

GHI Health Plan

www.EMBLEMHEALTH.com

877-VIA-EMBLEM (877-842-3625)



an EmblemHealth company

2020

A Prepaid Comprehensive Medical Plan.

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 3 for details. This plan is accredited.

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

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 12 for requirements.

Enrollment codes for this Plan:

804 Standard Option – Self Only

806 Standard Option - Self Plus One

805 Standard Option – Self and Family

811 HDHP Option -- Self Only

813 HDHP Option -- Self Plus One

812 HDHP Option -- Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2020: Page 16
- Summary of Benefits: Page 114

SPECIAL NOTICE

This Plan added a High Deductible Health Plan (HDHP) Option offering for 2020

Authorized for distribution by the:



United States
Office of Personnel Management

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

RI 73-007

**Important Notice from the GHI Health Plan About
Our Prescription Drug Coverage and Medicare**

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 thru December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

Table of Contents

Cover Page	1
Important Notice	1
Table of Contents	1
Introduction	3
Plain Language	3
Stop Health Care Fraud!	3
Discrimination is Against the Law	5
Preventing Medical Mistakes	5
FEHB Facts	8
No pre-existing condition limitation	8
Minimum essential coverage (MEC)	8
Minimum value standard	8
Where you can get information about enrolling in the FEHB Program	8
Types of coverage available for you and your family	8
Family member coverage	9
Children’s Equity Act	10
When benefits and premiums start	10
When you retire	11
When FEHB coverage ends	11
Upon divorce	11
Temporary Continuation of Coverage (TCC)	11
Section 1. How This Plan Works	13
Section 2. Changes for 2020	16
Section 3. How You Get Care	17
Identification cards	17
Where you get covered care	17
What you must do to get covered care	17
How to request precertification for an admission or get prior approval for Other services	19
Concurrent care claims	20
Emergency inpatient admission	20
Maternity care	20
The Federal Flexible Spending Account Program – FSAFEDS	21
If you disagree with our pre-service claim decision	21
To file an appeal with OPM	22
Section 4. Your Cost for Covered Services	23
Cost-sharing	23
Copayments	23
Deductible	23
Coinsurance	23
Differences between our Plan allowance and the bill	24
Your catastrophic protection out-of-pocket maximum	24
Section 5. Benefits	26
Section 5. Standard Option Benefits Overview	27
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals	28
Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals	40
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services	47

Section 5(d). Emergency Services/Accidents	50
Section 5(e). Mental Health and Substance Use Disorder Benefits	52
Section 5(f). Prescription Drug Benefits	54
Section 5(g). Dental Benefits	58
Section 5(h). Wellness and Other Special Features.....	60
Section 5. High Deductible Plan Option Benefits Overview	62
Section 5. Savings – HSAs and HRAs.....	65
Section 5. Preventive Care	70
Traditional Medical Coverage Subject to the Deductible	72
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals	73
Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals	79
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services	86
Section 5(d). Emergency Services/Accidents	89
Section 5(e). Mental Health and Substance Use Disorder Benefits	90
Section 5(f). Prescription Drug Benefits	92
Section 5(g). Dental Benefits	95
Section 5(h). Wellness and Other Special Features.....	96
Non-FEHB benefits available to Plan members	97
Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover	98
Section 7. Filing a Claim for Covered Services	99
Section 8. The Disputed Claims Process.....	101
Section 9. Coordinating Benefits with Medicare and Other Coverage	104
When you have other health coverage	104
TRICARE and CHAMPVA	104
Workers' Compensation	104
Medicaid.....	104
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage	105
Section 10. Definitions of Terms We Use in This Brochure	110
Index	113
Summary of Benefits for the Standard Option of the GHI Health Plan - 2020	114
Summary of Benefits for the HDHP Option of the GHI Healthplan - 2020	116
2020 Rate Information for GHI Health Plan	118

Introduction

This brochure describes the benefits of Group Health Incorporated (GHI) under our contract (CS 1056) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (877) 842-3625 or through our website: www.emblemhealth.com. The address for GHI administrative offices is:

Group Health Incorporated
55 Water St.
New York, NY 10041

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 Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2020, unless those benefits are shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2020, and changes are summarized beginning on page 16. Rates are shown at the end of this brochure.

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure you 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 (877) 842-3625 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

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

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

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
 - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- 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 (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

GHI complies with applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, GHI does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age disability, or sex.

You may file a 1557 complaint with the HHS Office of Civil Rights, an FEHB Program carrier, or OPM. You may file a civil rights complaint with OPM by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW Suite 3400-S
Washington, DC 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication 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 medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication 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 do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

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

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

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

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

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

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

Patient Safety Links

For more information on patient safety, please visit:

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

Preventable Healthcare Acquired Conditions ("Never Event")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation** We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Minimum essential coverage (MEC)** Coverage under this plan qualifies as minimum essential coverage. 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/healthcare for enrollment information as well as:
 - Information on the FEHB Program and plans available to you
 - A health plan comparison tool
 - A list of agencies that participate in Employee Express
 - A link to Employee Express
 - Information on and links to other electronic enrollment systems

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

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

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

- **Types of coverage available for you and your family** Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you and one eligible family member, or 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 Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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, you or they can not be enrolled in or covered as a family member by another enrollee in another FEHB plan.

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

• **Family member coverage**

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

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact 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**

Office of Personnel Management has implemented the Federal Employees Health Benefits Children’s Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program; if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- 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 lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not 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 2020 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 2019 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

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

Temporary Continuation of Coverage (TCC)

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

Converting to individual coverage

We will provide you with assistance in finding a non-group contract available inside or outside the Marketplace 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 decide 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.

You must contact us in writing within 31 days after you are no longer eligible for coverage. For assistance in finding coverage, please contact us at 1-800-624-2414 or visit our website at www.emblemhealth.com/federal.

Benefits and rates under the replacement coverage will differ from benefits and rates 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.

**Health Insurance
Marketplace**

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

Section 1. How This Plan Works

This Plan offers one Standard Option Exclusive Provider Organization (EPO) benefit package and one High Deductible Health Plan (HDHP). GHI seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, we can afford to offer a comprehensive range of benefits.

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

In addition to providing comprehensive health care services for illness and injury, we emphasize preventive benefits such as routine office visits, physicals, immunizations, and well-baby care. We encourage you to seek medical attention at the first sign of illness. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network.

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

General Features of our Standard Option

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

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.

General features of our High Deductible Health Plan (HDHP)

The enrollment codes for the HDHP are 811 (Self Only) and 813 (Self Plus One) and 812 (Self and Family). 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. This Plan has no out of network benefits.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayment, 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 services. Traditional Medical Services are subject to the Plan year deductible.

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 have received VA (except for veterans with a service-connected disability) 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 an 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.

How we pay providers

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

When you use a participating hospital, keep in mind that the professionals who provide services to you in the hospital may not all be participating providers. When you receive emergency and non-emergency services at a participating hospital but are seen by a non-participating anesthesiologist, radiologist, pathologist, or assistant surgeon, we will calculate payment based on an allowance that we determine under the GHI Plan Options. GHI will determine reimbursement for emergency services from non-participating providers based on a lesser of 100% of the 90th percentile of FAIR Health Prevailing Healthcare Charges System for Emergency Professional charges and Emergency Admission Professional Charges or the provider's billed charge. Our allowance may not cover the full charges and you will owe that portion of the charges that exceeds our payment. This policy does not apply to services that you receive at non-participating hospitals.

Under the Standard Option and HDHP, we do not cover care from non-participating providers and will not pay them for covered services even if Medicare is your primary health insurance coverage. To get full maximum use of the plans you must use GHI's participating EPO provider network for all covered services.

Surprise Bills. If your claim was for services from a non-participating provider, the claim may be for a "surprise bill," giving you protection from out-of-pocket costs in excess of what you would have paid in-network for the services. Please contact us at the number on the back of your member ID card or visit our website at [emblemhealth.com/outofnetwork](https://www.emblemhealth.com/outofnetwork) for more information about what constitutes a "surprise bill" and what you should do if you think your claim was for a "surprise bill."

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits out-of-pocket expenses for covered services obtained from participating providers, including deductibles and copayments, to no more than \$6,900 for Self-Only enrollment, or \$13,800 for a Self Plus One or Self and Family. The out-of-pocket limits for these Plans may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

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

- GHI has been in continuous existence for over eighty (80) years.
- GHI is a Not for Profit New York company.

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

If you want more information about us, call (877) 842-3625, or write to GHI, PO Box 1701, New York, NY 10023-9476. You may also visit our website at www.emblemhealth.com/federal.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit the EmblemHealth website at www.emblemhealth.com/federal to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that notice.

Your medical and claims records are confidential

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

Service area

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

In this Plan you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area.

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

Section 2. Changes for 2020

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

Changes for Standard Option:

- Your share of the non-Postal premium will increase for Self Only, Self Plus One, and Self and Family. See the back of the brochure for 2020 premium rate information.

Important Notice: GHI is now offering a High Deductible Health Plan for 2020. See section 5 HDHP Program.

Section 3. How You Get Care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, contact us at (877) 842-3625 or Group Health Incorporated (GHI) 55 Water Street, New York, NY 10041. You may also request replacement cards through the GHI website: www.emblemhealth.com/federal

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” Network providers file claims for you and we reimburse them directly for covered services. You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. Under the Standard Option coverage, we will not provide benefits for services that you receive from non-network providers.

- **Plan providers**

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

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

- **Plan facilities**

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

- **Covered Providers**

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

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

What you must do to get covered care

Under the Plan, you are free to choose any participating provider within your Plan’s GHI network. We strongly encourage you to select a doctor within the GHI network who will provide your care.

- **Specialty care**

You may see the specialist whenever you and your family feel you need care. You do not need a referral to see a specialist.

Here are other things you should know about specialty care:

- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or

- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
- reduce our service area and you enroll in another FEHB plan

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

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

• **Hospital care**

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (877) 842-3625. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

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

• **Inpatient hospital admission**

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

Your physician must obtain precertification for the following services:

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

You do not need precertification in the following situations:

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

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

• **Other services**

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

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

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

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

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

• **Non-urgent care claims**

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

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

- **Urgent care claims**

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

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (877) 842-3625. You may also call FEHB 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at (877) 842-3625. 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, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

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

- **Maternity care**

You do not need pre-certification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for pre-certification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for pre-certification of additional days.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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

If your physician requests 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, we will make a decision within 24 hours after we receive the claim.

- **The Federal Flexible Spending Account Program – FSAFEDS**

Health Care FSA (HCFSA) – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, 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.

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

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Cost for Covered Services

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

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

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

Example: When you see your primary care physician you pay a copayment of \$50 per office visit, and \$10 per office visit for dependent children to age 26, under the Standard Option.

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 them. Under the HDHP, when a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

Under the **Standard Option** the calendar year deductible for certain services is:

- For orthopedic and prosthetic devices, oxygen and other covered durable medical equipment you pay \$100 calendar year deductible per individual.

There are no other calendar year deductibles under Standard Option.

Under the **HDHP** the calendar year deductible is **\$1,600** per person.

