

# Government Employees Hospital Association, Inc. Benefit Plan

<http://www.geha.com>



## 2006

**A fee-for-service plan (high and standard option), and a high deductible health plan with a preferred provider organization**

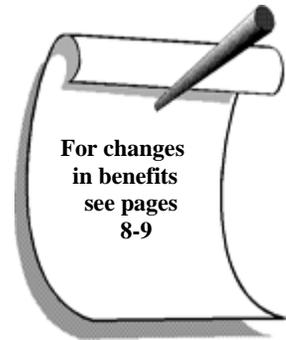
**Sponsored and administered by:**

**Government Employees Hospital Association, Inc.**

**Who may enroll in this Plan:** All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program may become members of GEHA. You must be, or must become a member of Government Employees Hospital Association, Inc.

**To become a member:** You join simply by signing a completed Standard Form 2809, Health Benefits Registration Form, evidencing your enrollment in the Plan.

**Membership dues:** There are no membership dues for the Year 2006.



**Enrollment codes for this Plan:**

- 311 High Option - Self Only**
- 312 High Option - Self and Family**
- 314 Standard Option - Self Only**
- 315 Standard Option - Self and Family**
- 341 High Deductible Health Plan (HDHP) - Self Only**
- 342 High Deductible Health Plan (HDHP) - Self and Family**



**URAC accreditation:** GEHA for Health Network  
**URAC UM accreditation:** ENCOMPASS for Health Utilization Management  
**JCAHO accreditation:** Medco for Home Care Pharmacy Dispensing Services  
See the 2006 Guide for more information about accreditation.

Authorized for distribution by the:



**United States  
Office of Personnel Management**  
Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>

RI 71-006

# Notice of the United States Office of Personnel Management's Privacy Practices

## **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the Government Accountability Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at [www.opm.gov/insure](http://www.opm.gov/insure) on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints  
United States Office of Personnel Management  
P.O. Box 707  
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

## **Important Notice from Government Employees Hospital Association, Inc. About Our Prescription Drug Coverage and Medicare**

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

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

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

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### **Please be advised**

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If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

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

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Introduction

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This brochure describes the benefits of **Government Employees Hospital Association, Inc.** under our contract (CS 1063) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by Government Employees Hospital Association, Inc. The address for the Government Employees Hospital Association, Inc. administrative offices is:

Government Employees Hospital Association, Inc.  
P.O. Box 4665  
Independence, Missouri 64051-4665

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on pages 8 and 9. Rates are shown at the end of this brochure.

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## Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- 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 (800) 821-6136 and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE  
202-418-3300**

**OR WRITE TO:  
United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street NW Room 6400  
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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## Preventing medical mistakes

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An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

**1. Ask questions if you have doubts or concerns.**

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

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

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

**3. Get the results of any test or procedure.**

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

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

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

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

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

Want more information on patient safety?

- ▶ [www.ahrq.gov/consumer/pathqpack.htm](http://www.ahrq.gov/consumer/pathqpack.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- ▶ [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- ▶ [www.talkaboutrx.org/index.jsp](http://www.talkaboutrx.org/index.jsp). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- ▶ [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- ▶ [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- ▶ [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## **Section 1 Facts about this fee-for-service plan**

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This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers. We give you a choice of enrollment in a High Option, a Standard Option, or a High Deductible Health Plan (HDHP).

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

### **General features of our High and Standard Options**

#### **We also have a Preferred Provider Organization (PPO)**

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. Government Employees Hospital Association, Inc. is solely responsible for the selection of PPO providers in your area. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our Web page, which you can reach through the FEHB Web site, [www.opm.gov/insure](http://www.opm.gov/insure). Contact Government Employees Hospital Association, Inc. to request a PPO directory.

We have entered into arrangements with Alliance PPO, Inc.; Arizona Foundation for Medical Care; FCHN; Freedom Network; HealthCare Preferred; HealthLink; MedSolutions; MultiPlan; PPO USA; Private Healthcare Systems; Providence Preferred; and SouthCare, which are Preferred Providers or networks of hospitals and/or doctors in all states. The doctors and hospitals participating in these networks have agreed to provide services to Plan members. You always have the right to choose a PPO provider or a non-PPO provider for medical treatment.

PPO networks are now available in many metropolitan areas and additional coverage areas will be added throughout the year. Enrollees residing in a PPO network area will receive a directory of the PPO providers in their service area. These providers are required to meet licensure and certification standards established by State and Federal authorities, however, inclusion in the network does not represent a guarantee of professional performance nor does it constitute medical advice. To locate a participating provider in your area, call (800) 296-0776 or visit the GEHA Web site at [www.geha.com](http://www.geha.com). When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. However, if the services are rendered at a PPO hospital, we will pay the services of radiologists, anesthesiologists and pathologists who are not preferred providers at the preferred provider rate. This non-standard benefit does not include the services of emergency room physicians. In addition, providers outside the United States will be paid at the PPO level of benefits.

### **How we pay providers**

Fee-for-service plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-service plans let you choose your own physicians, hospitals and other health care providers.

The FFS plan reimburses you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan.

We offer a preferred provider organization (PPO) arrangement. This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

### **General features of our High Deductible Health Plan (HDHP)**

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

### **Preventive care services**

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

### **Annual deductible**

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

## **Health Savings Account (HSA)**

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not 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 10% 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. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

## **Health Reimbursement Arrangement (HRA)**

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

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

## **Catastrophic protection**

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$5,000 for Self Only enrollment, or \$10,000 family coverage.

## **Health education resources and accounts management tools**

Our Web site at [www.geha.com](http://www.geha.com) offers access to the Health e-Report Newsletter and our Wellness Center for information on general health topics, health care news, cancer and other specific diseases, drugs/medication interactions, children's health and patient safety information.

You will find facts and frequently asked questions about health savings accounts and health reimbursement arrangements on our Web site at [www.geha.com](http://www.geha.com). You can access your HSA and HRA account balance in addition to complete claim payment history through our Web site.

## **Your Rights**

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

- Government Employees Hospital Association, Inc. was founded in 1937 as the Railway Mail Hospital Association. For more than 60 years now, GEHA has provided health insurance benefits to federal employees and retirees.
- GEHA is incorporated as a General Not-For-Profit Corporation pursuant to Chapter 355 of the Revised Statutes of the State of Missouri.
- GEHA's Preferred Provider Organization includes more than 4,100 hospitals and more than 600,000 physician locations throughout the United States. In circumstances where there is limited access to PPO providers, GEHA may negotiate discounts with some providers, which will reduce your overall out-of-pocket expenses.

If you want more information about us, call (800) 821-6136, or write to GEHA, P. O. Box 4665, Independence, MO 64051-4665. You may also contact us by fax at (816) 257-3233 or visit our Web site at [www.geha.com](http://www.geha.com).

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## Section 2 How we change for 2006

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

### Program-wide changes

- In Section 3, under **Covered providers**, Arizona and West Virginia are designated as medically underserved areas in 2006. Texas is no longer designated as a medically underserved area in 2006.

### Changes to this Plan

- Urgent Care Facilities are now covered for medically necessary treatment.
- Specialty Pharmacy Benefits are now available through Medco. Members who require prescription drugs included in the Specialty Pharmacy Benefit may receive them through Medco at the coinsurance rates described in the Prescription Drug Sections.
- Members in High and Standard Option who receive medications included in the Specialty Pharmacy Benefit from any other source, such as a doctor's office, home health agency or outpatient hospital, will pay a copayment of \$300 (High Option) and \$500 (Standard Option) in addition to the PPO or Non-PPO coinsurance.

### Changes to High Option only

- Your share of the non-Postal premium will increase by 5.7% for Self Only or 6% for Self and Family.
- The per admission deductible is no longer limited to two in a calendar year. Each inpatient admission is now subject to the per admission deductible.
- The out-of-pocket maximum is now \$4,000 for PPO providers and \$6,000 for combined expenses from PPO and Non-PPO providers.
- For single-source brand name drugs, non-Medicare members will now pay 25% of the cost, up to a maximum of \$150, for a 30-day supply at network retail pharmacies and up to a maximum of \$350 for a 90-day supply at Medco By Mail.
- For multi-source brand name drugs, non-Medicare members will now pay \$5 plus the difference in the cost of the generic and the brand name drug at network retail pharmacies and \$15 plus the difference in the cost of the generic drug and the brand name drug at Medco By Mail.
- For single-source brand name drugs, Medicare members will now pay 20% of the cost up to a maximum of \$150 for a 30-day supply at network retail pharmacies and 15% up to a maximum of \$350 for a 90-day supply at Medco By Mail.
- For multi-source brand name drugs, Medicare members will now pay \$5 plus the difference in the cost of the generic drug and brand name drug at network retail pharmacies and \$10 plus the difference in the cost of the generic and brand name drug at Medco By Mail.
- Member's copayments and coinsurance for prescription drugs dispensed by Medco go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills.

