooperative -designated tobacco cessation program.	Nothing (No deductible)
• Diabetes self-management	20% coinsurance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One enrollment or Self and Family enrollment, not to exceed a total family deductible of $3,000, each calendar year. The deductible applies to most benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The services listed below are for charges billed by a physician or other health care professional for your surgical care (not billed by the facility). See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PLAN DOCTOR MUST GET "PRIOR APPROVAL" FOR SOME SURGICAL PROCEDURES. Please refer to the “prior approval” information shown in Section 3 to be sure which services require "prior approval" and identify which surgeries require "prior approval."

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) Surgical treatment of morbid obesity (bariatric surgery), subject to the following criteria: • You must be at least 20 years of age • Your BMI (Body Mass Index) must be 40 or greater (or between 35 and 39, with medical record documentation of one or more complicating medical conditions) • You must have failed all non-surgical methods of weight loss • Your medical record must show the absence of medical contraindications for the procedure	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	
Note: You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the Group Health clinical review physician. • Insertion of internal prosthetic devices. See Section 5(a) – "Orthopedic and prosthetic devices" for device coverage information. **Note:** Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Non-routine circumcision	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Cost of penile implanted device* • *Cost of an artificial or mechanical heart* • *Weight loss programs* • *Adjustable gastric banding, Laparoscopic or Open* • *Bilio-pancreatic bypass* • *Distal gastric bypass* • *Duodenal Switch* • *Mini-gastric bypass*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	
- compression garments to treat lymphedemas (see Durable Medical Equipment) - 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. • Surgery for gender reassignment. Services must meet Plan protocols and be authorized in advance by your Plan and are limited to the following: - Skin tissue rearrangement - Formation of direct or tubed pedicle - Excision, excessive skin and subcutaneous tissue - abdomen - Electrolysis, when required for covered surgeries - Prophylactic mastectomy - Nipple/areola reconstruction - Urethroplasty 1- stage reconstruction - Repair procedure on urethra - Urethroplasty - 2 stage reconstruction - Excision procedures on penis - Orchiectomy - Insertion of testicular prosthesis - Scrotoplasty - Repair procedures on scrotum - Laparoscopic radical prostatectomy - Intersex surgery - male to female - Intersex surgery - female to male - Clitoroplasty for intersex state - Vaginectomy, Salpingo-Oophorectomy - Hysterectomy	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges
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 gender reassignment surgeries not listed above or as covered*	*All charges*

Benefit Description	You pay After the calendar year deductible...
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip or cleft palate • Removal of stones from salivary ducts • Excision of malignancies • Excision of non-dental cysts and incision of non-dental abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures • TMJ related services (non-dental)	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges
Not covered: • *Oral implants including preparation for implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Surgical correction of malocclusion done solely to improve appearance*	*All charges*
Organ/tissue transplants	
These **Solid organ transplants** are covered Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis.	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. • **Autologous tandem transplants** for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplant for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Epithelial ovarian cancer - Neuroblastoma - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges
Mini-transplants performed in a clinical trial setting (non myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
- Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges
Tandem transplants for covered transplants: Subject to medical necessity.	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges
These blood or marrow stem cell transplants are 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: • National Transplant Program (NTP) • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Childhood rhabdomyosarcoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Aggressive non-Hodgkin's lymphomas (Mantel Cell lymphoma, adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms)	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Group Health Cooperative contracts with transplant centers who deal directly with a National Organ Transplant Clearinghouse	20% coinsurance Outpatient surgery is subject to 20% coinsurance See Section 5(c) for hospital charges
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in - • Hospital (inpatient) • Skilled nursing facility	Nothing
Professional services provided in - • Hospital outpatient department • Ambulatory surgical center • Provider's office	20% coinsurance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One enrollment or Self and Family enrollment, not to exceed a total family deductible of $3,000, each calendar year. The deductible applies to most benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- 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).