- 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 **\$1,600**. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach **\$3,200**. 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 **\$3,200** under the HDHP.
- We also have separate deductibles for: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is \$100, the provider has an agreement with us to accept \$80, and you have not paid any amount toward meeting your calendar year deductible, you must pay \$80. We will apply \$80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible (**\$1,600**) has been satisfied

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

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

Example: Under **Standard Option**, under Durable Medical Equipment, after the applicable deductible is met you pay 20% of the Plan's fee schedule for a participating provider.

Example: Under **HDHP**, after the applicable deductible is met, you pay 10% of the Plan's allowance for a participating provider.

Differences between our Plan allowance and the bill

When you use network providers, you are not responsible for differences between GHI's allowance and the provider's charge. Non-network providers do not have an agreement with GHI to accept the GHI allowance as payment in full.

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10. Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

Your catastrophic protection out-of-pocket maximum

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

HDHP: After your (copayments deductibles and coinsurance) total **\$6,750** for Self Only or **\$13,500** for Self Plus One, or **\$13,500** per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

Copayments, deductibles and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

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

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

Carryover

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

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

When Government facilities bill us

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

Section 5. Benefits

See page 13 for how our benefits changed this year and page 113 for a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals	28
Diagnostic and treatment services.....	28
Lab, X-ray and other diagnostic tests.....	29
Preventive care, adult.....	29
Preventive care, children.....	30
Maternity care	31
Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals	40
Surgical procedures.....	40
Anesthesia	46
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services	47
Inpatient hospital.....	47
Outpatient hospital or ambulatory surgical center	48
Section 5(d). Emergency Services/Accidents	50
Emergency within our service area.....	51
Emergency outside our service area.....	51
Ambulance	51
Section 5(e). Mental Health and Substance Use Disorder Benefits.....	52
Mental Health and Substance Use Disorder Benefits	52
Autism Spectrum Disorders.....	53
Section 5(f). Prescription Drug Benefits.....	54
Covered medications and supplies.....	56
Section 5(g). Dental Benefits	58
Accidental injury benefit.....	58
Routine Dental Services.....	58
Section 5(h). Wellness and Other Special Features.....	60
Flexible benefits option.....	60
Large Case Management.....	60
Customer Service AnswerLine.....	60
Centers of Excellence.....	60

Section 5. Standard Option Benefits Overview

We offer one Standard Option plan. We describe the available benefits under this package in Section 5 of this brochure. Make sure that you review the benefits that are available under the option in which you are enrolled. The enrollment codes for Standard Option are 804 (Self Only) and 806 (Self Plus One) and 805 (Self and Family).

Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain more information about the Standard Option benefits, contact us at 212 501-4GHI (4444) or on our website at www.emblemhealth.com.

Standard Option features:

- Access to GHI's Exclusive Provider Option (EPO) network
- \$50 copayment per office visit to participating network doctors
- No copayment for United States Preventive Task Force (USPSTF) recommended preventive care services
- \$10 copayment for dependent children who are under the age of 26 as long as the services are performed by a participating network provider.
- \$500 per day up to a maximum of \$1,000 per admission for covered inpatient hospital admissions
- No copayment for up to 30 days of GHI approved skilled nursing facility benefit
- With the exception of durable medical equipment, there is no calendar year deductible

Standard Option also offers the following unique features:

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

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- In vitro fertilization benefits are not covered for Standard Option.
- With the exception of durable medical equipment, there is no calendar year deductible.

Benefit Description	You pay
Diagnostic and treatment services	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • At home • Professional services of physicians <ul style="list-style-type: none"> - Office medical consultations - Second surgical opinion - Routine physical examination every year - Advance care planning 	\$50 per office visit \$10 per office visit for children (under age 26) All charges for non-participating providers
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment 	Nothing for participating providers All charges for non-participating providers
Telehealth Services	Standard Option
If your provider offers covered services using telehealth: <ul style="list-style-type: none"> • Covered services will include the use of electronic information and communication technologies by a provider to deliver covered services to you while your location is different than your providers location. • Provider consultations are for non-emergency medical conditions only. • Subject to the Prescription Drug section, if necessary the telehealth physician may write a prescription and send it to an in-network participating retail pharmacy. Prescriptions are subject to cost sharing where applicable. <p>Telehealth services are administered by Teladoc</p> <p><i>Note: Covered services are subject to the same utilization review and quality assurance requirements and other terms and conditions of this plan.</i></p>	\$10 for consultations from physicians providing Telehealth services

Benefit Description	You pay
<p>Lab, X-ray and other diagnostic tests</p> <p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	<p>Standard Option</p> <p>\$50 per each diagnostic x-ray + laboratory test performed by a participating provider (a maximum of two diagnostic copays will apply per date of service)</p> <p>\$10 copayment per each diagnostic x-ray + laboratory test for children (under age 26) when performed by a participating provider (a maximum of two diagnostic copays will apply per date of service)</p> <p>All charges for non-participating providers.</p>
<p>Preventive care, adult</p> <p>Routine Screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Depression • Diabetes • High Blood Pressure • HIV • Colorectal Cancer Screening, including: <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy screening - every five (5) years starting at age fifty (50) - Colonoscopy screening - every five (5) years starting at age fifty (50) - Individual counseling on prevention and reducing health risks <p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p> <p>Well woman care -based on current recommendations such as:</p> <ul style="list-style-type: none"> • Human Papillomavirus testing for women age thirty (30) and up once every three years • Cervical cancer screening (Pap smear) • Chlamydia/Gonorrhea screening • Gonorrhea prophylactic medication to protect newborns • Osteoporosis screening • Breast cancer screening • 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 • Routine mammogram – covered for women • Perinatal depression: counseling and interventions 	<p>Standard Option</p> <p>Nothing for preventive care performed by a participating provider</p> <p>All charges for non-participating providers</p> <p>Nothing for preventive services performed by a participating provider</p> <p>All charges for non-participating providers</p> <p>Nothing for preventive services performed by a participating provider</p> <p>All charges for non-participating providers</p>

Benefit Description	You pay
<p>Preventive care, adult (cont.)</p> <p>Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster - once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine annually • Pneumococcal vaccine, age 65 and over • Varicella (Chickenpox) - for all persons aged 19-49 • Tetanus, Diphtheria and Pertussis (TDAP) - for persons aged 19-64, with a booster every 10 years • Shingles vaccine, age 50 and over <p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance and deductible.</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</p> <p>HHS: www.healthcare.gov/preventive-care-benefits/</p> <p>CDC: www.cdc.gov/vaccines/schedules/index.html</p> <p>Women's preventive services:</p> <p>https://www.healthcare.gov/preventive-care-women/</p> <p>For additional information:</p> <p>www.healthfinder.gov/myhealthfinder/default.aspx</p>	<p>Standard Option</p> <p>Nothing for preventive services performed by a participating provider</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	
<p>Preventive care, children</p> <ul style="list-style-type: none"> • Well-child visits, examinations, and immunizations as described in the Bright Futures Guidelines provided by the American Academy of Pediatrics <p>Examinations, limited to:</p> <ul style="list-style-type: none"> • Examinations for amblyopia and strabismus - limited to one screening examination (ages 3 through 5) • Ear exams to determine the need for hearing correction • Examinations done on the day of immunizations (ages 3 up to age 19) 	<p>Standard Option</p> <p>Nothing for participating providers</p> <p>All charges for non- participating providers</p> <p>Nothing for participating providers</p> <p>All charges for non-participating providers</p>

Benefit Description	You pay
<p>Preventive care, children (cont.)</p> <p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance and deductible.</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</p> <p>HHS: www.healthcare.gov/preventive-care-benefits/</p> <p>CDC: www.cdc.gov/vaccines/schedules/index.html</p> <p>Women's preventive services:</p> <p>https://www.healthcare.gov/preventive-care-women/</p> <p>For additional information:</p> <p>www.healthfinder.gov/myhealthfinder/default.aspx</p> <p>Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to www.brightfutures.asp.org/Pages/default.aspx</p>	<p>Standard Option</p>
<p>Maternity care</p> <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Screening for gestational diabetes for pregnant women • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not have to precertify your vaginal delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical Benefits, not maternity benefits, apply to circumcision if this is the case. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits (Section 5b). 	<p>Standard Option</p> <p>\$50 copay for first visit only (for all prenatal and postnatal care). You pay nothing thereafter.</p> <p>All charges for non-participating providers</p>

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	
<p>Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p>	<p>\$50 copay for first visit only (for all prenatal and postnatal care). You pay nothing thereafter.</p> <p>All charges for non-participating providers</p>
<ul style="list-style-type: none"> • Breastfeeding support, supplies and counseling for each birth 	<p>Nothing</p>
Family planning	
<p>Contraceptive counseling on an annual basis</p>	<p>Nothing</p>
<p>A range of voluntary family planning services for women, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal ligation <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>Nothing for participating providers</p> <p>All charges for non-participating providers</p>
<p>Voluntary family planning services for men, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (e.g. Vasectomy) <p>(See Surgical procedures Section 5b)</p>	<p>\$50 per visit</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing and counseling</i> 	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination (AI) <ul style="list-style-type: none"> - Intrauterine insemination (IUI) - Intrauterine insemination (IUI) - Intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>\$50 per visit</p> <p>All charges for non-participating providers</p> <p>Note: Subject to Prior Approval, see section 3</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cost of donor egg • Cost of donor sperm • In vitro fertilization (IVF) is NOT covered under Standard Option 	<p><i>All charges</i></p>

Benefit Description	You pay
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections • Treatment materials (such as allergy serum) 	<p>Standard Option</p> <p>\$50 per office visit</p> <p>\$10 per office visit for children (under age 26)</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 43.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 32 sessions. 	<p>Nothing in a participating provider doctor’s office</p> <p>Note: Subject to prior approval, we will provide up to ten out of area hemodialysis treatments performed by a non participating provider. You are responsible for all charges that exceed our allowable charges</p>
<ul style="list-style-type: none"> • High-tech nursing and infusion therapy <ul style="list-style-type: none"> - IV infusion therapy - Parenteral and enteral therapy - Other home IV therapies <p>Note: Contact us at (800) 223-9870 prior to receiving services to ensure coverage.</p> <ul style="list-style-type: none"> • Intermittent home nursing service <ul style="list-style-type: none"> - Provided by a Registered Nurse or Licensed Practitioner - Authorized and supervised by a doctor - Intermittent visits less than 2 hours per day 	<p>Nothing for a participating provider</p> <p>All charges for non-participating providers</p>
<ul style="list-style-type: none"> • Growth hormone therapy (GHT). <p>Note: This benefit is provided under our Prescription Drug Benefits. Please see Section 5(f) Prescription Drug benefits for information on growth hormone.</p> <p>Note: We only cover GHT when we preauthorize the treatment before you begin treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under You need prior to Plan approval for certain services on page .</p>	<p>Applicable prescription drug copay</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Treatment for experimental or investigational procedures</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Physical and occupational therapies	
<p>Rehabilitation</p> <p>Up to 60 visits per condition if significant improvement can be expected for the services of each of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists • Occupational therapists <p>Note: We only cover therapy when a physician orders the care.</p> <p>Habilitation</p> <p>Up to 60 visits per condition if significant improvement can be expected for the services for</p> <ul style="list-style-type: none"> • Health care services that help a person keep, learn or improve skills and functioning for daily living including: • the management of limitations and disabilities • services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. <p>Note: We cover Habilitation Services in the outpatient department of a Facility or in a Health Care Professional’s office.</p>	<p>\$50 per visit</p> <p>\$10 per visit for children (under age 26)</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative and habilitation therapy • Exercise programs 	<p><i>All charges</i></p>
Speech therapy	
<p>Rehabilitation</p> <p>Up to 60 visits of speech therapy each calendar year for services from the following:</p> <ul style="list-style-type: none"> • Licensed or certified speech therapists <p>Habilitation</p> <p>Up to 60 visits of speech therapy each calendar year for services for:</p> <ul style="list-style-type: none"> • Speech therapy services that help a person keep, learn or improve skills and functioning for daily living. including: • the management of limitations and disabilities • services or programs that help maintain or prevent deterioration in cognitive function. <p>Note: We Cover Habilitation Services in the outpatient department of a Facility or in a Health Care Professional’s office.</p>	<p>\$50 per visit</p> <p>\$10 per visit for children (under age 26)</p> <p>All charges for non-participating providers</p>