### Changes to Standard Option only

- Your share of the non-Postal premium will not increase for Self Only or for Self and Family.
- The out-of-pocket maximum is now \$5,000 for PPO providers and \$7,000 for combined expenses from PPO and Non-PPO providers.

### Changes to High Deductible Health Plan

- Your share of the non-Postal premium will decrease by 1.7% for Self Only or 2.8% for Self and Family.

**We have clarified the following:**

- We have clarified that pre-implantation genetic diagnosis (PGD) is not covered.
- We have clarified that hot and cold packs are not covered.
- We have clarified that topical hyperbaric oxygen therapy is not covered.
- We have clarified the criteria used to approve bariatric surgery.
- We have clarified that charges for photographs to document physical conditions are not covered.
- We have clarified that marriage counseling is not covered.
- We have clarified that Home Test Kits including but not limited to HIV and Drug Home Test Kits are not covered.
- We have clarified that Weight Loss Programs are not covered.
- We have clarified that telephone consultations are not covered.
- We have clarified the member's responsibility and GEHA rights on claims when a third party is responsible for the charge.
- We have clarified the definition of Intensive Day Treatment.
- We have deleted the language "If the cost of the medication is less than the applicable copayment, you are only responsible for the cost of the medication".

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## Section 3 How you get care

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### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 821-6136 or write to us at GEHA, P. O. Box 4665, Independence, MO 64051-4665. You may also request replacement cards through our Web site: [www.geha.com](http://www.geha.com).

### Where you get covered care

You can get care from any “covered provider” or “covered facility”. How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less.

#### • Covered providers

We consider the following to be covered providers when they perform services within the scope of their license or certification:

A licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.). Other covered providers include a chiropractor, nurse midwife, nurse anesthetist, audiologist, dentist, optometrist, licensed clinical social worker, licensed clinical psychologist, podiatrist, speech, physical and occupational therapist, nurse practitioner/clinical specialist, nursing school administered clinic, physician assistant and Christian Science practitioner.

The term “doctor” includes all of these providers when the services are performed within the scope of their license or certification. The term “primary care physician” includes family or general practitioners, pediatricians, obstetricians/gynecologists and medical internists.

**Medically underserved areas.** Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are “medically underserved”. For 2006, the states are: Alabama, Alaska, Arizona, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, West Virginia and Wyoming.

#### • Covered facilities

Covered facilities include:

##### • Freestanding ambulatory facility

A facility which is licensed by the state as an ambulatory surgery center or has Medicare certification as an ambulatory surgical center, has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility; does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other professional.

##### • Hospice

A facility which meets all of the following:

- (1) primarily provides inpatient hospice care to terminally ill persons;
- (2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;
- (3) is supervised by a staff of M.D.’s or D.O.’s, at least one of whom must be on call at all times;
- (4) provides 24 hour a day nursing services under the direction of an R.N. and has a full-time administrator; and
- (5) provides an ongoing quality assurance program.

- Hospital
  - (1) An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
  - (2) A medical institution which is operated pursuant to law, under the supervision of a staff of doctors, and with 24 hour a day nursing service, and which is primarily engaged in providing general inpatient care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or have such arrangements by contract or agreement: or
  - (3) An institution which is operated pursuant to law, under the supervision of a staff of doctors and with 24 hour a day nursing service and which provides services on the premises for the diagnosis, treatment, and care of persons with mental/substance abuse disorders and has for each patient a written treatment plan which must include diagnostic assessment of the patient and a description of the treatment to be rendered and provides for follow-up assessments by or under the direction of the supervising doctor.

The term hospital does not include a convalescent home or skilled nursing facility, or any institution or part thereof which: a) is used principally as a convalescent facility, nursing facility, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operating as a school or residential treatment facility.

## **What you must do to get covered care**

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.

### **• Transitional care**

**Specialty care:** If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for other than for cause,

you may be able to continue seeing your specialist and receiving any PPO benefits 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 PPO specialist based on the above circumstances, you can continue to see your specialist and any PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

### **• Hospital care**

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 (800) 821-6136.

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 in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

## How to get approval for...

### • Your hospital stay

**Precertification** is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.

#### Warning:

We will reduce our benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

#### How to precertify an admission:

- For medical and surgical services, you, your representative, your doctor, or your hospital must call Encompass before admission. The toll-free number is (888) 372-3190. (See pages 50-51 for mental health/substance abuse precertification.)
- 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 doctor, 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.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, proposed treatment, or surgery;
  - Name and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

#### Maternity care

You do not need to precertify 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 precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

#### If your hospital stay needs to be extended:

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days.

#### What happens when you do not follow the precertification rules

If no one contacted us, we will decide whether the hospital stay was medically necessary.

- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the \$500 penalty.
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but,
- For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

**Exceptions:**

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare Part A is the primary payer 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.

- **Radiology/Imaging procedures precertification**

Radiology precertification is the process by which prior to scheduling specific imaging procedures we evaluate the medical necessity of your proposed procedure to ensure the appropriate procedure is being requested for your condition. In most cases your physician will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your procedure, you should ask your doctor to contact us.

The following outpatient radiology services need to be precertified:

- CT - Computerized Axial Tomography
- MRI - Magnetic Resonance Imaging
- MRA - Magnetic Resonance Angiography
- NC - Nuclear Cardiac Imaging Studies
- PET - Positron Emission Tomography

**How to precertify a radiology/imaging procedure:**

For outpatient CT, MRI, MRA, NC and PET studies, you, your representative or your doctor must call MedSolutions before scheduling the procedure. The toll free number is (866) 879-8317. Provide the following information: patient's name, plan identification number, and birth date, requested procedure and clinical support for request, name and telephone number of ordering provider, and name of requested imaging facility.

**Exceptions:**

You do not need precertification in these cases:

- You have another health insurance policy that is primary payer including Medicare Part A & B or Part B only;
- The procedure is performed outside the United States;
- You are an inpatient in a hospital;
- The procedure is performed as an emergency.

**Warning:**

We will reduce our benefits for these procedures by \$100 if no one contacts us for precertification. If the procedure is not medically necessary, we will not pay any benefits.

- **Other services**

Some services require a referral, precertification, or prior authorization. You need to call us at (800) 821-6136 before receiving treatment for care such as:

- Physical therapy (See pages 29 and 81)
- Growth hormone therapy (GHT) (See pages 28-29 and 81)
- Surgical treatment of morbid obesity (See pages 36 and 86)
- Certain prescription drugs
- Organ and tissue transplant procedures (See pages 38-39 and 89)
- Surgical correction of congenital anomalies (See pages 35 and 86)
- In-network and out-of-network inpatient Mental Health and Substance Abuse Benefits and in-network outpatient Intensive Day Treatment (See pages 50-51 and 98-99)
- Psychological testing (See pages 50-51 and 98-99)
- Injectable hematopoietic drugs (drugs for anemia, low white blood count)
- Injectable drugs for arthritis, psoriasis or hepatitis

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## Section 4 Your costs for covered services

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

### Copayments

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

Example: When you see your PPO physician, under the High Option, you pay a copayment of \$20 per visit.

### 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. Copayments do not count toward any deductible.

- The calendar year deductible is \$350 per person under High Option and \$450 per person under Standard Option. After the deductible amount is satisfied for an individual, covered services are payable for that individual. Under a family enrollment, all family members' individual deductibles are considered to be satisfied when the family members' deductibles are combined and reach \$700 under High Option and \$900 under Standard Option.
- We also have separate deductibles for:
  - A High Option per admission (including in-network mental health) deductible of \$100 per person (PPO) and (excluding mental health) \$300 per person (non-PPO) for inpatient hospital services.
  - Mental health and substance abuse treatment of \$500, per person, per calendar year, for out-of-network hospital inpatient and hospital outpatient/intensive day treatment.