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as • Semiprivate room accommodations • Special care units such as intensive care or cardiac units • General nursing care • 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.	20% coinsurance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood and blood derivatives • Dressing, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	20% coinsurance
• Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing home, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines administered at the facility • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood derivatives • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Telehealth (audio and video communication) services between a consulting distant site provider, and the originating site provider, where the member is located. The originating site is in a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non- dental physical impairment. We do not cover the dental procedures.	Nothing See section 5(b) for professional services
Not covered: • *Telehealth services when the originating site is not a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services* • *The site fee from the originating location*	*All charges*
Rehabilitative therapies	
Physical therapy, occupational therapy, speech therapy - 2 months per condition per calendar year for the services of each of the following in a certified rehabilitation facility: • Qualified physical therapist • Qualified speech therapists; and • Qualified occupational therapists	20% coinsurance
Not covered: Long-term rehabilitative therapy	*All charges*

Benefit Description	You pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits	
Skilled nursing facility (SNF) benefit: When full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and authorized by the Plan, you will receive up to 60 days per calendar year.	Nothing
Not covered: • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care* • *Person comfort items such as telephone or television*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services could include: • Inpatient and outpatient care • Drugs • Biologicals • Medical appliances and supplies that are used primarily for the relief of pain and symptom management • Family counseling These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
Ground and air ambulance transportation to a Plan facility, Plan designated facility, or non-Plan designated facility, when medically appropriate and ordered or authorized by a Plan doctor.	20% of 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.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One enrollment or Self and Family enrollment, not to exceed a total family deductible of $3,000, each calendar year. The deductible applies to most benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, go to the nearest hospital emergency room. In extreme emergencies, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Remember, it is your responsibility to notify the Plan.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 24 hours by calling the Plan notification line at 888-457-9516, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full. If you have questions about acute illnesses other than emergencies, you should call your primary care physician.

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

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

If you need to be hospitalized, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay After the calendar year deductible...
Note: The HDHP Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Emergency within our service area	
• Emergency or urgent care at a Plan doctor's office • Emergency or urgent care at a Plan urgent care center	20% coinsurance
• Emergency care at a Plan or Plan designated emergency department • Emergency care at a non-Plan facility, including doctors' services	20% coinsurance
Not covered: Elective care or non-emergency care	*All charges except at Plan at Plan doctor's office or Plan urgent care center*
Emergency outside our service area	
• Emergency or urgent care at a doctor's office • Emergency or urgent care at an urgent care center	20% coinsurance
• Emergency care at a hospital, including doctors' services	20% coinsurance
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service which include both ground and air ambulance transportation, when medically appropriate and approved by the Plan. See Section 5(c) for non-emergency service.	20% of charges
Not covered: Cabulance	*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.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One enrollment or Self and Family enrollment, not to exceed a total family deductible of $3,000, each calendar year. The deductible applies to most benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible...
Professional Services	
We cover all diagnostic and treatment services for the treatment of mental health and substance abuse conditions that are clinically necessary and recommended by the member's primary physician and approved by the Plan Medical Director or designee.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostic and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Consultation services • Psychiatric treatment (individual, family and group therapy) by providers such as psychiatrists, psychologists, or clinical social workers • Diagnosis, treatment and counseling for alcoholism and drug addiction • Medication management visits • Alcohol and drug education • Diagnostic tests • Applied Behavioral Analysis (ABA) therapy - limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required.	20% coinsurance See Section 5(f) for mental health prescription drug coverage

Benefit Description	You pay After the calendar year deductible...
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	20% coinsurance
Inpatient hospital or other covered facility	
• Hospitalization (including inpatient professional services) • Detoxification • Diagnostic tests • Diagnostic evaluation • Consultation services • Residential treatment	20% coinsurance
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization	20% coinsurance 20% coinsurance for partial hospitalization; no day limit
Not Covered	
Not covered: *Mental health inpatient and outpatient treatment that the Plan excludes are:* • *Psychiatric evaluation or therapy that is court ordered as a condition of parole or probation unless determined by a Plan provider to be necessary and appropriate* • *Psychological testing that is not medically necessary* • *Services that are custodial in nature* • *Assessment and treatment services that are primarily vocational and academic in nature (i.e., educational testing)* • *Services provided under a Federal, state, or local government* • *Services rendered or billed by a school or a member of its staff* • *Continued services if you do not substantially follow your treatment plan* • *Treatment not authorized by a Plan provider, provided by the Plan, or specifically contracted for by the Plan*	*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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One enrollment or Self and Family enrollment, not to exceed a total family deductible of $3,000, each calendar year. The deductible applies to most benefits in this Section, unless we indicate differently.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