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Diagnostic and treatment services for disease or medical conditions affecting hearing For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist External hearing aids (See "Orthopedic and Prosthetic devices") 	<p>Standard Option</p> <p>\$50 per visit</p> <p>\$10 per visit for children (under age 26)</p> <p>All charges for non-participating providers</p>
<i>Not covered: Hearing services that are not listed as covered</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Medical and surgical benefits for diagnosis and treatment of diseases of the eye 	<p>Standard Option</p> <p>\$50 per visit</p> <p>\$10 per visit for children (under age 26)</p> <p>All charges for non-participating providers</p>
<ul style="list-style-type: none"> Examination of the eyes to determine if glasses are required: once each calendar year One set of single vision or bifocal lenses (toric kryptok or flat top 22mm): once each calendar year One pair of basic frames from available styles: one every two years Contact lenses for certain unusual medical conditions (such as post cataract surgery or keratoconus treatment) Replacement of broken lenses with lenses of the same prescription and material originally supplied <p>This benefit is administered by EyeMed -www.eyemed.com</p>	<p>Nothing for services provided by participating opticians, optometrists and vision centers</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Frames at any time unless lenses are also provided</i> <i>Replacement or repair of frames</i> <i>Certain bifocals and trifocals, tinted, plastic and oversized lenses and sunglasses and frames other than basic frames; contact lenses for cosmetic purposes</i> <i>Charges in excess of the maximum GHI allowance</i> 	<i>All charges</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes, including the routine treatment of corns, calluses, and bunions, and the partial removal of toenails</p> <p>Note: There is a limit of 4 visits per calendar year.</p>	<p>Standard Option</p> <p>\$50 per visit</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>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</i> 	<i>All charges</i>

Foot care - continued on next page

Benefit Description	You pay
<p>Foot care (cont.)</p> <ul style="list-style-type: none"> • 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) • <i>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)</i> • <i>Orthotics devices for the feet</i> 	<p>Standard Option</p> <p><i>All charges</i></p>
<p>Orthopedic and prosthetic devices</p> <ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • External hearing aids (Once every two years) • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Orthopedic devices, such as braces • Ostomy supplies • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.</p>	<p>Standard Option</p> <p>20% of the Plan's fee schedule for a participating provider</p> <p>All charges for non-participating providers</p> <p>Note: \$100 annual deductible applies per individual.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Corrective appliances for treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
<p>Durable medical equipment (DME)</p> <p>We cover rental or purchase of durable medical equipment at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • oxygen • dialysis equipment • hospital beds • wheelchairs • crutches • walkers • blood glucose monitors • diabetic pumps <p>Note: Call us at 800-223-9870 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>Standard Option</p> <p>20% of the Plan’s fee scheduled for a participating provider</p> <p>All charges for non-participating providers</p> <p>Note: \$100 annual deductible applies per individual.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Air purification devices</i> • <i>Alarm and Alert Services</i> 	<p><i>All charges</i></p>
<p>Home health services</p> <p>Services include:</p> <ul style="list-style-type: none"> • Part-time or intermittent nursing care by a registered professional nurse (R.N.) or a home health aide under the supervision of a registered professional nurse • Physical therapy • Respiration or inhalation therapy • Prescription drugs • Medical supplies which serve a specific therapeutic or diagnostic purpose • Other medically necessary services or supplies that would have been provided by a hospital if the subscriber were still hospitalized <p>In order for us to cover home health care services, the following conditions must be met: 1) Home health care must be provided and billed by a certified home health agency, which has an agreement with GHI to provide home health care services; 2) You must remain under the care of a medical doctor; 3) The services are provided according to a plan of treatment approved by the attending medical doctor; and 4) Medical evidence substantiates that you would have required further inpatient care had the home health care not been available.</p>	<p>Standard Option</p> <p>Nothing for a participating provider</p> <p>All charges for a non-participating provider</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter</i> • <i>Services and supplies related to normal maternity care</i> 	<p><i>All charges</i></p>

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	
<ul style="list-style-type: none"> • <i>Services and supplies provided following a noncovered hospital admission or admission to a facility that is not a participating facility</i> • <i>Services and supplies provided when the subscriber would not have required continued inpatient care</i> • <i>Services and supplies provided by a non-participating facility for home health care</i> • <i>High-tech nursing and infusion therapy</i> • <i>Nursing care requested by or for the convenience of the patient's family and/or private duty nursing</i> 	<p><i>All charges</i></p>
Chiropractic	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjustment procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	<p>Standard Option</p> <p>\$50 per visit</p> <p>\$10 per visit for children (under age 26)</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>chiropractic services not shown as covered</i> 	<p><i>All charges</i></p>
Alternative treatments	
<p>Acupuncture – unlimited visits; no utilization management</p> <p>Services obtained through American Specialty Health at www.choosehealthy.com 1 (877) 327-2746</p> <ul style="list-style-type: none"> • anesthesia • pain relief 	<p>\$50 per visit</p> <p>\$10 per visit for children (under age 26)</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>naturopathic services</i> • <i>hypnotherapy</i> • <i>biofeedback</i> 	<p><i>All charges</i></p>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self-management • Cholesterol Management • Arthritis • Asthma • Hepatitis C • Multiple Sclerosis • Depression • Osteoporosis • Nutritional Counseling • Childhood obesity education 	<p>Nothing</p> <p>For diabetes self management call Diabetes Health Solutions at (800) 881-4008</p> <p>For arthritis and osteoporosis information call Arthritis Foundation NYC Chapter at (212) 984-8713</p> <p>To enroll in our Asthma program call (212) 615-0363</p>
<p>Tobacco Cessation/E-cigarettes Program</p>	<p>Nothing</p>

Educational classes and programs - continued on next page

Benefit Description	You pay
<p>Educational classes and programs (cont.)</p> <p>The Program is provided in partnership with the American Cancer Society's Quit For Life (ACSQFL) program implemented by Free Participation is initiated by a phone call to the call center. Under the program, you have access to the following:</p> <ul style="list-style-type: none"> • Unlimited telephonic access to professional counselors; • Educational information tailored to the member's stage of readiness to quit; • Access to ACSQFL Web site; and • Full coverage for smoking cessation pharmaceutical products (Nicotine Patch, Gum, Lozenge, Bupropion (generic Zyban®) and Chantix™). <p>Note - See Section 5(f) Prescription Drug Benefits for information on physician prescribed smoking cessation medication. See Section 5(e) for information on group and individual psychotherapy.</p>	<p>Standard Option</p> <p>Nothing</p>

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.
- If you are enrolled in the Standard Option EPO, you must use participating providers within the EPO network.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3, page 19, to be sure which services require precertification and identify which surgeries require precertification.
- With the exception of durable medical equipment, there is no calendar year deductible.

Benefit Description	You pay
Surgical procedures	Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery)– see services requiring our prior approval on page 18. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns 	<p>\$50 per office visit based surgical procedure</p> <p>\$10 per office visit based on surgical procedure for children under age 26</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Stand-by services</i> • <i>Routine treatment of conditions of the foot (see Foot care)</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and; - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • Gender Reassignment Surgery (GRS) when all Plan criteria are met. Pre-authorization is required for all services. 	<p style="text-align: center;">Standard Option</p> <p>\$50 per office based procedure</p> <p>All charges for non-participating providers</p> <p>See Section 5(c) for outpatient hospital or ambulatory surgical center copayments</p>
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; or - breast prostheses and surgical bras and replacements (see Prosthetic devices). <p>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.</p>	<p>\$50 per office based procedure</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures, and • Removal of impacted teeth • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$50 per office based procedure</p> <p>All charges for non-participating providers</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> 	<p><i>All charges</i></p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
<p>Oral and maxillofacial surgery (cont.)</p> <ul style="list-style-type: none"> • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) • All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>Standard Option</p> <p>All charges</p>
<p>Organ/tissue transplants</p> <p>These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. See Other services under You need prior Plan approval for certain services on page xx:</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Lung: single/bilateral/lobar • Liver • Pancreas 	<p>Standard Option</p> <p>\$50 per office based procedure</p> <p>\$10 per office procedure for children (under age 26)</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgical center</p> <p>All charges for non-participating providers</p>
<p>The tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by Plan. Refer to Other services in Section 3 for prior authorization procedures.</p> <p>Autologous tandem transplants for</p> <ul style="list-style-type: none"> • AL Amyloidosis • Multiple myeloma (de nova and treated) • Recurrent germ cell tumors (including testicular cancer) 	<p>\$50 per office based procedure</p> <p>\$10 per office procedure for children (under age 26)</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgical center</p> <p>All charges for non-participating providers</p>
<p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as indicated below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Sickle cell anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non- lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis 	<p>\$50 per office based procedure</p> <p>\$10 per office procedure for children (under age 26)</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgical center</p> <p>All charges for non-participating providers</p>

Organ/tissue transplants - continued on next page
Standard Option Section 5(b)

Benefit Description	You pay
Organ/tissue transplants (cont.)	Standard Option
<ul style="list-style-type: none"> - Breast cancer - Epithelial ovarian cancer - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors 	<p>\$50 per office based procedure</p> <p>\$10 per office procedure for children (under age 26)</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgical center</p> <p>All charges for non-participating providers</p>
<p>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.</p> <p>Refer to <i>Other Services</i> in Section 3 for prior authorization procedures:</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Acute myeloid leukemia • Advanced Hodgkin’s lymphoma with recurrence (relapsed) • Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia <p>Autologous transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma with recurrence (relapsed) • Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma 	<p>\$50 per office based procedure</p> <p>\$10 per office procedure for children (under age 26)</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgical center</p> <p>All charges for non-participating providers</p>
<p>These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p>	<p>\$50 per office based procedure</p> <p>\$10 per office procedure for children (under age 26)</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgical center</p> <p>All charges for non-participating providers</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	Standard Option
<p>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 patients 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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination - Early state (indolent or non advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for <ul style="list-style-type: none"> - Advanced Childhood kidney cancers 	<p>\$50 per office based procedure</p> <p>\$10 per office procedure for children (under age 26)</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgical center</p> <p>All charges for non-participating providers</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	Standard Option
<ul style="list-style-type: none"> - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphom - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis 	<p>\$50 per office based procedure</p> <p>\$10 per office procedure for children (under age 26)</p> <p>Nothing for a participating provider in the hospital or a participating ambulatory surgical center</p> <p>All charges for non-participating providers</p>
<p><i>Note:</i></p> <ul style="list-style-type: none"> • <i>We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in additiona to the testing of family members. Donor coverage is provided up to a maximum of \$10,000 per transplant.</i> • <i>Travel expenses up to a maximum of \$150 per person per day and \$10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center. This includes food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place.</i> <p><i>Note: The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery.</i></p>	<p>A maximum of \$150 per person per day and \$10,000 per lifetime.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Anesthesia	
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	<p style="text-align: center;">Standard Option</p> Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Professional services provided in – <ul style="list-style-type: none"> • Hospital (outpatient) • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Services administered by the same practitioner performing surgery</i> 	<i>All charges</i>

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.
- Under Standard there is a \$500 copay per day up to a maximum of \$1000 per admission.
- A participating provider must provide or arrange all inpatient Hospital care and you must be hospitalized in a participating facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. FAILURE TO DO SO WILL RESULT IN A MINIMUM \$125 PENALTY UP TO A MAXIMUM OF \$250** Please refer to Section 3, page 19, to be sure which services require precertification.
- With the exception of durable medical equipment, there is no calendar year deductible.