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

And, 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 doesn't begin until you meet your deductible. We will base this percentage on either the billed charge or the Plan Allowance, whichever is less.

Example: Under the High Option, you pay 25% of our allowance for non-PPO office visits.

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges \$100 for a service but routinely waives your 25% coinsurance, the actual charge is \$75. We will pay \$56.25 (75% of the actual charge of \$75).

### Differences between our allowance and the bill

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.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a PPO physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, with High Option, you pay just – 10% of our \$100 allowance (\$10). Because of the agreement, your PPO physician will not bill you for the \$50 difference between our allowance and his bill.

- Non-PPO providers, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance – plus any difference between our allowance and charges on the bill. Here is an example. You see a non-PPO physician who charges \$150 and our allowance is again \$100. Because you’ve met your deductible, you are responsible for your coinsurance, so with High Option you pay 25% of our \$100 allowance (\$25). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the \$50 difference between our allowance and his bill.

The following table illustrates the examples of how much you have to pay out-of-pocket, under the High Option, for services from a PPO physician vs. a non-PPO physician. The table uses our example of a service for which the physician charges \$150 and our allowance is \$100. The table shows the amount you pay if you have met your calendar year deductible.

<b>EXAMPLE</b>	<b>PPO physician</b>	<b>Non-PPO physician</b>
Physician’s charge	\$150	\$150
Our allowance	We set it at: 100	We set it at: 100
We pay	90% of our allowance: 90	75% of our allowance: 75
You owe: Coinsurance	10% of our allowance: 10	25% of our allowance: 25
+Difference up to charge?	No: 0	Yes: 50
<b>TOTAL YOU PAY</b>	<b>\$10</b>	<b>\$75</b>

**Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments**

For High and Standard Option medical and surgical services with coinsurance, we pay 100% of our allowable amount for the remainder of the calendar year after out-of-pocket expenses for coinsurance exceed:

**PPO**

- \$4,000 High Option or \$5,000 Standard if you use PPO providers. Out-of-pocket expenses from both PPO and non-PPO providers count toward this limit. If you reach this limit, expenses from non-PPO providers must reach the non-PPO out-of-pocket limit before they are paid at 100% of our allowable amount.

**Non-PPO**

- \$6,000 High Option or \$7,000 Standard Option if you use non-PPO providers. Any of the above expenses for PPO providers also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use PPO providers.

Out-of-pocket expenses for PPO and Non-PPO benefits are:

- The 10% (High Option) or 15% (Standard Option) you pay for PPO charges under medical services and supplies, surgical and anesthesia services and hospital, facility, ambulance services and mental health and substance abuse services.
- The 25% (High Option) or 35% (Standard Option) you pay for non-PPO charges under medical services and supplies, surgical and anesthesia services and hospital, facility and ambulance services. (This does not include out-of-network mental health and substance abuse services.)
- For High Option member’s, copayments and coinsurance for prescription drugs dispensed by Medco go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills.

The following cannot be counted toward catastrophic protection out-of-pocket expenses and you must continue to pay them even after your expenses exceed the limits described above:

- The \$350 (High Option) or \$450 (Standard Option) calendar year deductible;
- The (High Option) \$100 (PPO) or \$300 (non-PPO) per in-hospital admission deductible;
- The \$20 copayment for doctor’s office visits (High Option); or the \$10 copayment for primary care physician/\$25 specialist office visits (Standard Option);
- Expenses in excess of our allowable amount or maximum benefit limitations;

- Expenses for well child care and immunizations;
- Expenses for dental and chiropractic care;
- Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements (see pages 12-13);
- Expenses for prescription drugs purchased through retail or Medco By Mail;
- The \$300 copayment (High Option) or \$500 copayment (Standard Option) for Specialty Pharmacy medication not dispensed by Medco Specialty Pharmacy.

**Non-PPO mental conditions and substance abuse benefits**

For High and Standard Option the Plan pays 100% of reasonable and customary charges for the remainder of the calendar year up to the calendar year day or visit maximum after the \$500 deductible is met, if out-of-pocket expenses for inpatient or outpatient mental conditions and outpatient substance abuse treatment total \$8,000 for all family members combined in that calendar year.

Out-of-pocket expenses for purposes of this benefit are:

- \$500 deductible for Inpatient Hospital and Intensive Day Treatment under the Mental Conditions/Substance Abuse Benefit;
- The **50%** you pay for inpatient hospital and intensive day treatment expenses;
- The **50%** you pay for inpatient visits;
- The **50%** you pay for outpatient care.

The following cannot be included in the accumulation of out-of-pocket expenses and you must continue to pay them even after the limits described above:

- Expenses in excess of plan allowance or maximum benefit limitations;
- Expenses for outpatient psychotherapy sessions in excess of 30 sessions per year;
- Expenses for inpatient care in excess of 100 days per year;
- Expenses for inpatient provider visits in excess of 100 visits per year;
- Expenses for intensive day treatment in excess of 60 days per year;
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 12-13);
- Expenses for prescription drugs purchased through retail or Medco By Mail;
- Expenses in excess of the **50%** of plan allowance for inpatient substance abuse charges.

**Your catastrophic protection out-of-pocket maximum for deductibles, and coinsurance**

For HDHP covered medical and surgical services with coinsurance, we pay 100% of our allowable amount for the remainder of the calendar year after out-of-pocket expenses for deductibles and coinsurance exceed:

**PPO and Non-PPO**

\$5,000 for Self Only or \$10,000 for Self and Family. Out-of-pocket expenses from both PPO and non-PPO providers count toward this limit. If you reach this limit, additional charges up to the Plan allowance will be paid at 100%.

Out-of-pocket expenses for this benefit are:

- The calendar year deductible of \$1,100 for Self Only or \$2,200 for Self and Family.
- The 15% coinsurance you pay for PPO charges under medical services and supplies, surgical and anesthesia services and hospital, facility, ambulance services, mental health and substance abuse services.
- The 30% coinsurance you pay for non-PPO charges under medical services and supplies, surgical and anesthesia services and hospital, facility and ambulance services and pharmacy charges at retail whether in or out-of-network and by mail.

The following cannot be counted toward catastrophic protection out-of-pocket expenses and you must continue to pay them even after your expenses exceed the limits described above:

- Expenses in excess of our allowable amount or maximum benefit limitations such as the amounts in excess of the chiropractic benefit and dental care;
- Expenses paid by GEHA for preventive care including well child care and immunizations;
- Expenses in excess of the allowable amount or maximum benefit limitations under the Supplemental Vision Care Plan;
- The difference between our allowance and the cost of drugs purchased at a non-network pharmacy;
- Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements (see pages 12-13).

### **Non-PPO mental conditions and substance abuse benefits**

For HDHP the Plan pays 100% of reasonable and customary charges for the remainder of the calendar year up to the calendar year day or visit maximum when the combined out-of-pocket with other medical, surgical, hospital and pharmacy charges exceed \$5,000 for Self Only or \$10,000 for Self and Family members.

Out-of-pocket expenses for purposes of this benefit are:

- The additional \$500 deductible for out-of-network non-PPO providers for inpatient hospital and outpatient hospital/intensive day treatment per person, limit of two per family, per calendar year;
- The **50%** you pay for inpatient hospital and intensive day treatment expenses;
- The **50%** you pay for inpatient visits;
- The **50%** you pay for outpatient care.

The following cannot be included in the accumulation of out-of-pocket expenses:

- Expenses in excess of plan allowance or maximum benefit limitations;
- Expenses for outpatient psychotherapy sessions in excess of 30 sessions per year;
- Expenses for inpatient care in excess of 100 days per year;
- Expenses for inpatient provider visits in excess of 100 visits per year;
- Expenses for intensive day treatment in excess of 60 days per year;
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 12-13);
- Expenses in excess of the plan allowance for inpatient substance abuse charges.

### **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 got in January before the effective date of your coverage in this Plan. If you already met the covered out-of-pocket maximum expense level in full, your old plan's catastrophic protection benefit will continue to apply until the effective date. 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. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

### **When Government facilities bill us**

Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Service 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.