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

- **Who can write your prescription.** A Plan physician or referral doctor, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy**.**
- **We use a formulary.** Prescriptions written by Plan physicians are dispensed in accordance with the Plan's drug formulary. A drug formulary is a list of preferred pharmaceutical products that our pharmacists and physicians have developed to assure that you receive quality prescription drugs at a reasonable price. Non-formulary drugs will be covered only if based on medical necessity and if prescribed by a Plan doctor. For information about specific formulary drugs, please call Customer Service at 888-901-4636.
- A generic equivalent to a brand name drug will be dispensed if it is available. If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. You pay a higher copayment when a brand name drug is prescribed. If you elect to purchase a brand name drug instead of the generic equivalent (if available), you will be responsible for paying the difference in cost in addition to the prescription drug cost share.
- **These are the dispensing limitations.** Prescription drugs prescribed by Plan doctors and filled at Plan pharmacies will be dispensed for up to a 30-day supply. You will be required to pay a copayment for each 30-day supply. If your prescription is written for more than a 30-day supply, such as a 90-day supply, you are responsible for three copayments, one for each 30-day supply. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Customer Service at 888-901-4636.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells that drug. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand name product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a name-brand drug.

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs (including injectable)s for which a prescription is required by Federal law • Insulin • Diabetic supplies limited to: - Disposable needles, syringes, lancets, urine and blood glucose testing reagents; a copayment charge applies per item per each 30-day supply • Compound dermatological preparations • Disposable needles and syringes for the administration of covered prescribed medications • Allergy serum Intravenous fluids and medication for home use are covered under (Section 5(a) for Treatment therapies)	$10 copayment for generic formulary drugs or 20% coinsurance up to $100 for brand name formulary drugs (including insulin and diabetic supplies), per prescription unit or refill for up to a 30-day supply or 100- unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). 40% coinsurance up to $250 for non- formulary drugs when prescribed by a Plan doctor. 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs. Nothing for allergy serum.
Women's contraceptive drugs and devices, including over-the-counter emergency contraceptives, such as the morning after pill.	Nothing (No deductible)
Mail Order Drug Program • Prescription medications mailed to your home by the Group Health mail order pharmacy. (Mail order issues up to a 90-day supply)	2 times the applicable prescription drug cost share with 2 times the applicable prescription drug max for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.
Limited benefits: • Drugs to aid in tobacco cessation when prescribed and dispensed as part of the GHC-designated tobacco cessation program	Nothing (No deductible)
• Sexual dysfunction drugs; dosage limits set by the Plan. Contact Customer Service at 888-901-4636 for details.	50% coinsurance
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except when due to an out-of-area emergency* • *Vitamins and nutritional substances not listed as a covered benefit even if a physician prescribes or administers them, including dietary formulas and special diets, except for the treatment of phenylketonuria (PKU); total parenteral; and enteral nutrition therapy* • *Oral nutritional supplements* • *Medical supplies such as dressings, antiseptics, etc.* • *Experimental drugs, devices and biological products* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	
• *Fertility drugs* • *Replacement of lost or stolen drugs, medicines or devices* • *Weight loss medications* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See Section 5(a))*	*All charges*
Preventive care medications	
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 • Liquid iron supplements for children age 6 months -1 year • 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 (No deductible)