Benefit Description	You pay
Inpatient hospital	Standard Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>\$500 per day up to a maximum of \$1,000 per inpatient admission</p> <p>Note: Except for medically necessary emergency admissions you pay all charges for an inpatient admission at a non-participating facility.</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	<p>Nothing (included in the inpatient hospital copay)</p> <p>Note: Except for medically necessary emergency admissions you pay all charges for an inpatient admission at a non-participating facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care, rest cures, domiciliary or convalescent care</i> 	<p><i>All charges</i></p>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • <i>Non-covered facilities, such as nursing homes and schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>Long term rehabilitation</i> 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition. For approved inpatient admissions, you are responsible for the applicable hospital admission copay (see inpatient hospital benefits).</p>	<p>\$150 copayment per visit</p> <p>All charges for a non-participating provider</p>
<ul style="list-style-type: none"> • Diagnostic laboratory tests, X-rays, and pathology services 	<p>\$50 copayment per visit</p> <p>All charges for non-participating providers</p>
<ul style="list-style-type: none"> • Chemotherapy and radiation 	<p>Nothing for chemotherapy and radiation provided in a participating facility</p> <p>All charges for non-participating providers</p> <p>Note: Prior Approval Required, see Section 3</p>
<i>Not covered: Blood and blood derivatives replaced by the member</i>	<i>All charges</i>
Skilled nursing facility benefits	
<p>Skilled nursing facility (SNF) care is limited to 30 days per calendar year and includes the following:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplied and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your doctor as governed by Medicare guidelines. 	<p>Nothing for a participating provider</p> <p>All charges for a non-participating provider</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<i>All charges</i>

Benefit Description	You pay
Hospice care	Standard Option
<p>Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include:</p> <ul style="list-style-type: none"> • inpatient/outpatient care; and • family counseling under the direction of a doctor. <p>Note: Your provider must certify that you are in the terminal stages of illness, with a life expectancy of approximately six months or less. The hospice must have an agreement with us or recognized by Medicare as a hospice.</p>	Nothing for a participating provider
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>
End of life care	Standard Option
<p>Acute care provided in a licensed Article 28 facility or acute care facility that specializes in terminally ill patients, for members diagnosed with advanced cancer with less than sixty (60) days to live.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>
Ambulance	Standard Option
<p>Ambulance services for each trip to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility.</p>	<p>All charges in excess of \$100.</p> <p>Note: We will not pay more than \$100 for covered ambulance services.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Air ambulance</i> • <i>Ambulette services</i> 	<i>All charges</i>

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- GHI will determine reimbursement for emergency services from non-participating providers based on a lesser of 100% of the 90th percentile of FAIR Health Prevailing Healthcare Charges System for Emergency Professional charges and Emergency Admission Professional Charges or the provider's billed charge.
- With the exception of durable medical equipment, there is no calendar year deductible.

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

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

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

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

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

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

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

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> Emergency medical/surgical care at a doctor's office Emergency medical/surgical care at an urgent care center 	<p>Standard Option</p> <p>\$50 per office visit for a participating provider.</p> <p>\$75 per visit to urgent care center</p> <p>Any difference between our allowance and the billed amount for a non-participating provider.</p>
<ul style="list-style-type: none"> Emergency care as an outpatient at hospital <p>Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.</p>	<p>\$200 copay per hospital emergency room visit plus all charges that exceed the emergency allowance for non-participating hospitals.</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> Emergency medical/surgical care at a doctors' office Emergency medical/surgical care at an urgent care center Emergency care as an outpatient at a hospital, including doctors' services 	<p>Standard Option</p> <p>\$50 per office visit for a participating provider.</p> <p>\$75 per visit to urgent care center</p> <p>Any difference between our allowance and the billed amount for a non-participating provider.</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Ambulance	
<p>Professional ambulance service to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility.</p> <p>See 5(c) for non-emergency service.</p>	<p>Standard Option</p> <p>All charges in excess of \$100</p> <p>Note: We do not pay more than \$100 for covered ambulance services.</p>
<i>Not covered: air ambulance and ambullette services</i>	<i>All charges</i>

Section 5(e). Mental Health and Substance Use Disorder 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 the Standard Option, you must obtain care from within the participating provider network.
- With the exception of durable medical equipment, there is no calendar year deductible.
- 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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Mental Health and Substance Use Disorder Benefits	Standard Option
<p>All diagnostic and treatment services obtained from a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>Nothing for outpatient mental health care.</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing</p>
<p><i>Not Covered</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> • <i>Facility charges of a non-participating general hospital or facility</i> • <i>Treatment by a non-participating professional provider</i> <p>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</p> <p>Note: See Section 5(d) Emergency Benefits for information on emergency services</p>	<p><i>All charges</i></p>

Benefit Description	You pay
<p>Autism Spectrum Disorders</p> <p>Inpatient and Outpatient Coverage for the Treatment of Autism Spectrum Disorder</p> <p>Coverage is provided for medically necessary and appropriate services associated with the screening, diagnosis and treatment of Autism Spectrum Disorder. Services must be provided by an in-network provider through Beacon Health Options. There are no age, visit or annual benefit limits. Treatment includes the following care and assistive communication devices prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> • Behavioral Health Treatment; • Psychiatric Care; • Psychological Care; • Medical care provided by a licensed health provider; • Therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative; • Assistive Communication Devices; • Applied Behavioral Analysis <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p>Standard Option</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved.</i> • <i>Services received from out-of-network providers</i> 	

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- We will send each new enrollee a description of the prescription drug program and a mail order form/patient profile and a preaddressed reply envelope. You may use your Plan identification card to access the prescription drug benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.

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

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

- **A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand.** If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- You will be able to choose from pharmacies in the Express Advantage Network (EAN), provided by Express Scripts. This is a smaller network that is available in addition to the larger ESI network of pharmacies you can choose from that are included in your GHI FEHB plan. By choosing an EAN pharmacy, you could see smaller copays.

Why use a generic drug?

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

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

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from either a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs for which a prescription is required by Federal law of the United States • FDA approved prescription drugs and devices for birth control • Fertility drugs (oral and injectable) • Insulin • Drugs to treat sexual dysfunction (with Prior authorization) • Disposable needles and syringes needed for the administration of covered medication • Intravenous fluids and medications for home use through our Participating Provider network for home infusion therapy • Nutritional supplements for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria 	<p>Standard Option</p> <p>Network Retail:</p> <p>\$15 generic</p> <p>\$50 brand name listed on the preferred prescription drug formulary</p> <p>\$100 brand name drug not listed on the preferred prescription drug formulary.</p> <p>25% coinsurance up to a maximum of \$200 per prescription for specialty drugs</p> <p>Network Mail Order: 90 day supply</p> <p>\$40 generic</p> <p>\$125 brand name listed on the preferred prescription drug formulary</p> <p>\$170 brand name drug not listed on the preferred prescription drug formulary</p> <p>Express Advantage Network (EAN)</p> <p>\$10 generic</p> <p>\$45 brand name listed on the preferred prescription drug formulary</p> <p>\$95 brand name drug not listed on the preferred prescription drug formulary</p>
<ul style="list-style-type: none"> • Physician prescribed over-the-counter and prescription smoking cessation medication approved by the FDA to treat tobacco dependence • Insulin • Diabetic supplies limited to <ul style="list-style-type: none"> - Disposable needles and syringes for the administration of covered medications • Vitamin D supplements for adults 65 years of age and older • Women's contraceptive medications and devices, including the "morning after pill" as an over-the-counter (OTC) emergency contraceptive drug. 	<p>Nothing</p>
<p>Preventive Care medications to promote better health as recommended by ACA.</p> <p>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.</p> <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age (400 & 800 mcg) • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older 	<p>Nothing</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
<p>Covered medications and supplies (cont.)</p> <ul style="list-style-type: none"> Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 <p>Note: Over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation/E-cigarettes benefit. (See page 54).</p>	<p>Standard Option</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Nonprescription medications</i> <i>Drugs obtained at a non-participating pharmacy, except for emergencies.</i> <i>Vitamins, nutrients and food supplements not listed as a covered benefit, even if a physician prescribes or administers them</i> <i>Medical supplies</i> <i>Drugs and supplies for cosmetic purposes</i> <i>Drugs to enhance athletic performance</i> <i>Network Mail Order for Specialty Drugs</i> 	<p><i>All charges</i></p>

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay
Accidental injury benefit	Standard Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury caused by external means and services must be completed within one year.	Any difference between our fee schedule and the actual charges.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Therapeutic service</i> • <i>Other dental services not shown as covered</i> • <i>Charges which exceed the Plan's fee schedule</i> 	<i>All charges</i>
Routine Dental Services	Standard Option
Examinations (maximum 2 per calendar year)	Nothing for a participating provider All charges for non-participating providers.
Prophylaxes (under age 12 - maximum 2 per calendar year)	Nothing for a participating provider All charges for non-participating providers
Prophylaxes (over age 12 - maximum 2 per calendar year)	Nothing for a participating provider All charges for non-participating providers
Emergency visits for relief of pain (1 per calendar year)	Nothing for a participating provider All charges for non-participating provider
X-rays (Full-mouth series, 1 every 3 years)	Nothing for a participating provider All charges for non-participating providers

Routine Dental Services - continued on next page

Benefit Description	You Pay
Routine Dental Services (cont.)	Standard Option
Bitewings (4 per calendar year)	Nothing for a participating provider All charges for non-participating providers
Space maintainers	Nothing for a participating provider All charges for non-participating providers
Fluoride Treatments – dependent children to age 26	Nothing for a participating provider All charges for non-par provider