### **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 you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care is not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

### If you...

- are age 65 or over, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

### Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount – the "equivalent Medicare amount" – set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your applicable deductibles, coinsurance, or copayments you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the Medicare equivalent amount.

When inpatient claims are paid according to a Diagnostic Related Group (DRG) limit (for instance, for admissions of certain retirees who do not have Medicare), we will pay 30% of the total covered amount as room and board charges and 70% as other charges and will apply your coinsurance accordingly.

### And, for your physician care, the law requires us to base our payment and your coinsurance on...

- an amount set by Medicare and called the "Medicare approved amount", or
- the actual charge if it is lower than the Medicare approved amount.

If your physician...	Then you are responsible for...
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is <b>not</b> in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

**When you have the  
Original Medicare Plan  
(Part A, Part B, or both)**

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician **accepts** Medicare assignment, then we waive some of your deductibles, copayment and coinsurance for covered charges.
- If your physician **does not accept** Medicare assignment, then you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the “limiting charge.” The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

**Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.**

**High and Standard Option Benefits**

See pages 8-9 for how our benefits changed this year. Pages 132-134 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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### Section 5 High and Standard Option Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the *General exclusions* in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at (800) 821-6136 or at our Web site at [www.geha.com](http://www.geha.com).

Each option offers unique features.

- **High Option**

- Extensive provider network,
- No requirement to choose a single doctor as your primary physician,
- No referral needed to see a specialist,
- \$5 copay for generic prescription drugs,
- Within the provider network, 100% coverage for room and board and 90% for other hospital charges. Precertification is required,
- Freedom to choose any doctor with extra savings when you see a preferred provider.

- **Standard Option**

- Affordable premiums,
- Low \$10 copay for office visits to any primary care physician including family or general practitioners, pediatricians, OB/GYN and medical internists,
- No requirement to choose a single doctor as your primary physician,
- No referral needed to see a specialist,
- \$5 copay for generic prescription drugs,
- Preventive dental services covered at 50% without a deductible,
- Freedom to choose any doctor with extra savings when you see a preferred provider.

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$350 per person (\$700 per family) under the High Option and \$450 per person (\$900 per family) under the Standard Option. 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.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay the services of radiologists, anesthesiologists and pathologists who are not preferred providers at the preferred provider rate. This non-standard benefit does not include the services of emergency room physicians.
- **YOU MUST GET PRECERTIFICATION OF CERTAIN OUTPATIENT IMAGING PROCEDURES. FAILURE TO DO SO WILL RESULT IN A MINIMUM OF \$100 PENALTY.** Please refer to precertification information in Section 3 to be sure which procedures require precertification.

Benefits Description	You pay After the calendar year deductible...	You pay After the calendar year deductible...
<p><b>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does <i>not</i> apply.</b></p>		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• Routine physical examinations</li> <li>• Office medical consultations</li> <li>• Second surgical opinions</li> <li>• In an urgent care center</li> </ul> Note: The facility charge for clinic or office visits is considered a part of the fee charged by the physician.	PPO: \$20 copayment (No deductible)  Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: \$10 copayment for office visits to primary care physicians; \$25 copayment for office visits to specialists (No deductible)  Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> <li>• Emergency room physician care (non-accidental injury)</li> <li>• During a hospital stay</li> <li>• At home</li> </ul>	PPO: 10% of the Plan allowance  Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance  Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

## High and Standard Option

Lab, X-ray and other diagnostic tests	You pay High Option	You pay Standard Option
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT Scans/MRI (outpatient requires precertification)</li> <li>• Double contrast barium enemas</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	PPO: 10% of the Plan allowance  Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount  Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.	PPO: 15% of the Plan allowance  Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount  Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Professional fees for automated lab tests</li> </ul>	<i>All charges</i>	<i>All charges</i>
Preventive care, adult		
Routine screenings, limited to: <ul style="list-style-type: none"> <li>• Total blood cholesterol screenings</li> <li>• Chlamydial infection</li> <li>• Colorectal cancer screening, including               <ul style="list-style-type: none"> <li>– Annual coverage of one fecal occult blood test for members age 40 and older</li> <li>– Sigmoidoscopy</li> <li>– Colonoscopy</li> </ul> </li> <li>• Prostate cancer screening               <ul style="list-style-type: none"> <li>– Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older</li> </ul> </li> <li>• Routine Pap test               <ul style="list-style-type: none"> <li>– Annual coverage of one Pap smear for women age 18 and older.</li> </ul> </li> <li>• Routine mammogram               <ul style="list-style-type: none"> <li>– Mammograms for diagnostic and/or routine screening</li> </ul> </li> <li>• Routine immunizations               <ul style="list-style-type: none"> <li>– Tetanus-diphtheria (Td) booster</li> <li>– Influenza/Pneumococcal vaccines</li> </ul> </li> <li>• Osteoporosis screening               <ul style="list-style-type: none"> <li>– Bone density tests for routine screening for women 65 or older or women 60 or older who are at increased risk</li> </ul> </li> </ul>	PPO: 10% of the Plan allowance  Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance  Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Professional fees for automated lab tests</li> </ul>	<i>All charges</i>	<i>All charges</i>

<b>Preventive care, children</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>For dependent children under age 22:</p> <ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Well-child care charges for routine examinations, immunizations and care</li> <li>• Initial examination of a newborn child covered under a family enrollment</li> </ul>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)</p>
<p>Vision examinations, limited to:</p> <ul style="list-style-type: none"> <li>• Examinations for amblyopia and strabismus</li> </ul>	<p>PPO: \$20 copayment (No deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: \$10 copayment for office visits to primary care physicians; \$25 copayment for office visits to specialists (No deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Professional fees for automated lab tests</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Maternity care</b>		
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> <li>• Physician care such as sonograms</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your doctor, or your hospital must precertify.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay.</li> <li>• We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b))</li> <li>• Circumcision is covered under Surgery benefits. (Section 5(b))</li> </ul>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> <li>• Approved fetal monitors are covered the same as other medical benefits for diagnostic and treatment services.</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Maternity care – continued on next page*

## High and Standard Option

Maternity care <i>(continued)</i>	You pay High Option	You pay Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Home uterine monitoring devices, unless preauthorized by our Medical Director;</li> <li>• Charges 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 rape or incest;</li> <li>• Charges for services and supplies incurred after termination of coverage.</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Family planning</b>		
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5(b))</li> <li>• Surgically implanted contraceptives</li> <li>• Injectable contraceptive drugs (such as Depo provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Reversal of voluntary surgical sterilization</li> <li>• Genetic counseling</li> <li>• Preimplantation genetic diagnosis (PGD)</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Infertility services</b>		
<p>Diagnosis and treatment of infertility except as shown in <i>Not covered</i>.</p> <p>Note: Benefits are limited to a maximum of \$3,000 per calendar year per person.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Infertility services after voluntary sterilization</li> <li>• Fertility drugs</li> <li>• Preimplantation genetic diagnosis (PGD)</li> <li>• Assisted reproductive technology (ART) procedures, such as; <ul style="list-style-type: none"> <li>– artificial insemination</li> <li>– in vitro fertilization</li> <li>– embryo transfer and gamete intrafallopian transfer (GIFT)</li> <li>– intravaginal insemination (IVI)</li> <li>– intracervical insemination (ICI)</li> <li>– intrauterine insemination (IUI)</li> </ul> </li> <li>• Services and supplies related to ART procedures</li> <li>• Cost of donor sperm</li> <li>• Cost of donor egg</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

<b>Allergy care</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<ul style="list-style-type: none"> <li>• Testing and treatment, including materials (such as allergy serum)</li> <li>• Allergy testing is limited to \$500 per person per calendar year</li> <li>• Allergy injections</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Clinical ecology and environmental medicine</i></li> <li>• <i>Provocative food testing and sublingual allergy desensitization</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Treatment therapies</b>		
<ul style="list-style-type: none"> <li>• Antibiotic therapy</li> <li>• Outpatient cardiac rehabilitation</li> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 38-39.</p> <ul style="list-style-type: none"> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy (see note)</li> <li>• Respiratory and inhalation therapies</li> </ul> <p>Note: – Some medications required for treatment therapies may be available through Medco By Mail or a Medco participating pharmacy. Medications obtained from these sources are covered under the Prescription Drug Benefits in Section 5(f).</p> <p>Note: Please refer to the Specialty Pharmacy Benefits on pages 28-29 for benefits which apply to some categories of prescription drug treatment.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Chelating therapy except for acute arsenic, gold or lead poisoning</i></li> <li>• <i>Maintenance cardiac rehabilitation</i></li> <li>• <i>Topical hyperbaric oxygen therapy</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