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. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Consulting Nurse Service	For urgent care information and after hours care 24 hours a day, 7 days a week, call toll-free 800-297-6877.
Services for deaf and hearing impaired	Members who are hearing or speech-impaired may use the following number to access a Group Health Facility, staff member, or Group Health provider. Washington: 711 or 800-833-6388 Idaho: 711 or 800-377-3529
Reciprocity benefit	Plan members who temporarily reside or are traveling outside the service area of this Plan may have access to care with Kaiser Permanente Plans. If you need services when out of the area, and are in the service area of a Kaiser Permanente Plan, you may obtain care from any Kaiser Permanente provider, medical office, or medical center. Applicable cost - shares will apply. If you plan to travel and wish to obtain more information about the benefits available to you, please call our Customer Service Center at 888-901-4636.
Travel benefit	If you are traveling, and are outside the Plan's service area by more than 100 miles, certain health services are covered. You pay the applicable deductible and coinsurance per visit for services. Services are covered up to a Plan maximum of $2,000 per person per calendar year. You must pay the provider at the time you receive the services. If the services are covered under this benefit, you will be reimbursed the reasonable charges for the care, up to a maximum of $2,000 per person per calendar year, and the coinsurance per visit will be deducted from the payment you receive from the Plan. Submit a claim to the Plan for the services on a CMS-1500 form, with necessary supporting documentation, i.e., itemized bills and receipts, along with an explanation of the services, and the identification information from your ID card. Send the claims to Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585.

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

Special features	Description
Health education resources	Through **MyGroupHealth** on our website at www.ghc.org you will find information on: • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids' health • Patient safety information • Helpful website links
Account management tools	For each HSA and HRA account holder, complete payment history and balance information can be found online at www.MyHealthEquity.com. This information is also available by calling the HealthEquity® customer service line toll-free at 866-346-5800. You may view monthly statements, year-end statements and tax statements online at healthequity.com. If you have an HSA, you may also change your investment options online at www.MyHealthEquity.com.
Consumer choice information	Provider Directories are available online at www.ghc.org. Pricing information for prescription drugs and a link to our online pharmacy are available at www.ghc.org by clicking on Pharmacy. Educational materials regarding HSAs and HRAs are available at healthequity.com.
Care support	Patient safety information is available online through **MyGroupHealth** on our website at www.ghc.org.

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 a FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximum. These programs and materials are the responsibility of the Plan and all appeals must follow their guidelines. For additional information contact the Plan at 888-901-4636 or visit our website at www.ghc.org.

Additional Benefits

Vision hardware discount – Shop at convenient Group Health Eye Care locations.

- Get a 20% vision hardware discount on eyeglasses or prescription sunglasses.
- Get a 20% discount on contact lenses once a year.
- Fitting and evaluation fees are not discounted. Call Customer Service toll-free at 888-901-4636, or go online to www.gheyecare.org for more information.

Dental benefits website – Sign in to this site and get a customized page where you can access information like recent dental activity, easy-to-understand explanations about your coverage, and more. Visit www.DeltaDentalWA.com for more information.

Additional Services

Group Health Audiology/Hear Center – Get a full range of the latest hearing aid technology from leading manufacturers, as well as other custom devices and accessories at Group Health Medical Centers locations in Everett, Bellevue, Seattle, Tacoma, and Olympia. Go to www.ghc.org/html/public/services/audiology for more information.

24-hour Consulting Nurse Service – When you want care advice or need to know if you should get immediate medical attention, Group Health's Consulting Nurse Service can help 24 hours a day. For assistance, call 800-297-6877.

Online Services

MyGroupHealth for Members – Online services at www.ghc.org are available to all members. Select doctors and read their profiles, see medical clinic locations and programs, and browse thousands of health care topics. Plus, you can refill pharmacy prescriptions, view or download your FEHB Brochure, and take the Health Profile to assess your health.

Getting care at a Group Health Medical Centers – When you log on to www.ghc.org, you can exchange secure messages with your health care team, check your online medical record, get your lab and test results, and request an appointment.