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, than you may dispute our regular contract benefits decision under the OPM disputed claim process (see section 8).
Large Case Management	<p>The Plan provides a large case management program that seeks to provide alternatives for improving the quality and cost effectiveness of care. The large case management program focuses on catastrophic illnesses — for example, major head injury, high-risk infancy, stroke and severe amputations. The large case management process begins when we are notified that you or covered family member has experienced a specific illness or injury with potential long-term effects or changes in lifestyle. Case Managers evaluate individual needs, and the full range of treatment and financial exposures, from the onset of a condition or illness to recovery or stabilization. They review the efforts of the health care team and family with the goal of helping the patient return to pre-illness/injury functioning or of lessening the burden of a chronic or terminal condition. Case Managers provide the family with support and advice ranging from referral to family counseling. If it is determined that involvement of a Case Manager would be both care- and cost-effective, we will obtain the necessary authorization from the patient to proceed. Throughout the process, we will maintain strict confidentiality.</p>
Customer Service AnswerLine	<p>For information and assistance 24 hours a day, 7 days a week, access our automated telephone AnswerLine at 212/501-4GHI (4444).</p>
Services for deaf and hearing impaired	<p>If you have a question concerning Plan benefits or how to arrange for care, contact (212) 721-4962 (Hearing impaired — TDD) or you may write to us at Post Office Box 1701, New York, NY 10023-9476 or contact our office nearest you. You may also contact the Plan at its website at http://www.emblemhealth.com.</p>
High risk pregnancies	<p>The Plan provides an intensive case management program to identify and manage high risk pregnancies as described in large case management above.</p>
Centers of Excellence	<p>We have a special network of hospitals that perform a broad range of cardiac care and organ transplants. These centers are recognized leaders in their respective specialties and their services are available to you at no out-of-pocket expense. Call GHI Managed Care at least 10 days before the hospital admission to pre-certify coverage and for details on how to use this program.</p>

Section 5 Benefits

See page 13 for how our benefits changed this year and page 115 for a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5 Benefits61

Section 5. High Deductible Plan Option Benefits Overview62

Section 5. Savings – HSAs and HRAs.....65

Section 5. Preventive Care70

Traditional Medical Coverage Subject to the Deductible72

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals73

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals79

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services86

Section 5(d). Emergency Services/Accidents89

Section 5(e). Mental Health and Substance Use Disorder Benefits90

Section 5(f). Prescription Drug Benefits92

Section 5(g). Dental Benefits95

Section 5(h). Wellness and Other Special Features.....96

Section 5. High Deductible Plan Option 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 about these benefits 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 (877)842-3625 or on our website at www.emblemhealth.com

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.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

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 page 69. 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), routine prenatal and well-child care, child and adult immunizations, tobacco cessation/E-cigarettes programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in Section 5. Preventive care. You do not have to meet the deductible before using these services.
- **Traditional medical care** After you have paid the Plan’s deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 90% for in-network.

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 services; other facility or ambulance services
 - Emergency services/accidents
 - Mental health and substance use disorder benefits
 - Prescription drug benefits
- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see 62 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 veterans with a 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 2020, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$66.67 per month for a Self Only enrollment or \$133.33 per month for a Self Plus One enrollment or \$133.33 per month for a Self and Family. 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 \$3,550 for an individual and \$7,100 for a family. See maximum contribution information on page 69.

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. 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 Health Equity
- 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 it, funds up to the actual HSA balance are available

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), 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 an HRA for you.

Health Reimbursement Arrangements (HRA)

If you are not eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2020, we will give you an HRA credit of \$800 per year for a Self Only enrollment and \$1,600 per year for a Self Plus One or \$1,600 per year Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don’t count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Health Equity
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- 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
- HRA credit does not earn interest
- 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. See Who is eligible to enroll at www.fsafeds.com

• Catastrophic protection for out-of-pocket expenses

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$ 6,750 per person or \$13,500 per Self Plus One enrollment or, \$13,500 per Self and family enrollment. 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.

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 for you with Health Equity, this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	Health Equity is the HRA fiduciary for this Plan.
Fees	Set-up fee is paid by the HDHP. \$2.95 per month administrative fee charged by the fiduciary and taken out of the account balance.	Set-up fee is paid by the HDHP. \$3.95 per month administrative fee charged by the fiduciary and taken out of the account balance.
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • 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 (except for veterans with a service-connected disability) and/or Indian Health Services (IHS) benefits in the last three months • Complete and return all banking paperwork 	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	<p>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.</p> <p>Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month.</p> <p>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.).</p>	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• Self Only enrollment	For 2020, a monthly premium pass through of \$66.67 will be made by the HDHP directly into your HSA each month.	For 2020, your HRA annual credit is \$800 (prorated for mid-year enrollment).

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
<ul style="list-style-type: none"> • Self Plus One enrollment 	<p>For 2020, a monthly premium pass through of \$133.33 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2020, your HRA annual credit is \$1,600 (prorated for mid-year enrollment).</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>For 2020, a monthly premium pass through of \$133.33 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2020, your HRA annual credit is \$1,600 (prorated for mid-year enrollment).</p>
<p>Contributions/credits</p>	<p>The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of \$3,550 for an individual and \$7,100 for a family.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 (does not affect your annual maximum contribution).</p>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.</p>
<ul style="list-style-type: none"> • Self Only enrollment 	<p>You may make an annual maximum contribution of \$2,750.</p>	<p>You cannot contribute to the HRA.</p>

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
<ul style="list-style-type: none"> • Self Plus One enrollment 	<p>You may make an annual maximum contribution of \$5,500.</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>You may make an annual maximum contribution of \$5,500.</p>	<p>You cannot contribute to the HRA.</p>
<p>Access funds</p>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit card • Withdrawal form • Checks 	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.</p>
<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical 	<p>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.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p>
	<p>See IRS Publication 502 for a list of eligible medical expenses.</p>	<p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See Availability of funds below for information on when funds are available in the HRA.</p> <p>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.</p>
<ul style="list-style-type: none"> • Non-medical 	<p>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.</p> <p>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.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.</p>
<ul style="list-style-type: none"> • Availability of funds 		<p>The entire amount of your HRA will be available to you upon your enrollment in the HDHP.</p>

	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> - Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). - The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. - The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you. 	
<p>• Account owner</p>	FEHB enrollee	HDHP
<p>• Portable</p>	<p>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.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>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.</p> <p>Unused funds are forfeited.</p>
<p>• Annual rollover</p>	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 amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax- deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. 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 data 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.

- **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.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

- **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 1-800-829-3676, 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 from your HSA** You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least \$25.

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 63 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.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- The Plan pays 100% for the preventive care services listed in this Section as long as you use a network provider. For all other covered expenses, please see page 70 –Traditional medical coverage.
- 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.

Benefits Description	You pay
Preventive care, adult	
<p>Professional services, such as:</p> <ul style="list-style-type: none"> • Routine physicals • Routine screenings • Routine immunizations endorsed by the Centers for Disease control and Prevention (CDC) • Routine prenatal care • Tobacco cessation/E-cigarettes programs • Obesity weight loss programs • Disease management programs • Wellness programs <p>Routine physical every year which includes: Screenings, such as:</p> <ul style="list-style-type: none"> - Total blood Cholesterol - Depression - Diabetes - High blood pressure - HIV - Colorectal cancer screening <p>Individual counseling on prevention and reducing health risks</p> <p>Well woman care based on current recommendations such:</p> <ul style="list-style-type: none"> • Cervical cancer screening (Pap smear) • Human papillomavirus (HPV) testing • Chlamydia/gonorrhea screening • Gonorrhea prophylactic medication to protect newborns • Osteoporosis screening • Breast cancer screening • 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 • Perinatal depression: counseling and interventions 	Nothing
<ul style="list-style-type: none"> • Routine mammogram — covered for women. 	Nothing
<ul style="list-style-type: none"> • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges</i>

Benefits Description	You pay
<p>Preventive care, children</p>	
<ul style="list-style-type: none"> Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics <p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm HHS: https://www.healthcare.gov/preventive-care-benefits/ , ACIP recommendations on immunizations, please refer to the National Immunization Program Web site at: www.cdc.gov/vaccines/schedules/index.html</p> <p>Women’s preventive services www.healthcare.gov/preventive-care-women/</p> <p>Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel. Immunizations, boosters, and medications for travel or work-related exposure. 	<p><i>All charges</i></p>

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 68) and is not subject to the calendar year deductible.
- The deductible is \$1,600 per person \$3,200 per Self Plus One enrollment, or \$3,200 per Self and Family enrollment). The family deductible can be satisfied by one or more family members. 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 \$6,750 per person, \$13,500 per Self Plus One enrollment or \$13,500 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. 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 benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage.

Benefits 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 \$1,600 per person, \$3,200 per Self Plus One enrollment or \$3,200 per Self and Family enrollment.
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.	In-network: 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. If you have an HRA, we will withdraw the amount from your HRA if funds are available.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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.
- The deductible is \$1,600 for Self Only enrollment, \$3,200 per Self Plus One enrollment, or \$3,200 for a Self and Family enrollment) each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all 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 for information about how we pay if you have other coverage or if you are age 65 or over.

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	HDHP
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • At home 	10% of the Plan Allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • Routine physical checkups and related tests. • Retail Health Services 	<i>All charges</i>
TeleHealth services	You Pay HDHP
If your provider offers covered services using telehealth: <ul style="list-style-type: none"> • Covered services will include the use of electronic information and communication technologies by a provider to deliver covered services to you while your location is different than your providers location. • Provider consultations are for non-emergency medical conditions only. Subject to the Prescription Drug section, if necessary the telehealth physician may write a prescription and send it to an in-network participating retail pharmacy. Prescriptions are subject to cost sharing where applicable. Telehealth services are administered by Teladoc 	10% of the Plan Allowance

TeleHealth services - continued on next page

	You Pay
TeleHealth services (cont.)	HDHP
Note: Covered services are subject to the same utilization review and quality assurance requirements and other terms and conditions of this plan.	10% of the Plan Allowance
<i>Not covered: Telemedicine</i>	<i>All charges</i>
Lab, X-ray and other diagnostic tests	HDHP
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	10% of the Plan Allowance
Maternity care	HDHP
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal/Postnatal care • Screening for gestational diabetes for pregnant women after 24 weeks 	Prenatal/Postnatal Care: Covered in full
Delivery	10% of the Plan Allowance
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: <ul style="list-style-type: none"> • You do not need to precertify your vaginal delivery; see page xx 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 if we cover the infant under a Self Plus One or a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). <p>Note: When a newborn requires definitive treatment during or after the mother’s confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p>	

	You Pay
Family planning	HDHP
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal Ligation <p>Note: We cover oral contraceptives under the prescription drug benefit.</p> <p>Note: We cover contraceptive drugs in Section 5(f).</p>	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic testing and counseling 	<i>All charges</i>
Allergy care	HDHP
<ul style="list-style-type: none"> • Testing and treatment, including materials (such as allergy serum) • Allergy injections 	10% of the Plan Allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • Provocative food testing • Sublingual allergy desensitization 	<i>All charges</i>
Treatment therapies	HDHP
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 81.</p> <ul style="list-style-type: none"> • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under You need prior Plan approval for certain services on page 19</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapies • Cardiac rehabilitation following qualifying event/condition is provided for up to 32 sessions. 	10% of the Plan Allowance