## High and Standard Option

Specialty Pharmacy Benefits	You pay High Option	You pay Standard Option
<p>Medications to treat severe, chronic medical conditions and are usually administered by injection or infusion in the following categories:</p> <ul style="list-style-type: none"> <li>• Antihemophilic factors such as Helixate FS, Recombinate</li> <li>• Blood growth factors such as Aranesp, Epogen, Leukine, Neulasta, Neupogen, Procrit</li> <li>• Calcimimetic Agent such as Sensipar</li> <li>• Cytomegalovirus Immune Globulin such as Cytogam</li> <li>• Gonadotropin-releasing hormone analog such as Lupron</li> <li>• Growth Hormone medications such as Genotropin, Humatrope, Nutropin</li> <li>• Immunoglobulin preparations such as, Gamunex, Iveegam, Respigam</li> <li>• Immunosuppressives such as Amevive, Copaxone, Raptiva</li> <li>• Interferons such as Avonex, Betaseron, Intron A, Pegasys, Peg-Intron</li> <li>• Interleukin-Receptor Antagonist such as Kineret</li> <li>• Low molecular weight heparin such as Fragmin, Lovenox</li> <li>• Monoclonal antibody such as Synagis, Xolair</li> <li>• Mucolytic Enzyme such as Pulmozyme</li> <li>• Platelet Aggregation Inhibitor such as Remodulin</li> <li>• Prostaglandin drugs such as Flolan</li> <li>• RHo (D) Immune Globulin such as MicRhoGam, RhoGam</li> <li>• Synthetic Nucleoside Analog such as Copegus, Rebetol, Ribavirin</li> <li>• Tumor necrosis factor modulators such as Enbrel, Humira, Remicade</li> </ul> <p>Drugs in these categories are subject to the Specialty Pharmacy benefits. The medication examples provided above are not all inclusive. Call our customer service department at 1-800-821-6136 to determine if other medications not listed apply to this benefit.</p> <p>Note: Under the High Option, coinsurance for medications dispensed by Medco Specialty Pharmacies go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments).</p>	<p>Medications dispensed by Medco Specialty Pharmacies:</p> <p>When GEHA is primary:</p> <p>25% coinsurance up to a maximum of \$150 for up to a 30-day supply,</p> <p>\$350 maximum coinsurance for up to a 90-day supply.</p> <p>When Medicare is primary:</p> <p>15% coinsurance up to a maximum of \$150 for up to a 30-day supply,</p> <p>\$350 maximum coinsurance for up to a 90-day supply.</p> <p>Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals:</p> <p>PPO: \$300 copayment per prescription fill and 10% of the Plan allowance,</p> <p>Non-PPO: \$300 copayment per prescription fill and 25% of the Plan allowance,</p> <p>\$300 copayment per prescription fill does not apply to the out-of-pocket maximum.</p> <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p>	<p>Medications dispensed by Medco Specialty Pharmacies:</p> <p>50% coinsurance.</p> <p>Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals:</p> <p>PPO: \$500 copayment per prescription fill and 15% of the Plan allowance,</p> <p>Non-PPO: \$500 copayment per prescription fill and 35% of the Plan allowance,</p> <p>\$500 copayment per prescription fill does not apply to the out-of-pocket maximum.</p> <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p>

*Specialty Pharmacy Benefits – continued on next page*

<b>Specialty Pharmacy Benefits</b> <i>(continued)</i>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p><b>Non Specialty Pharmacy retail purchase</b></p> <p>If Medco Specialty Pharmacies are not used and you purchase medications in the above categories through a retail pharmacy, you must submit your claim to:</p> <p>Medco P.O. Box 14711 Lexington, KY 40512</p> <p>Reimbursement will be based on GEHA's costs had you used the specialty pharmacies.</p> <p>You must submit original drug receipts.</p> <p>Note: Under the High Option, coinsurance for medications dispensed at retail pharmacies go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments).</p>	<p>When GEHA is primary: \$300 copayment per prescription fill and 25% of the Plan allowance (plus any difference between our allowance and the cost of the drug).</p> <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p> <p>When Medicare is primary: \$300 copayment per prescription fill and 20% of the Plan allowance (and any difference between our allowance and the cost of the drug).</p> <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p>	<p>\$500 copayment per prescription fill and 35% of the Plan allowance (plus any difference between our allowance and the cost of the drug).</p> <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p>
<p><b>Physical and occupational therapies</b></p>		
<ul style="list-style-type: none"> <li>• 60 visits per calendar year for the combined services of the following: (One visit is two hours or less of physical or occupational therapy.) <ul style="list-style-type: none"> <li>– qualified physical therapists and</li> <li>– qualified occupational therapists</li> </ul> </li> </ul> <p>Prior to beginning physical therapy treatments, you should contact our Medical Management Department, (800) 821-6136, to preauthorize benefits. Continuing physical therapy claims will be subject to concurrent review for medical necessity. Physical therapy claims will be denied if we determine the therapy is not medically necessary. Please preauthorize.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and when a physician:</p> <ul style="list-style-type: none"> <li>– orders the care;</li> <li>– identifies the specific professional skills the patient requires and the medical necessity for skilled services; and</li> <li>– indicates the length of time the services are needed.</li> </ul> <p>Note: When you receive medically necessary physical or occupational therapy on an outpatient basis from a qualified professional therapist at a skilled nursing facility, your therapy is covered up to plan limits.</p>		

*Physical and occupational therapies – continued on next page*

## High and Standard Option

Physical and occupational therapies <i>(continued)</i>	You pay High Option	You pay Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Exercise programs</li> <li>• Long-term rehabilitative therapy</li> <li>• Hot and cold packs</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p><b>Speech therapy</b></p> <ul style="list-style-type: none"> <li>• 30 visits per calendar year for the services of a qualified speech therapist. (One visit is two hours or less of speech therapy.)</li> </ul> <p>Note: We only cover speech therapy when a physician:</p> <ul style="list-style-type: none"> <li>– orders the care;</li> <li>– identifies the specific professional skills the patient requires and the medical necessity for skilled services; and</li> <li>– indicates the length of time the services are needed.</li> </ul> <p>Note: When you receive medically necessary speech therapy on an outpatient basis from a qualified speech therapist at a skilled nursing facility, your therapy is covered up to plan limits.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Computer devices to assist with communications;</li> <li>• Computer programs of any type, including but not limited to those to assist with speech therapy</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p><b>Hearing services (testing, treatment, and supplies)</b></p>		
<p>Diagnostic hearing tests performed by a M.D., D.O. or audiologist.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Hearing aids, testing and examinations for them</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p><b>Vision services (testing, treatment, and supplies)</b></p>		
<ul style="list-style-type: none"> <li>• First pair of contact lenses or ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury.</li> <li>• 30 outpatient vision therapy visits by an ophthalmologist or optometrist per person per lifetime.</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Computer programs of any type, including but not limited to those to assist with vision therapy.</li> <li>• Eyeglasses or contact lenses and examinations for them except as shown above</li> <li>• Radial keratotomy and other refractive surgery</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

<b>Foot care</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>Routine foot care only when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>PPO: \$20 copayment for the office visit (No deductible) plus 10% of the Plan allowance for other services performed during the visit</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: \$10 copayment for the office visit to primary care physicians; \$25 copayment for office visits to specialists (No deductible) plus 15% of the Plan allowance for other services performed during the visit</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming of toenails or removal of corns, calluses, or similar routine treatment of conditions of the foot, except as stated above.</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Orthopedic and prosthetic devices</b>		
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy.</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy.</li> </ul> <p>Note: See Section 5(b) for coverage of the surgery to insert the device.</p> <p>Note: We will pay only for the cost of the standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Diabetic shoes</i></li> <li>• <i>Bioelectric, computer programmed prosthetic devices</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