Mobile App

Our convenient smartphone app – You can use your smartphone to access many of the features you enjoy online at MyGroupHealth for Members. Plus, there is a symptom checker that guides you through a series of questions that can help you identify potential explanations for your symptoms. Find out all the things you can do at www.ghc.org/mobile.

Wellness Programs

Health Profile – Uncover your risks and make positive changes with support from Group Health. Learn more once you're registered at www.ghc.org.

Wellness visits – Schedule immunizations and screening tests based on age and gender. Search for adult wellness visits on www.ghc.org.

Fitness club and discounts – Find out more at www.globalfit.com/grouphealth.

Tobacco cessation – Giving up smoking isn't easy, but Group Health offers a highly successful program with a 49% quit rate. For more information, visit www.quitnow.net/ghc.

SilverSneakers® fitness program – As a Group Health Medicare Advantage plan member you can participate in this popular program at no extra charge at health and fitness facilities throughout the state. Individuals must have both Part A and Part B to enroll. Find a facility at www.silversneakers.com.

Individual and family plans – Consider a range of individual and family plans for those who do not qualify for coverage under the FEHB program. Learn more at www.ghc.org/individual-family.

For more information about these and other benefits available to Group Health members, please call Group Health Customer Service at 888-901-4636 toll-free or go online to our website at www.ghc.org/fehb.

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 Plan Approval for certain services.*

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants), or related extra care costs or research costs.
- 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.
- Cosmetic procedures related to sex transformations.
- Procedures, services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

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 claim procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your applicable cost-shares.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Facilities will file on the UB-04 form. For claims questions and assistance, contact us at 888-901-4636 or at our website at www.ghc.org.

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

- Covered member's name, 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)
- Receipts, if you paid for your services.

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

Submit your claims to: Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585

Phone: 888-901-4636

Prescription drugs

Outpatient drugs and medicines obtained at non-Plan pharmacies are not covered; except when due to an out of area emergency.

Submit your claims to: Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585

Phone: 888-901-4636

Other supplies or services

Submit your claims to: Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585

Phone: 888-901-4636

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition 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 requirement not listed in Sections 3, 7, and 8 of this brochure please visit www.ghc.org/fehb

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 describe 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 to P.O. Box 34593, Seattle, WA 98124-1593 or calling 866-458-5479.

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 judgment (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 judgment 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.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Group Health Cooperative, Member Appeal Department, P.O. Box 34593, Seattle, WA 98124-1593, 866-458-5479; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. 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 on 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.

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

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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, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email 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.

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

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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 888-901-4636. 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 3 at 202-606-0737 between 8am and 5pm 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 Workers' Compensation Programs if you are receiving Workers' 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 care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary 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.ghc.org.

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, up to the benefit limits of this Plan. You must use our providers.

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 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, successors, 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 damages 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.

If you need more information, contact our Customer Service toll-free at 888-901-4636 for our subrogation procedures.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337, (TTY 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 may provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. This plan does not cover these costs when provided as part of the clinical trial, except when Group Health Cooperative's exception to clinical trial exclusion criteria are met.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.

- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- 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 two Medicare Advantage plans for Federal Employees. Please review the information about 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 help in 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 800-772-1213 (TTY: 800-325-0778).

- **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 process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 888-901-4636.

We do not waive any costs on the High Option Plan if the Original Medicare Plan is your primary payor.

We waive some costs on the High Deductible Plan (HDHP) and Standard Option, if the Original Medicare Plan is your primary payor and if you have <u>both</u> Part A and Part B of Medicare.