	You Pay
Physical and occupational therapies	HDHP
<ul style="list-style-type: none"> • 60 visits per calendar year for the services of each of the following: <ul style="list-style-type: none"> - Qualified physical therapists - Occupational therapists <p>Note: We only cover therapy and when a physician:</p> <ul style="list-style-type: none"> • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. 	10% of the Plan Allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges</i>
Speech therapy	HDHP
<ul style="list-style-type: none"> • 60 visits per calendar year 	10% of the Plan Allowance
Hearing services (testing, treatment, and supplies)	HDHP
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist <p>Note: For routine hearing screening performed during a child’s preventive care visit, see Section 5(a) Preventive care, children.</p>	10% of the Plan Allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Hearing services that are not shown as covered 	<i>All charges</i>
Foot care	HDHP
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	10% of the Plan Allowance
<p>Not covered:</p> <ul style="list-style-type: none"> • 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) 	<i>All charges</i>
Orthopedic and prosthetic devices	HDHP
<ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) Services provided by a hospital or other facility, and ambulance services.</p>	10% of the Plan Allowance

Orthopedic and prosthetic devices - continued on next page

	You Pay
Orthopedic and prosthetic devices (cont.)	HDHP
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements are unlimited based on medical necessity 	<i>All charges</i>
Durable medical equipment (DME)	HDHP
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices <p>Note: Call us at 1 (800) 223-9870 as soon as your physician prescribes this equipment. We arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	10% of the Plan Allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Air purification Devices • Alarm and Alert Services 	<i>All Charges</i>
Home health services	HDHP
<p>200 days per calendar year</p> <ul style="list-style-type: none"> • a registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • the attending physician orders the care; • the physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • the physician indicates the length of time the services are needed. 	10% of the Plan Allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative 	<i>All charges</i>

	You Pay
Chiropractic	HDHP
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjustment procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	10% of the Plan Allowance
<p>Not covered:</p> <ul style="list-style-type: none"> • chiropractic services not shown as covered 	<i>All charges</i>
Alternative treatments – No benefit	HDHP
	<i>All Charges</i>
Educational classes and programs	HDHP
<p>Coverage is provided for:</p> <ul style="list-style-type: none"> • Tobacco Cessation/E-cigarettes programs, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. <p>Tobacco Cessation Program</p> <p>The Program is provided in partnership with the American Cancer Society’s Quit For Life (ACSQFL) program implemented by Free & Clear, a vendor with expertise in smoking cessation. Participation is initiated by a phone call to the call center. Under the program, you have access to the following:</p> <ul style="list-style-type: none"> • Unlimited telephonic access to professional counselors; • Educational information tailored to the member’s stage of readiness to quit; • Access to ACSQFL Web site; and • Full coverage for smoking cessation pharmaceutical products (Nicotine Patch, Gum, Lozenge, Bupropion (generic Zyban®)and Chantix™). • Diabetes self management • Childhood obesity education 	<p>Nothing for counseling for up to two quit attempts per year.</p> <p>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.</p>

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.
- The deductible is \$1,600 for Self Only enrollment, \$3,200 per Self Plus One enrollment, and \$3,200 Self and Family enrollment each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional medical coverage begins.
- 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, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay after the calendar year deductible is met
Surgical Procedures	HDHP
<p>A comprehensive range of services, such as:</p> <p>Operative procedures</p> <ul style="list-style-type: none"> • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsyprocedures • Removal of tumors and cysts • Correction of congenital anomalies(see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>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.</p>	10% of the Plan Allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary</i> • <i>Routine treatment of conditions of the foot (see Foot care)</i> • <i>Surgery to correct a functional defect</i> 	<i>All Charges</i>

Benefit Description	You pay
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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 toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage) 	<p>10% of the Plan Allowance</p>
<p>Note: We pay for internal breast prostheses as hospital benefits.</p> <p>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.</p>	
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures 	<p>10% of the Plan Allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis] • Cornea • Heart • Heart/lung • Intestinal transplants 	<p>10% of the Plan Allowance</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	HDHP
<ul style="list-style-type: none"> -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 	10% of the Plan Allowance
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for AL <ul style="list-style-type: none"> -Amyloidosis -Multiple myeloma (de novo and treated) -Recurrent germ cell tumors (including testicular cancer) 	10% of the Plan Allowance
<p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as indicated below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> -Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia -Acute myeloid leukemia -Advanced Hodgkin’s lymphoma with recurrence (relapsed) -Advanced Myeloproliferative Disorders (MPDs) -Advanced neuroblastoma -Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) -Amyloidosis -Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) -Hemoglobinopathy -Infantile malignant osteopetrosis -Kostmann’s syndrome -Leukocyte adhesion deficiencies -Marrow failure and related disorders (i.e., Fanconi’s, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) 	10% of the Plan Allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	HDHP
<ul style="list-style-type: none"> -Myelodysplasia/Myelodysplastic syndromes -Paroxysmal Nocturnal Hemoglobinuria -Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) -Severe combined immunodeficiency -Severe or very severe aplastic anemia -Sickle cell anemia -X-linked lymphoproliferative syndrome 	10% of the Plan Allowance
<p>Autologous transplants for:</p> <ul style="list-style-type: none"> -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 -Ependyoblastoma -Epithelial ovarian cancer -Ewing’s sarcoma -Medulloblastoma -Multiple myeloma -Pineoblastoma -Neuroblastoma -Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors <p>Pineoblastoma</p>	10% of the Plan Allowance
<p>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.</p> <p>Refer to Other services in Section 3 for prior authorization procedures:</p> <p>Allogeneic transplants for:</p> <ul style="list-style-type: none"> -Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia -Acute myeloid leukemia -Advanced Hodgkin’s lymphoma with recurrence (relapsed) -Advanced Myeloproliferative Disorders (MPDs) 	10% of the Plan Allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	HDHP
<ul style="list-style-type: none"> -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 	10% of the Plan Allowance
<ul style="list-style-type: none"> -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 	10% of the Plan Allowance
<p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient’s condition) if it is not provided by the clinical trial. Section 9 has additional 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.</p> <p>Allogeneic transplants for:</p> <ul style="list-style-type: none"> -Advanced Hodgkin’s lymphoma -Advanced non-Hodgkin’s lymphoma -Beta Thalassemia Major -Chronic inflammatory demyelination polyneuropathy (CIDP) -Early stage (indolent or non-advanced) small cell lymphocytic lymphoma -Multiple myeloma -Multiple sclerosis -Sickle Cell anemia 	10% of the Plan Allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	HDHP
<p>Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for:</p> <ul style="list-style-type: none"> -Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia -Advanced Hodgkin’s lymphoma -Advanced non-Hodgkin’s lymphoma -Breast cancer -Chronic lymphocytic leukemia -Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) -Chronic myelogenous leukemia -Colon cancer -Early stage (indolent or non-advanced) small cell lymphocytic lymphoma -Multiple myeloma -Myelodysplasia/Myelodysplastic Syndromes -Multiple sclerosis -Myeloproliferative disorders (MDDs) -Non-small cell lung cancer -Ovarian cancer -Prostate cancer -Renal cell carcinoma -Sarcomas -Sickle cell anemia 	<p>10% of the Plan Allowance</p>
<p>Autologous Transplants for:</p> <ul style="list-style-type: none"> -Advanced childhood kidney cancers -Advanced Ewing sarcoma -Advanced Hodgkin’s lymphom -Advanced non-Hodgkin’s lymphoma -Aggressive non-Hodgkin lymphomas -Breast Cancer -Childhood rhabdomyosarcoma -Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) -Chronic myelogenous leukemia 	<p>10% of the Plan Allowance</p>

Benefit Description	You pay
Organ/tissue transplants (cont.)	HDHP
<ul style="list-style-type: none"> -Early stage (indolent or non-advanced) small cell lymphocytic lymphoma -Epithelial Ovarian Cancer -Mantle Cell (Non-Hodgkin lymphoma) -Multiple sclerosis -Small cell lung cancer -Systemic lupus erythematosus -Systemic sclerosis 	10% of the Plan Allowance
National Transplant Program (NTP)	
<p><i>Note:</i></p> <ul style="list-style-type: none"> • We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. Donor coverage is provided up to a maximum of \$10,000 per transplant. • Travel expenses up to a maximum of \$150 per person per day and \$10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center. This includes food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place. <p><i>Note: The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery.</i></p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	All charges
Anesthesia	HDHP
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	10% of the Plan Allowance

Benefit Description	You pay
Inpatient hospital (cont.)	HDHP
<ul style="list-style-type: none"> • Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting • Custodial care; see definition • Non-covered facilities, such as nursing homes, schools, • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	All charges
Outpatient hospital or ambulatory surgical center	HDHP
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p>	10% of the Plan Allowance
Extended care benefits/Skilled nursing care facility benefits	HDHP
<p>Skilled nursing facility (SNF): We cover semiprivate room, board, services and supplies in a SNF for up to 30 days per confinement when:</p> <ul style="list-style-type: none"> • you are admitted directly from a precertified hospital stay of at least 3 consecutive days; • you are admitted for the same condition as the hospital stay; • your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and • SNF care is medically appropriate. 	10% of the Plan Allowance
<i>Not covered: Custodial care</i>	<i>All charges</i>
Hospice care	HDHP
<p>Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include:</p> <ul style="list-style-type: none"> • inpatient/outpatient care; and • family counseling under the direction of a doctor. <p>Note: Your provider must certify that you are in the terminal stages of illness, with a life expectancy of approximately six months or less. The hospice must have an agreement with us or recognized by Medicare as a hospice.</p>	10% of the Plan Allowance
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>

Benefit Description	You pay
Ambulance	HDHP
Local professional ambulance service when medically appropriate	10% of the Plan allowance, after deductible Member pays the difference between the provider's billed charge and Plan allowance Note: Plan allowance based on the 90 percentile of FAIR Health

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 \$1,600 for Self Only enrollment, \$3,200 per Self Plus One enrollment and \$3,200 Self and Family enrollment each calendar year. The Self and Family and Self Plus One can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings. We do not cover dental care for accidental injury.