## High and Standard Option

Durable medical equipment (DME)	You pay High Option	You pay Standard Option
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ul style="list-style-type: none"> <li>• Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury);</li> <li>• Are medically necessary;</li> <li>• Are primarily and customarily used only for a medical purpose;</li> <li>• Are generally useful only to a person with an illness or injury;</li> <li>• Are designed for prolonged use; and</li> <li>• Serve a specific therapeutic purpose in the treatment of an illness or injury.</li> </ul> <p>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> <li>• Hospital beds;</li> <li>• Wheelchairs;</li> <li>• Crutches; and</li> <li>• Walkers.</li> </ul> <p>Note: Call us at (800) 821-6136 as soon as your physician prescribes this equipment. We will 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> <p>Note: Benefits for durable medical equipment are limited to \$10,000 per person, lifetime maximum.</p> <p>Note: We will pay only for the cost of the standard item. Coverage for specialty equipment such as all-terrain wheelchairs is limited to the cost of the standard equipment.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Computer devices to assist with communications</i></li> <li>• <i>Computer programs of any type</i></li> <li>• <i>Air purifiers, air conditioners, heating pads, cold therapy units, whirlpool bathing equipment, sun and heat lamps, exercise devices (even if ordered by a doctor), and other equipment that does not meet the definition of durable medical equipment (page 120)</i></li> <li>• <i>Lifts, such as seat, chair or van lifts</i></li> <li>• <i>Wigs</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

<b>Home health services</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>25 in-home visits per calendar year, not to exceed one visit up to two hours per day when:</p> <ul style="list-style-type: none"> <li>• A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services;</li> <li>• The attending physician orders the care;</li> <li>• The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and</li> <li>• The physician indicates the length of time the services are needed.</li> </ul> <p>Note: Covered services are based on our review for medical necessity.</p> <p>Note: Please refer to the Specialty Pharmacy Benefits on pages 28-29 for information on benefits for home infusion therapies.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;</i></li> <li>• <i>Custodial care;</i></li> <li>• <i>Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;</i></li> <li>• <i>Inpatient private duty nursing.</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p><b>Chiropractic</b></p>		
<p>Chiropractic services limited to:</p> <ul style="list-style-type: none"> <li>• 30 visits per calendar year for manipulation of the spine;</li> <li>• X-rays, used to detect and determine nerve interferences due to spinal subluxations or misalignments.</li> </ul> <p>Note: No other benefits for the services of a chiropractor are covered under any other provision of this Plan. In medically underserved areas, services of a chiropractor that are listed above are subject to the stated limitations. In medically underserved areas, services of a chiropractor that are within the scope of his/her license and are not listed above are eligible for regular Plan benefits.</p>	<p>PPO and Non-PPO:</p> <p>All charges in excess of \$9 per visit</p> <p>All charges in excess of \$25 for X-rays of the spine</p> <p>Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.</p>	<p>PPO and Non-PPO:</p> <p>All charges in excess of \$9 per visit</p> <p>All charges in excess of \$25 for X-rays of the spine</p> <p>Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Any treatment not specifically listed as covered;</i></li> <li>• <i>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

## High and Standard Option

Alternative treatments	You pay High Option	You pay Standard Option
<p>Acupuncture</p> <p>Benefits are limited to 20 procedures per calendar year for medically necessary acupuncture treatments if performed by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.).</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other alternative treatments, including clinical ecology and environmental medicine</i></li> <li>• <i>Any treatment not specifically listed as covered</i></li> <li>• <i>Naturopathic services</i></li> </ul> <p><i>(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 10.)</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Educational classes and programs		
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Smoking Cessation – Up to \$100 to aid in smoking cessation-per person per lifetime, including related expenses such as drugs.</li> </ul>	<p>PPO: all charges in excess of \$100</p> <p>Non-PPO: all charges in excess of \$100</p>	<p>PPO: all charges in excess of \$100</p> <p>Non-PPO: all charges in excess of \$100</p>

**Section 5(b) Surgical and anesthesia services  
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 calendar year deductible is \$350 per person (\$700 per family) under the High Option and \$450 per person (\$900 per family) under the Standard Option. 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.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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 amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay the services of radiologists, anesthesiologists and pathologists who are not preferred providers at the preferred provider rate. This non-standard benefit does not include the services of emergency room physicians.
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefits Description	You pay After the calendar year deductible...	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does <i>not</i> apply.</p>		
Surgical procedures	High Option	Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Electroconvulsive therapy</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies - limited to children under the age of 18 unless there is a functional deficit. (See Reconstructive surgery)</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Surgical procedures – continued on next page*

## High and Standard Option

Surgical Procedures ( <i>continued</i> )	You pay High Option	You pay Standard Option
<p>A comprehensive range of services - <i>continued</i></p> <ul style="list-style-type: none"> <li>• Surgical treatment of obesity (bariatric surgery) is covered only if: <ul style="list-style-type: none"> <li>– eligible enrollee is 18 or over,</li> <li>– clinical records support a body mass index of 40 or greater (or 35-40 when there is a co-morbid condition such as life-threatening cardiopulmonary problems or severe diabetes mellitus) for a period of six months,</li> <li>– documentation of failure to lower the body mass index by a medically supervised program of diet and exercise of at least six months duration.</li> </ul> </li> <li>• Insertion of internal prosthetic devices. See Section 5(a) Orthopedic and prosthetic devices for device coverage information.</li> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> <li>• Surgically implanted contraceptives</li> <li>• Intrauterine devices (IUDs)</li> <li>• Treatment of burns</li> <li>• Assistant surgeons are covered up to 20% of our allowance for the surgeon's charge for procedures when it is medically necessary to have an assistant surgeon.</li> </ul> <p>Note: Post-operative care is considered to be included in the fee charged for a surgical procedure by a doctor. Any additional fees charged by a doctor are not covered unless such charge is for an unrelated condition.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are:</p> <ul style="list-style-type: none"> <li>• For the primary procedure based on: <ul style="list-style-type: none"> <li>– Full Plan allowance</li> </ul> </li> <li>• For the secondary procedure(s) based on: <ul style="list-style-type: none"> <li>– One-half of the Plan allowance</li> </ul> </li> <li>• For the subsequent procedure(s) based on: <ul style="list-style-type: none"> <li>– 25% of the Plan allowance</li> </ul> </li> </ul> <p>Note: Multiple or bilateral surgical procedures performed through the same incision are “incidental” to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our payment and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our payment and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Services of a standby physician or surgeon</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Reconstructive surgery	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery.</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm – limited to children under the age of 18 unless there is a functional deficit. Examples of congenital anomalies are: cleft lip; cleft palate; birth marks; and webbed fingers and toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance of breasts;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage)</li> </ul> </li> </ul> <p>Note: We pay for internal breast prostheses as hospital benefits if billed by a hospital. If included with the surgeon’s bill, surgery benefits will apply.</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>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <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 if repair is initiated promptly or as soon as the member’s condition permits;</i></li> <li>• <i>Surgeries related to sex transformation or sexual dysfunction;</i></li> <li>• <i>Surgeries to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit.</i></li> <li>• <i>Charges for photographs to document physical conditions.</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Oral and maxillofacial surgery		
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate;</li> <li>• Excision of cysts and incision of abscesses unrelated to tooth structure;</li> <li>• Extraction of impacted (unerupted or partially erupted) teeth;</li> <li>• Alveoplasty, partial or radical removal of the lower jaw with bone graft;</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Oral and maxillofacial surgery – continued on next page*

## High and Standard Option

Oral and maxillofacial surgery <i>(continued)</i>	You pay High Option	You pay Standard Option
<p>Oral surgical procedures - <i>continued</i></p> <ul style="list-style-type: none"> <li>• Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues;</li> <li>• Open reduction of dislocations and excision, manipulation, aspiration or injection of temporomandibular joints;</li> <li>• Removal of foreign body, skin, subcutaneous areolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones and incision/excision of salivary glands and ducts;</li> <li>• Repair of traumatic wounds;</li> <li>• Incision of the sinus and repair of oral fistulas;</li> <li>• Surgical treatment of trigeminal neuralgia.</li> <li>• Repair of accidental injury to sound natural teeth such as: expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. Masticating (biting or chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at 100% for charges incurred within 72 hours of an accident (see page 47).</li> <li>• Orthognathic surgery but only for treatment of severe sleep apnea and only after conservative treatment of sleep apnea has failed. Orthognathic surgery for any other condition is not covered.</li> <li>• Other oral surgery procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> <li>• Oral implants and transplants</li> <li>• Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</li> <li>• Orthodontic treatment</li> <li>• Any oral or maxillofacial surgery not specifically listed as covered</li> <li>• Orthognathic surgery (except as outlined above for severe sleep apnea), even if necessary because of TMJ dysfunction or disorder.</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p><b>Organ/tissue transplants</b></p>		
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Organ/tissue transplants – continued on next page*