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
	HDHP	Standard Option	HDHP	Standard Option
Deductible	$1,500	$350	$0	$0
Out of Pocket Maximum	$3,500 Self Only/$7,000 family	$5,000 Self Only/$5,000 family	$1,500 Self Only/$3,000 family	$1,500 Self Only/$3,000 family
Primary Care Physician	20%	$25	$25	$25
Specialist	20%	$35	$25	$35
Inpatient Hospital	20% per admission	$500 per admission	$150 per admission	$150 per admission
Outpatient Hospital	20% per visit	$100 per visit	$50 per visit	$50 per visit
RX	Tier 1 - $10 Tier 2 - 20% up to $100 Tier 3 - 40% up to $250 Tier 4 - Preferred Specialty 25% to $200 Tier 5 - Non-preferred Specialty 50% to $500	Tier 1 - $20 Tier 2 - $40 Tier 3 - $60 Tier 4 - Preferred Specialty 25% to $200 Tier 5 - Non-preferred Specialty 50% to $500	Tier 1 - $10 Tier 2 - 20% up to $100 Tier 3 - 40% up to $250 Tier 4 - Preferred Specialty 25% to $200 Tier 5 - Non-preferred Specialty 50% to $500	Tier 1 - $20 Tier 2 - $40 Tier 3 - $60 Tier 4 - Preferred Specialty 25% to $200 Tier 5 - Non-preferred Specialty 50% to $500
Rx - Mail order (90-day supply)	2x retail copay	2x retail copay	2x retail copay	2x retail copay

You can find more information about how our plan coordinates benefits with Medicare at www.ghc.org/fehb.

- **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 (800-633-4227), (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 and our Medicare Advantage plan: We offer a Medicare Advantage plan known as Group Health Federal Employees Health Benefits Medicare Advantage plan. If you are a Medicare eligible retiree and have Medicare Parts A and B, you can enroll in our Federal Employees Medicare Advantage plan with no increase to your FEHB or Group Health premium. The Federal Employees Medicare Advantage plan enhances your FEHB coverage by lowering cost shares for certain services and/or adding benefits. Your enrollment in our Federal Employee Medicare Advantage plan is in addition to your FEHB High Option or Standard Option enrollment. If you are considering enrolling in the Federal Employees Medicare Advantage plan, please call us at 800-446-8882 (TTY: 711), 8 a.m. to 8 p.m., Monday through Friday. Note: you must complete an election form to enroll in the Federal Employee Medicare Advantage plan.

If you are already a member of Group Health for Federal Members and would like to understand your additional benefits in more detail, please refer to your Federal Employee Medicare Advantage Evidence of Coverage.

Below is a summary of features of the Federal Employees Medicare Advantage plans:

High Option:

- Deductible: None
- Office visits: $0 copayment per primary or specialty care visit
- Emergency care: $50 copayment per visit
- Inpatient hospital: $0 copayment per admission
- Outpatient surgery: $0 copayment per visit
- Prescription drugs: $20 copayment generic, $40 copayment brand-name, $60 copayment non-formulary, 25% coinsurance to $200 preferred specialty, 50% coinsurance to $500 non-preferred specialty (up to 30-day supply)
- Services provided under the travel benefit: $25 copayment, see Section 5(h). Special features

Standard Option:

- Deductible: None
- Office visits: $10 copayment per primary or specialty care visit
- Emergency care: $50 copayment per visit
- Inpatient hospital: $100 copayment per admission
- Outpatient surgery: $50 copayment per visit
- Prescription drugs: $3 copayment generic, $30 copayment brand-name, $40 copayment non-formulary, 25% coinsurance to $200 preferred specialty, 50% coinsurance to $500 non-preferred specialty (up to 30-day supply)
- Services provided under the travel benefit: $25 copayment, see Section 5(h). Special features

High Deductible Health Plan Option:

- Deductible: None
- Office visits: $0 copayment per primary or specialty care visit
- Emergency care: $0 copayment per visit
- Inpatient hospital: $0 copayment per admission
- Outpatient surgery: $0 copayment per visit
- Prescription drugs: $3 copayment generic, $30 copayment brand-name, $40 copayment non-formulary, 25% coinsurance to $200 preferred specialty, 50% coinsurance to $500 non-preferred specialty (up to 30-day supply)