Benefit Description	After calendar year deductible is met you pay
Accidental injury	HDHP
<p>If you receive care for your accidental injury within 48 hours, we cover:</p> <ul style="list-style-type: none"> • Non-surgical physician services and supplies • Related outpatient hospital services <p>Note: We pay hospital benefits if you are admitted.</p>	10% of the Plan Allowance
<p>Outpatient medical or surgical services and supplies Emergency within our service area</p> <ul style="list-style-type: none"> • Emergency medical/surgical care at a doctor's office • Emergency medical/surgical care at an urgent care center • Emergency care as an outpatient at hospital • Emergency medical/surgical care at a doctors' office • Emergency medical/surgical care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' 	10% of the Plan Allowance
<p>Emergency outside our service area</p>	10% of the Plan Allowance
<p><i>Not covered: Elective care or non-emergency care</i></p>	<i>All Charges</i>
Ambulance	HDHP
<p>Ambulance</p>	<p>10% of the Plan allowance, after deductible</p> <p>Member pays the difference between the provider's billed charge and Plan allowance</p> <p>Note: Plan allowance based on the 90 percentile of FAIR Health</p>
<p><i>Not covered:</i></p> <p><i>Air ambulance</i></p> <p><i>Ambulette services</i></p>	<i>All charges</i>

Section 5(e). Mental Health and Substance Use Disorder 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 calendar year deductible is: \$1,600 per person \$3,200 per Self Plus One enrollment, or \$3,200 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- 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.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Professional services	HDHP
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider’s office or other professional setting • Electroconvulsive therapy 	10% of the Plan Allowance
Diagnostics	HDHP
<ul style="list-style-type: none"> • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment 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 	10% of the Plan Allowance

Benefit Description	You pay
Inpatient hospital or other covered facility	HDHP
<p>Inpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services 	10% of the Plan Allowance
Outpatient hospital or other covered facility	HDHP
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment 	10% of the Plan Allowance
Autism Spectrum Disorders	HDHP
<p>Inpatient and Outpatient Coverage for the Treatment of Autism Spectrum Disorder</p> <p>Coverage is provided for medically necessary and appropriate services associated with the screening, diagnosis and treatment of Autism Spectrum Disorder. Services must be provided by an in-network provider through Beacon Health Options. There are no age, visit or annual benefit limits.</p> <p>Treatment includes the following care and assistive communication devices prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> • Behavioral Health Treatment; • Psychiatric Care; • Psychological Care; • Medical care provided by a licensed health provider; • Therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative; • Assistive Communication Devices; • Applied Behavioral Analysis <p>Note: OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</p>	10% of the Plan Allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved.</i> • <i>Services received from out-of-network providers</i> 	<i>All charges</i>

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 prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible is: \$1,600 per person \$3,200 per Self Plus One enrollment, or \$3,200 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply. After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy by presenting your Plan Identification Card. You must obtain certain generic maintenance drugs or name brand formulary drugs by mail order.
- **We use a formulary.** Our formulary is a list of effective medications and other items that we have approved for our members' use. A special committee of medical and pharmacy professionals reviews the formulary annually. We add or delete items on the list based on their findings. We have found that the drugs on our formulary are safe, effective, and therapeutic in the treatment of disease or illness. Please call GHI Pharmacy Services 877-444-3614 for a copy of our formulary.
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription. Under the HDHP Option you pay \$10 for generic formulary drugs, 50% coinsurance for name brand formulary drugs, up to \$200, 50% coinsurance for non-formulary drugs up to \$300, 50% coinsurance up to a maximum of \$350 per script for speciality formulary drugs or 50% coinsurance up to a maximum of \$700 per script for speciality non-formulary drugs
- **Maintenance Medication by mail-order.** Your prescription coverage includes a mail order program for all maintenance medications. You must obtain a new prescription from your provider for a 90 day supply, to be sent to GHI Pharmacy Services. Please call GHI Pharmacy Services at 877-444-3614. Specialty drugs and Sexual dysfunction drugs are not available by mail-order and require prior approval.
- **Step Therapy Prior Authorization Program.** For prior authorization, your physician or you should call GHI Pharmacy Services at 877-444-3614. Step Therapy programs apply edits to drugs in specific therapeutic classes at the point of service. Coverage for second-line therapies is determined at the member level based on the presence or absence of first-line drugs in the member’s claims history. Step Therapy coverage criteria are automated whenever possible so that rejects are further reduced. Only claims for members whose histories do not show use of first-line drugs are rejected for payment at the point of service and online messaging is sent to the pharmacy indicating that prior authorization is required for coverage of the second-line therapy.

- **Drug Quantity Management Program.** The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copayment is consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Clinicians maintain a list of quantity limit drugs, which is based upon FDA-approved dosing guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per copayment and per days’ supply.
- **Diabetic Supplies Close Category Program.** The Diabetic Supplies Category Program refers only to prescriptions for test strips and meters. You will be granted authorization for test strips and meters when you present a prescription for a covered diabetic supply product (Roche and J&J products are covered).
- **A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand.** If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. See 2020 GHI Health Plan HDHP Option Section 5(f)
- **You will be able to choose from pharmacies in the Express Advantage Network (EAN), provided by Express Scripts.** This is a smaller network that is available in addition to the larger ESI network of pharmacies you can choose from that are included in your GHI FEHB plan. By choosing an EAN pharmacy, you could see smaller copays.

Why use a generic drug?

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

Benefit Description	You pay
<p>Preventive Medications</p> <p>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.</p> <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age (400 & 800 mcg) • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 <p>Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.</p>	<p>Nothing</p>

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope.</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from either a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs for which a prescription is required by Federal law of the United States • FDA approved prescription drugs and devices for birth control • Fertility drugs (oral and injectable) • Insulin • Drugs to treat sexual dysfunction (with Prior authorization) • Disposable needles and syringes needed for the administration of covered medication • Intravenous fluids and medications for home use through our Participating Provider network for home infusion therapy • Nutritional supplements for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria 	<p>HDHP</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Retail: Tier 1 - \$10 Copay Tier 2 – 50% coinsurance, up to \$200 Tier 3 - 50% coinsurance, up to \$300</p> <p>Mail: Tier 1 - \$20 Copay Tier 2 - 50% coinsurance up to \$400 Tier 3 - 50% coinsurance, up to \$600</p> <p>Specialty Generic: - 50% coinsurance up to \$350 Specialty Formulary - 50% coinsurance up to \$350 Specialty Non Formulary - 50% coinsurance up to \$700</p>
<p>Women's contraceptive drugs and devices</p> <p>A range of voluntary family planning services for women, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal ligation <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>10% of the Plan Allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of- area emergencies</i> • <i>Nonprescription medications medicines</i> <p><i>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation/E- cigarettes benefit. (See page 78.)</i></p>	<p><i>All Charges</i></p>

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- The deductible is \$1,600 for Self Only enrollment, \$3,200 per Self Plus One enrollment and \$3,200 Self and Family enrollment each calendar year. The Self and Family and Self Plus One deductibles can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- 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, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: 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. We do not cover the dental procedure. See Section 5 (c) for inpatient hospital benefits.

Benefit Description	You Pay
Accidental injury benefit	HDHP
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	10% of the Plan Allowance after the Plan Year Deductible is met
Dental - No Benefit	HDHP
	<i>All charges</i>

Section 5(h). Wellness and Other Special Features

Special feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, than you may dispute our regular contract benefits decision under the OPM disputed claim process (see section 8).
Large Case Management	<p>The Plan provides a large case management program that seeks to provide alternatives for improving the quality and cost effectiveness of care. The large case management program focuses on catastrophic illnesses — for example, major head injury, high-risk infancy, stroke and severe amputations. The large case management process begins when we are notified that you or covered family member has experienced a specific illness or injury with potential long-term effects or changes in lifestyle. Case Managers evaluate individual needs, and the full range of treatment and financial exposures, from the onset of a condition or illness to recovery or stabilization. They review the efforts of the health care team and family with the goal of helping the patient return to pre-illness/injury functioning or of lessening the burden of a chronic or terminal condition. Case Managers provide the family with support and advice ranging from referral to family counseling. If it is determined that involvement of a Case Manager would be both care- and cost-effective, we will obtain the necessary authorization from the patient to proceed. Throughout the process, we will maintain strict confidentiality.</p>
High risk pregnancies	<p>The plan provides an intensive case management program to identify and manage high risk pregnancies as described in Large Case Management above</p>
Customer Service AnswerLine	<p>For information and assistance 24 hours a day, 7 days a week, access our automated telephone AnswerLine at 212/501-4GHI (4444).</p>
Services for deaf and hearing impaired	<p>If you have a question concerning Plan benefits or how to arrange for care, contact (212) 721-4962 (Hearing impaired — TDD) or you may write to us at Post Office Box 1701, New York, NY 10023-9476 or contact our office nearest you. You may also contact the Plan at its website at http://www.emblemhealth.com.</p>
Centers of Excellence	<p>We have a special network of hospitals that perform a broad range of cardiac care and organ transplants. These centers are recognized leaders in their respective specialties and their services are available to you at no out-of-pocket expense. Call GHI Managed Care at least 10 days before the hospital admission to pre-certify coverage and for details on how to use this program.</p>

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, all appeals must follow their guidelines. For additional information contact the Plan at (877) 842-3625 or visit their website at www.emblemhealth.com/federal

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

Weight Loss Services- Save on programs including Jenny Craig.

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

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

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

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

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

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

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

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

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

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

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

We do not cover the following:

- 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).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a Claim for Covered Services

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

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

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 877-442-8755, or at our website at www.emblemhealth.com

In most cases, providers and facilities file claims for you. Your provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

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

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment; private duty nursing; and physical therapy, occupational therapy, or speech therapy, you must provide a written statement from the provider specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing provider name, date, and charge.

We will provide translation and currency conversion services for claims for overseas (foreign) services.

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.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

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

Overseas claims

For covered services you receive by providers and hospitals outside the United States and Puerto Rico, send a completed HCFA 1500 Claim Form and the itemized bills to: GHI PO Box 3000 New York, NY 10116-3000. Obtain Claim Forms from: www.emblemhealth.com. If you have questions about the processing of overseas claims, contact 877-442-8755

When we need more information

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

Authorized Representative

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

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable 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 and its corresponding meaning, and the treatment code and its corresponding meaning).

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 or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing EmblemHealth Customer Service, 55 Water Street, New York, NY 10041 calling (877)842-3625.

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

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

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

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: GHI Customer Service Department, 55 Water St. , New York, NY 10041; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. <p>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision or reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.</p>
2	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim or b) Write to you and maintain our denial or

	<p>c) Ask you or your provider for more information.</p> <p>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.</p> <p>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.</p>
<p>3</p>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, D.C., 20415-3620.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; • Your daytime phone number and the best time to call; and • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p>4</p>	<p>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.</p> <p>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.</p> <p>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.</p>

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

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

Some FEHB Plans already cover dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 1-877-888-3337 (TTY 1-877-889-5680), you will be asked to provide information on your FEHB Plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

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

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

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

When you have Medicare

- **What is Medicare?**

Medicare is a Health Insurance Program for:

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

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 18 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 (800-6334227), (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 plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-722-1213 (TTY 877-486-2048).

- **- Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213 (TTY 800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you did not 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 (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 your claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (877) 842-3625, or access our website at www.emblemhealth.com/federal.

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

- Medical services and supplies provided by physicians and other health care professionals.