<b>Organ/tissue transplants (continued)</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>Limited to - <i>continued</i></p> <ul style="list-style-type: none"> <li>• Lung: Single or double lung transplants, limited to patients for the following end-stage pulmonary diseases: (1) pulmonary fibrosis, (2) primary pulmonary hypertension, (3) emphysema, or (4) cystic fibrosis</li> <li>• Pancreas (limited to patients whose condition is not treatable by insulin therapy)</li> <li>• Allogeneic bone marrow transplants— only for patients with Acute leukemia, Advanced Hodgkin’s lymphoma, Advanced non-Hodgkin’s lymphoma, Advanced neuroblastoma (limited to children over age one), Aplastic anemia, Chronic myelogenous leukemia, Infantile malignant osteopetrosis, Severe combined immunodeficiency, Thalassemia major, or Wiskott-Aldrich syndrome</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver, small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>• Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support - limited to patients with Acute lymphocytic, or non-lymphocytic leukemia, Advanced Hodgkin’s lymphoma, Advanced non-Hodgkin’s lymphoma, Advanced neuroblastoma (limited to children over age one), Breast cancer or Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors, Multiple myeloma or Epithelial ovarian cancer.</li> </ul> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated below. This benefit applies only if the recipient is covered by us and if the donor’s expenses are not otherwise covered.</p> <p>Transportation Benefit</p> <ul style="list-style-type: none"> <li>• We will also provide up to \$10,000 per covered transplant for transportation (mileage or airfare) to a plan designated facility and reasonable temporary living expenses (i.e. lodging and meals) for the recipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 100 miles from the designated transplant facility.</li> <li>• Transportation benefits are payable for follow-up care up to one year following the transplant. The transportation benefit is not available for cornea or kidney transplants. You must contact Customer Service for what are considered reasonable temporary living expenses.</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Organ/tissue transplants – continued on next page*

## High and Standard Option

Organ/tissue transplants ( <i>continued</i> )	You pay High Option	You pay Standard Option
<p>Limited Benefits</p> <ul style="list-style-type: none"> <li>The process for preauthorizing organ transplants is more extensive than the normal precertification process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact our Medical Director so we can arrange to review the clinical results of the evaluation and determine if the proposed procedure meets our definition of “medically necessary” and is on the list of covered transplants. Coverage for the transplant must be authorized in advance, in writing by our Medical Director. (Cornea and kidney transplants do not require preauthorization by GEHA's Medical Director.)</li> </ul>		
<ul style="list-style-type: none"> <li>We will pay for a second transplant evaluation recommended by a physician qualified to perform the transplant, if: the transplant diagnosis is covered and the physician is not associated or in practice with the physician who recommended and will perform the organ transplant. A third transplant evaluation is covered only if the second evaluation does not confirm the initial evaluation.</li> <li>The transplant must be performed at a Plan-designated organ transplant facility to receive maximum benefits.</li> <li>If benefits are limited to \$100,000 per transplant, included in the maximum are all charges for hospital, medical and surgical care incurred while the patient is hospitalized for a covered transplant surgery and subsequent complications related to the transplant. Outpatient expenses for chemotherapy and any process of obtaining stem cells or bone marrow associated with bone marrow transplant (stem cell support) are included in benefits limit of \$100,000 per transplant. Tandem bone marrow transplants approved as one treatment protocol are limited to \$100,000 when not performed at a Plan designated facility. Expenses for aftercare such as outpatient prescription drugs are not a part of the \$100,000 limit.</li> </ul>	<p>PPO: \$20 copayment (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>If prior approval is not obtained or a Plan-designated organ transplant facility is not used, our allowance will be limited for hospital and surgery expenses up to a maximum of \$100,000 per transplant. If we cannot refer a member in need of a transplant to a designated facility, the \$100,000 maximum will not apply.</p>	<p>PPO: \$10 copayment for office visits to primary care physicians; \$25 copayment for office visits to specialists (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>If prior approval is not obtained or a Plan-designated organ transplant facility is not used, our allowance will be limited for hospital and surgery expenses up to a maximum of \$100,000 per transplant. If we cannot refer a member in need of a transplant to a designated facility, the \$100,000 maximum will not apply.</p>
<ul style="list-style-type: none"> <li>Chemotherapy and procedures related to bone marrow transplantation must be performed only at a Plan-designated organ transplant facility to receive maximum benefits.</li> <li>Simultaneous transplants such as kidney/pancreas, heart/lung, heart/liver are considered as one transplant procedure and are limited to \$100,000 when not performed at a Plan-designated organ transplant facility.</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Organ/tissue transplants – continued on next page*

<b>Organ/tissue transplants (continued)</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Services or supplies for or related to surgical transplant procedures (including administration of high-dose chemotherapy) for artificial or human organ/tissue transplants not listed as specifically covered.</i></li> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor.</i></li> <li>• <i>Donor search expense for bone marrow transplants.</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Anesthesia</b>		
<p>Professional fees for the administration of anesthesia in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

**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.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. In that case, we added “(calendar year deductible applies)”. The calendar year deductible is \$350 per person (\$700 per family) under the High Option and \$450 per person (\$900 per family) under the Standard Option.
- A High Option per admission deductible applies of \$100 (PPO) and \$300 (non-PPO) for inpatient hospital services.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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 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 5(b).
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay the services of radiologists, anesthesiologists and pathologists who are not preferred providers at the preferred provider rate. This non-standard benefit does not include the services of emergency room physicians.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM \$500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefits Description	You pay	You pay
<p align="center"><b>Note: The calendar year deductible applies ONLY when we say below: “calendar year deductible applies”</b></p>		
Inpatient hospital	High Option	Standard Option
<p>Room and board, such as:</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> <p>Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate.</p> <p>Note: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.</p>	<p>PPO: Nothing</p> <p>Non-PPO: Nothing</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance (calendar year deductible applies)</p>

*Inpatient hospital – continued on next page*

<b>Inpatient hospital</b> ( <i>continued</i> )	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery and other treatment rooms;</li> <li>• Prescribed drugs and medicines;</li> <li>• Diagnostic laboratory tests and X-rays;</li> <li>• Blood or blood plasma, if not donated or replaced;</li> <li>• Dressings, splints, casts, and sterile tray services;</li> <li>• Medical supplies and equipment, including oxygen;</li> <li>• Anesthetics, including nurse anesthetist services;</li> <li>• Take-home items;</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. (Note: calendar year deductible applies.)</li> </ul> <p>Note: We base payment on whether the facility or a health-care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.</p>	<p>PPO: 10% of the Plan allowance (\$100 per admission deductible applies)</p> <p>Non-PPO: 25% of the Plan allowance (\$300 per admission deductible applies)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance (calendar year deductible applies)</p>
<p>Maternity Care – Inpatient Hospital</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify.</li> </ul> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Delivery room, recovery, and other treatment rooms;</li> <li>• Prescribed drugs and medicines;</li> <li>• Diagnostic laboratory tests and X-rays;</li> <li>• Blood or blood plasma, if not donated or replaced;</li> <li>• Dressings and sterile tray services;</li> <li>• Medical supplies and equipment, including oxygen;</li> <li>• Anesthetics, including nurse anesthetist services;</li> <li>• Take-home items;</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies).</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay.</li> </ul>	<p>PPO: Nothing</p> <p>Non-PPO: Nothing for room and board; 25% of the Plan allowance for other hospital services (\$300 per admission deductible applies)</p>	<p>PPO: Nothing</p> <p>Non-PPO: 35% of the Plan allowance (calendar year deductible applies)</p>