	• Services provided under the travel benefit: 20% coinsurance, See HDHP Section 5(h). Special features
	This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.
	Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.
• **Medicare prescription drug coverage (Part D)**	When we are the primary 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 condition whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of our allowance (see definition below) that you must pay for your care. You may also be responsible for additional amounts. See page 24. We also have different coinsurance percentages for some benefits, and in those cases, we specify the percentage that you must pay. For example, there is a 50% coinsurance for certain types of infertility services, and the Plan coinsurance does not apply. Durable medical equipment and ambulance services are others services that require you to pay a coinsurance, and the Plan coinsurance does not apply.
Copayment	A copayment is a fixed amount of money you pay when you receive certain services. See page 24.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by the Medicare managed care plan, or Medicare, unless provided in conjunction with skilled nursing care and/or skilled rehabilitation services. Custodial care that lasts 90 days or longer is sometimes known as long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 24.
Experimental or investigational service	The Plan makes its determination of experimental or investigational treatment, including medical and surgical services, drugs, devices and biological products upon review of evidence provided by evaluations of national medical associations, consensus panels, and/or other technological evaluations, including the scientific quality of such supporting evidence and rationale. The information it reviews comes from the U.S. Food and Drug Administration, and from scientific evidence in published medical literature, as well as in published peer-reviewed medical literature.
Group health coverage	Coverage offered by your employer.

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

Medical necessity Medical services or hospital services which are determined by the Plan Medical Director or designee to be:

a) Rendered for the treatment or diagnosis of an injury or illness; and

b) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and

c) Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service.

Whether there is "sufficient scientific evidence" shall be determined by the Plan based on the following: peer-reviewed medical literature; publications, reports, evaluations, and regulations issued by state and federal government agencies; Medicare local carriers, and intermediaries; and such other authoritative medical sources as deemed necessary by the Plan.

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: the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies.

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 workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the 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 workers' 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 of 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-serve 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, 888-901-4636. 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 Cooperative.
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 to 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 they 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. 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, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers 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 the 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 Employees Dental and Vision Insurance Program – FEDVIP

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **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 plan's FEDVIP dental brochure for information on this benefit.**

Vision Insurance

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

Summary of benefits for the High Option of Group Health Cooperative - 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$25 copayment per office visit for primary care or specialist	29
• Diagnostic tests, lab and X-ray services	Nothing	30
Services provided by a hospital:		
• **Inpatient**	$350 per person per hospitalization	49
• **Outpatient**	Nothing/See Section 5(b) for other related cost	50
Emergency benefits:		
• **In-area**	$100 copayment per visit	54
• **Out-of-area**	$100 copayment per visit	54
Mental health and substance abuse treatment:	Regular cost-sharing	55
Prescription drugs:		
• Pharmacy, for a 30-day supply per prescription unit or refill	$20 copayment for generic prescription $40 copayment for brand name prescription $60 copayment for non-formulary prescription 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs	59
• Mail order, for a 90-day supply or less per prescription unit or refill	2 times the applicable prescription drug copayment Mail order not available for specialty drugs	59
Dental care: See dental schedule for complete coverage	Nothing after deductible.	61
Vision care: Routine eye exam and refractions for eyeglasses	$25 copayment per office visit.	36
Special features:	Flexible benefits option; consulting nurse service; services for deaf and hearing impaired; reciprocity benefit; and travel benefit	63
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $3,000/Self Only or $6,000/Self and Family enrollment per year. Some costs do not count toward this protection	24

Summary of benefits for the Standard Option of Group Health Cooperative - 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $350 for Self Only, $700 Self Plus One or Self and Family calendar year deductible.