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

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

You can find more information about how our plan coordinates benefits with Medicare at www.emblemhealth.com

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B	Member Cost without Medicare	Member Cost with Medicare Part B
Benefit Description	Standard Option	Standard Option	High Deductible Health Plan	High Deductible Health Plan
Deductible	\$0	\$0	\$1600 Self Only/\$3200 Self Plus One or Self and Family	\$1600 Self Only/\$3200 Self Plus One or Self and Family
Out-of- Pocket Maximum	\$6,850 Self Only/ \$13,700 Self Plus One or Self and Family	\$6,850 Self Only/ \$13,700 Self Plus One or Self and Family	\$6,750 Self Only/ \$13,500 Self Only/ Self Plus One or Self and Family	\$6,750 Self Only/ \$13,500 Self Plus One or Self and Family

Primary Care Physician	\$50	\$0	10% allowance, after CY deductible	10% allowance, after CY deductible
Specialist	\$50	\$0	10% allowance, after CY deductible	10% allowance, after CY deductible
Inpatient Hospital	\$500 copay per day to a maximum of \$1,000	\$0	10% allowance, after CY deductible	10% allowance, after CY deductible
Outpatient Hospital	\$150	\$0	10% allowance, after CY deductible	10% allowance, after CY deductible
Incentives Offered	N/A	N/A	N/A	N/A

- **- 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 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	<p>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.</p> <p>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.</p> <ul style="list-style-type: none">• Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient’s cancer, whether the patient is in a clinical trial or is receiving standard therapy• Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care• Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services.
Covered services	Care we provide benefits for, as described in this brochure.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.
Exclusive Provider Option (EPO)	Coverage that utilizes a network(s) of providers and uses provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long-term health care costs savings.
Experimental or investigational service	<p>Experimental treatment is a treatment that has not been tested in human beings; or that is being tested but has not yet been approved for general use; or that is subject to review or approval by an Institutional Review Board.</p> <p>Investigational treatment includes, but is not limited to, services or supplies which are under study or in a clinical trial to evaluate their toxicity, safety and efficiency for a particular diagnosis or set of indications.</p> <p>Clinical trials include, but are not limited to, controlled experiments having a clinical event as an outcome measurement involving persons having a specific disease or health condition; or involving the administration of different study treatments in a parallel treatment design done to evaluate the efficacy and safety of a test measurement. Clinical trials include Phase I, Phase II, and Phase III studies. Clinical trials also include randomized trials or studies.</p>
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	Medically necessary services are services; supplies or equipment provided by a hospital or covered provider of the health care services that the carrier determines:

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

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

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

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

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

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

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

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

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

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

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

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

- Waiting could seriously jeopardize your life or health;

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at **(877)842-3625**. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Group Health Incorporated

You

You refers to the enrollee and each covered family member.

Index

<p>Accidental injury.....40-46, 58-59</p> <p>Acupuncture.....</p> <p>Allergy Care.....28-39</p> <p>Allogeneic Transplant.....40-46</p> <p>Alternative Treatments.....23-25, 28-39</p> <p>Ambulance.....28-39, 47-49, 51</p> <p>Anesthesia.....5-7, 40-46, 48</p> <p>Autism Spectrum Disorder.....53</p> <p>Autologous Bone Marrow Transplant.....33</p> <p>Casts.....47-48</p> <p>Catastrophic protection out-of-pocket maximum.....24, 97</p> <p>Changes for 2019.....16</p> <p>Chemotherapy.....28-39, 48</p> <p>Chiropractic.....28-39</p> <p>Cholesterol.....29-30, 38-39</p> <p>Claims...10, 13-15, 17, 20-21, 54-56, 99-101</p> <p>Coinsurance.....13-15, 23-25, 114</p> <p>Congenital anomalies.....40-41</p> <p>Cost-sharing.....13-15, 23, 52</p> <p>Deductible.....13-15, 23, 40, 97</p> <p>Definitions.....110-112, 114</p> <p>Dental.....41-42, 48, 58-59</p> <p>Diagnostic Tests.....29, 52</p> <p>Dressings.....47-48</p> <p>Durable medical equipment.....23, 37</p> <p>Educational Classes and Programs...38-39</p> <p style="padding-left: 20px;">Tobacco Cessation Program</p> <p>Emergency.....13-15, 20, 50-51</p> <p>Experimental or investigational.....110</p> <p>Family planning.....32</p> <p>Foot care.....35-36, 40</p>	<p>Fraud.....3-4</p> <p>Hearing Services.....35</p> <p>Home health services.....37-38</p> <p>Hospital...13-15, 17-22, 27, 42-45, 47-52, 114</p> <p style="padding-left: 20px;">Inpatient...27, 47-49, 52-53, 58, 114-115</p> <p style="padding-left: 20px;">Outpatient hospital or ambulatory surgical center.....40-49</p> <p>Immunizations.....28-39</p> <p>Infertility.....28-39</p> <p>Insulin.....56-57</p> <p>Laboratory tests.....47-49</p> <p>Mammogram.....28-39</p> <p>Maternity benefits.....20-21, 31-32</p> <p>Medicaid.....104-108</p> <p>Medically necessary...18-19, 31-33, 40, 47-48, 54, 98, 110-111</p> <p>Medicare.....1, 18-19</p> <p>Mental Health and Substance Misuse Disorder Benefits.....52-53</p> <p>Nurse.....33, 37-38</p> <p>Office visits.....13-15</p> <p>Organ Tissue Transplants.....13-15</p> <p style="padding-left: 20px;">Blood or Marrow Stem Cell.....40-46</p> <p>Orthopedic and Prosthetic devices.....23, 36</p> <p>Out-of-pocket expenses.....13-15, 24</p> <p>Oxygen.....23, 37</p> <p>Precertification.....17-22, 40, 47</p> <p>Prescription drug benefits.....33, 54-57</p> <p>Preventive care, adult.....29-30</p> <p>Preventive care, children.....30-31</p> <p>Prior approval.....18-19, 40, 54, 98, 111</p>	<p>Psychologist.....52-53</p> <p>Radiation therapy.....33</p> <p>Registered Nurse.....33</p> <p>Skilled nursing facility benefits.....27, 48</p> <p>Social worker.....52</p> <p style="padding-left: 20px;">Centers of Excellence.....27, 60</p> <p style="padding-left: 20px;">Flexible benefits.....60</p> <p style="padding-left: 20px;">Large Case Management.....60</p> <p style="padding-left: 20px;">Services for deaf and hearing impaired.....60</p> <p>Speech therapy.....28-39</p> <p>Splints.....47-48</p> <p>Subrogation.....104-105, 111</p> <p>Substance misuse disorder.....19, 52-53</p> <p>Surgery.....5-7, 19, 41-42, 46</p> <p style="padding-left: 20px;">Oral and Maxillofacial.....41-42</p> <p style="padding-left: 20px;">Organ/Tissue Transplants.....19, 42-45</p> <p style="padding-left: 20px;">Reconstructive.....40-41</p> <p>Syringes.....56-57</p> <p>Telehealth.....28</p> <p>Temporary Continuation of Coverage (TCC).....11</p> <p>Tobacco Cessation/E-Cigarettes</p> <p>Treatment therapies.....28-39</p> <p style="padding-left: 20px;">Physical and occupational therapies...34</p> <p>Urgent Care Center...28-39, 50-51, 114-115</p> <p>Vision services.....35, 105</p> <p>Wellness and Other Special Features...60</p> <p>X-ray.....29, 48, 58-59</p>
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Summary of Benefits for the Standard Option of the GHI Health Plan - 2020

- **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. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at: www.emblemhealth.com/Federal. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- You must use participating providers under the Standard Option coverage. We do not cover services from non-participating providers.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$50 per visit \$10 per visit for dependent children (under age 26) All charges for non-participating providers.	24
Services provided by a hospital:		
• Inpatient	\$500 per day inpatient admission up to a maximum of \$1,000 per admission.	43
• Outpatient	\$150 copayment for outpatient hospital or ambulatory facility and \$50 copayment for diagnostic labs, x-rays, and pathology. \$10 copayment for dependent children (under age 26) for diagnostic labs, x-rays and pathology.	44
Emergency benefits:		
• In-area	\$200 per hospital emergency room visit and charges that exceed the Plan's emergency fee schedule.	46
• Out-of-area	\$200 per hospital emergency room visit for non-participating facilities plus charges that exceed our allowance.	46
Mental health and substance use disorder treatment:	Same cost-sharing as for other illnesses or conditions	48
Prescription drugs:		
• Retail pharmacy - Up to a 30-day supply per prescription unit or refill (limit of two refills per prescription at a participating pharmacy)	\$15 copay for generic drugs, \$50 copay for brand preferred drugs, \$100 copay for brand non-preferred drugs, 25% coinsurance up to \$200 maximum per script for speciality drugs.	50
• Mail order - For a 90-day supply of maintenance medication	\$40 copay for generic drugs, \$125 copay for brand preferred drugs or \$170 copay for generic or brand non-preferred drugs	50
Dental care: Routine preventive care	Nothing to participating providers	54
Vision care: Limited to one annual eye refraction	Nothing to participating providers	31

Standard Option Benefits	You pay	Page
Special features: Large Case Management , High Risk Pregnancies, Centers of Excellence for organ/tissue transplants, Heart Surgery, etc.	Copays or coinsurance as indicated	56

Summary of Benefits for the HDHP Option of the GHI Healthplan - 2020

- **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. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at: www.emblemhealth.com/Federal. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- You must use participating providers under the High Deductible Health Plan Option coverage. We do not cover services from non-participating providers.

HDHP Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	10% plan allowance after calendar year deductible All charges for non-participating providers	71
Services provided by a hospital:		
• Inpatient	10% plan allowance after calendar year deductible All charges for non-participating providers	84
• Outpatient	10% plan allowance after calendar year deductible All charges for non-participating providers	85
Emergency benefits:		
• In-area	10% plan allowance after calendar year deductible All charges for non-participating providers	87
• Out-of-area	Reimbursed at 90%ile of FAIR Health Any difference between our allowance and the billed amount for a non-participating provider.	87
Mental health and substance use disorder treatment:	Same cost-sharing as for other illnesses or conditions	88
Prescription drugs:		
• Retail pharmacy - Up to a 30-day supply per prescription unit or refill (limit of two refills per prescription at a participating pharmacy)	Tier 1 - \$10 Copay Tier 2 – 50% coinsurance, up to \$200 Tier 3 - 50% coinsurance, up to \$300 Specialty Generic: - 50% coinsurance up to \$350 Specialty Formulary - 50% coinsurance up to \$350	92

	Specialty Non Formulary - 50% coinsurance up to \$700	
<ul style="list-style-type: none"> • Mail order - For a 90-day supply of maintenance medication 	Tier 1 - \$20 Copay Tier 2 - 50% coinsurance up to \$400 Tier 3 - 50% coinsurance, up to \$600	92

2020 Rate Information for GHI Health Plan

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

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, and NPMHU.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on <https://liteblue.usps.gov/fehb>.
- **Postal Category 2** rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

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.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career employees represented by the NRLCA agreement.

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

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service 800-877-8339

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

New York/New Jersey

Standard Option Self Only	804	\$235.77	\$227.92	\$510.84	\$493.82	\$224.64	\$214.82
Standard Option Self Plus One	806	\$504.12	\$574.46	\$1,092.26	\$1,244.66	\$567.46	\$546.45
Standard Option Self and Family	805	\$546.47	\$578.49	\$1,184.02	\$1,253.39	\$570.90	\$548.14
HDHP Option Self Only	811	\$234.12	\$78.04	\$507.26	\$169.09	\$74.92	\$64.77
HDHP Option Self Plus One	813	\$501.95	\$167.32	\$1,087.57	\$362.52	\$160.62	\$138.87
HDHP Option Self and Family	812	\$511.86	\$170.62	\$1,109.03	\$369.68	\$163.80	\$141.61