Standard Option Benefits	You Pay	Page
***Medical services provided by physicians:**		
• Diagnostic and treatment services provided in the office	$25 copayment for primary care services or $35 copayment for specialty care services per office visit	29
• Diagnostic tests, lab and X-ray services	Nothing after the deductible is satisfied.	30
***Services provided by a hospital:**		
• Inpatient	$500 per person per hospitalization	49
• Outpatient	Nothing/See Section 5(b) for other related cost.	50
***Emergency benefits:**		
• In-area	$150 copayment per visit	54
• Out-of-area	$150 copayment per visit	54
***Mental health and substance abuse treatment:**	Regular cost-sharing	55
Prescription drugs:	(No deductible, no Plan coinsurance for pharmacy)	
• Pharmacy, for a 30-day supply per prescription unit or refill	$20 copayment for generic prescriptions $40 copayment for brand name prescriptions $60 copayment for non-formulary prescription 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs	59
• Mail order, for a 90-day supply or less per prescription unit or refill	2 times the applicable prescription drug copayment Mail order not available for specialty drugs	59
Dental care:	Not covered	61
***Vision care:** Routine eye exam and refractions for eyeglasses	$25 copayment for primary care services or $35 copayment for specialty care services per office visit	36
Special features:	Flexible benefits option; consulting nurse service; services for deaf and hearing impaired; reciprocity benefit; and travel benefit	63

Standard Option Benefits	You Pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/Self Only or $5,000/Self and Family enrollment per year. Some costs do not count toward this protection.	24

Summary of benefits for the HDHP of Group Health Cooperative - 2017

Do not rely on this chart alone. All benefits 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.

In 2017 for each month you are eligible for the Health Savings Account (HSA) Group Health Cooperative will deposit $62.50 per month for Self Only enrollment, $125 for Self Plus One enrollment or for Self and Family enrollment to your HSA. For the High Deductible Health Plan you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $1,500 for Self Only, $3,000 for Self Plus One and Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $750 for Self Only enrollment, $1,500 for Self Plus One and Self and Family enrollment. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the $1,500 calendar year deductible.

We only cover services provided or arranged by Plan physicians, except in emergencies.

HDHP Benefits	You Pay	Page
Medical preventive care:	Nothing	76
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	20% coinsurance*	79
Services provided by a hospital:		
• Inpatient	20% coinsurance*	94
• Outpatient	20% coinsurance*	95
Emergency benefits:		
• In-area	20% coinsurance*	98
• Out-of-area	20% coinsurance*	98
Mental health and substance abuse treatment:	Regular cost-sharing*	99
Prescription drugs:		
• Pharmacy, for a 30-day supply per prescription unit or refill	$10 copayment for generic prescription* 20% coinsurance up to $100 for brand name prescription* 40% coinsurance up to $250 for non-formulary prescription* 25% up to $200 per 30-day supply for preferred specialty drugs* 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs*	102
• Mail order, for a 90-day supply or less per prescription unit or refill	2 times the applicable prescription drug cost-share* Mail order not available for specialty drugs	102
Vision care: Routine eye exam and refractions for eyeglasses	20% coinsurance*	36

HDHP Benefits	You Pay	Page
Special features:	Flexible benefits option; consulting nurse service; services for deaf and hearing impaired; reciprocity benefit; and travel benefit	104
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $3,500/Self Only or $7,000/Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection.	24

Notes

2017 Rate Information for Group Health Cooperative

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

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

Postal rates apply to Postal Service employees.

Postal Category 1 rates apply to career employees bargaining unit employees who are represented by the APWU (including IT/ASC, MDC, OS and NPPN employees) and NRLCA.

Postal Category 2 rates apply to career bargaining unit employees who are represented by the NALC, NPMHU and PPO.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: 877-477-3273, option 5, TTY: 866-260-7507

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career postal employees.

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	541	221.67	127.79	480.29	276.87	118.56	115.48
High Option Self Plus One	543	475.79	240.59	1,030.88	521.28	220.76	214.16
High Option Self and Family	542	505.22	403.37	1,094.64	873.97	382.31	375.30
Standard Option Self Only	544	196.91	65.63	426.63	142.21	57.10	54.48
Standard Option Self Plus One	546	403.65	134.55	874.58	291.52	117.06	111.68
Standard Option Self and Family	545	505.22	177.37	1,094.64	384.31	156.31	149.30
HDHP Option Self Only	PT1	175.16	58.38	379.50	126.50	50.79	48.46
HDHP Option Self Plus One	PT3	359.08	119.69	778.01	259.33	104.13	99.34
HDHP Option Self and Family	PT2	455.42	151.80	986.73	328.91	132.07	126.00