*Inpatient hospital – continued on next page*

## High and Standard Option

Inpatient hospital <i>(continued)</i>	You pay High Option	You pay Standard Option
<p>Maternity Care – Inpatient Hospital - <i>continued</i></p> <ul style="list-style-type: none"> <li>We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment.</li> </ul>	<p>PPO: Nothing for room and board; 10% of the plan allowance for other hospital services (\$100 per admission deductible applies)</p> <p>Non-PPO: Nothing for room and board; 25% of the Plan allowance for other hospital services (\$300 per admission deductible applies)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>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. <i>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.</i></li> <li>Custodial care; see definition</li> <li>Non-covered facilities, such as nursing homes, schools</li> <li>Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>Private nursing care</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center		
<ul style="list-style-type: none"> <li>Operating, recovery, and other treatment rooms</li> <li>Prescribed drugs and medicines</li> <li>Diagnostic laboratory tests, X-rays, and pathology services</li> <li>Administration of blood, blood plasma, and other biologicals</li> <li>Blood and blood plasma, if not donated or replaced</li> <li>Pre-surgical testing</li> <li>Dressings, casts, and sterile tray services</li> <li>Medical supplies, including oxygen</li> <li>Anesthetics and anesthesia service</li> <li>Cardiac rehabilitation</li> </ul> <p>Note: Please refer to pages 28-29 for information on benefits for Specialty Pharmacy medications dispensed by hospitals.</p> <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>	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 25% of the Plan allowance (calendar year deductible applies)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Maintenance cardiac rehabilitation</li> </ul>	<p><i>All charges-</i></p>	<p><i>All charges</i></p>

*Outpatient hospital or ambulatory surgical center – continued on next page*

<b>Outpatient hospital or ambulatory surgical center</b> <i>(continued)</i>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<p>Maternity Care – Outpatient Hospital</p> <ul style="list-style-type: none"> <li>• Delivery room, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia services</li> </ul>	<p>PPO: Nothing</p> <p>Non-PPO: 25% of the Plan allowance (calendar year deductible applies)</p>	<p>PPO: Nothing</p> <p>Non-PPO: 35% of the Plan allowance (calendar year deductible applies)</p>
<b>Extended care benefits/Skilled nursing care facility benefits</b>		
<i>No benefits</i>	<i>All charges</i>	<i>All charges</i>
<b>Hospice care</b>		
<p>Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration.</p> <ul style="list-style-type: none"> <li>• We pay \$2,000 for hospice care on an outpatient basis.</li> <li>• We pay \$150 per day for room and board and care while an inpatient in a hospice up to a maximum of \$3,000.</li> </ul> <p>These benefits will be paid if the hospice care program begins after a person’s primary doctor certifies terminal illness and life expectancy of six months or less and any services or inpatient hospice stay that is part of the program is:</p> <ul style="list-style-type: none"> <li>• Provided while the person is covered by this Plan;</li> <li>• Ordered by the supervising doctor;</li> <li>• Charged by the hospice care program; and</li> <li>• Provided within six months from the date the person entered or re-entered (after a period of remission) a hospice care program.</li> </ul> <p>Remission is the halt or actual reduction in the progression of illness resulting in discharge from a hospice care program with no further expenses incurred. A readmission within three months of a prior discharge is considered as the same period of care. A new period begins after three months from a prior discharge with maximum benefits available.</p>	<p>PPO: Nothing up to the Plan limits (calendar year deductible applies)</p> <p>Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)</p>	<p>PPO: Nothing up to the Plan limits (calendar year deductible applies)</p> <p>Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)</p>

*Hospice Care – continued on next page*

## High and Standard Option

Hospice care (continued)	You pay High Option	You pay Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Charges incurred during a period of remission, charges incurred for treatment of a sickness or injury of a family member that are covered under another Plan provision, charges incurred for services rendered by a close relative, bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services.</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p><b>Ambulance – accidental injury</b></p> <p>Ambulance service within 72 hours of an accident is covered as follows:</p> <ul style="list-style-type: none"> <li>Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary).</li> <li>Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.</li> </ul>	<p>PPO: Nothing up to the Plan allowance</p> <p>Non-PPO: Nothing up to the Plan allowance</p>	<p>PPO: Nothing up to the Plan allowance</p> <p>Non-PPO: Nothing up to the Plan allowance</p>
<p><b>Ambulance – non-accidental injury</b></p> <ul style="list-style-type: none"> <li>Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary).</li> <li>Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.</li> </ul>	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means.</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

**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 calendar year deductible is \$350 per person (\$700 per family) under the High Option and \$450 per person (\$900 per family) under the Standard Option. 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.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay the services of radiologists, anesthesiologists and pathologists who are not preferred providers at the preferred provider rate. This non-standard benefit does not include the services of emergency room physicians.

**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.

Benefits Description	You pay After the calendar year deductible...	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does <i>not</i> apply.</p>		
Accidental injury	High Option	Standard Option
<p>If you receive care for your accidental injury within 72 hours, we cover:</p> <ul style="list-style-type: none"> <li>• Treatment outside a hospital or in the outpatient/emergency room department of a hospital</li> <li>• Related outpatient physician care</li> </ul> <p>Note: Emergency room charges associated directly with an inpatient admission are considered “Other charges” under Inpatient Hospital Benefits (see page 43) and are not part of this benefit, even though an accidental injury may be involved. Expenses incurred after 72 hours, even if related to the accident, are subject to regular benefits and are not paid at 100%. This provision also applies to dental care required as a result of accidental injury to sound natural teeth. Masticating (chewing) incidents are not considered to be accidental injuries.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Only the difference between our allowance and the billed amount (No deductible)</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Only the difference between our allowance and the billed amount (No deductible)</p>
<p>If you receive care for your accidental injury after 72 hours, we cover:</p> <ul style="list-style-type: none"> <li>• Non-surgical physician services and supplies</li> <li>• Surgical care</li> </ul> <p>Note: We pay hospital benefits if you are admitted.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

## High and Standard Option

Medical emergency	You pay High Option	You pay Standard Option
<p>Outpatient medical or surgical services and supplies billed by a hospital for emergency room treatment.</p> <p>Note: We pay hospital benefits if you are admitted.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
Ambulance – accidental injury		
<p>Ambulance service within 72 hours of an accident is covered as follows:</p> <ul style="list-style-type: none"> <li>Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary).</li> <li>Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.</li> </ul>	<p>PPO: Nothing up to the Plan allowance (no deductible)</p> <p>Non-PPO: Nothing up to the Plan allowance (no deductible)</p>	<p>PPO: Nothing up to the Plan allowance (no deductible)</p> <p>Non-PPO: Nothing up to the Plan allowance (no deductible)</p>
Ambulance – non-accidental injury		
<ul style="list-style-type: none"> <li>Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary).</li> <li>Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.</li> </ul>	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means.</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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

You may choose to get care In-Network or Out-of-Network. When you receive In-Network care, you must get precertification for certain services. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$350 per person (\$700 per family) under the High Option and \$450 per person (\$900 per family) under the Standard Option. 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.
- A High Option per admission deductible applies of \$100 (In-Network PPO) for inpatient hospital services.
- A per calendar year deductible of \$500 (Out-of-Network non-PPO) applies per person for inpatient hospital and Intensive Day Treatment.
- 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-Network mental health and substance abuse benefits are below; then Out-of-Network benefits begin on page 51.
- **YOU MUST GET PREAUTHORIZATION OF INPATIENT HOSPITAL SERVICES and IN-NETWORK OUTPATIENT INTENSIVE DAY TREATMENT.** See the instructions after the benefits descriptions below.

Benefits Description	You pay After the calendar year deductible...	You pay After the calendar year deductible...
<p><b>Note: The calendar year deductible applies to almost all benefits in this Section.</b> We say “(No deductible)” when it does <i>not</i> apply.</p>		
In-Network benefits	High Option	Standard Option
<p>Covered services for in-network providers.</p> <p>Note: In-network inpatient hospital and outpatient intensive day treatment benefits are payable only when we determine the care is clinically appropriate to treat your condition and is precertified.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>\$20 copayment per office visit (No deductible)</p>	<p>\$25 copayment per office visit (No deductible)</p>
<ul style="list-style-type: none"> <li>• Psychological tests (requires precertification)</li> <li>• Inpatient professional fees</li> <li>• Diagnostic tests</li> <li>• Laboratory tests to monitor the effect of drugs prescribed for your condition</li> </ul>	<p>10% of the Plan allowance</p>	<p>15% of the Plan allowance</p>

*In-Network benefits – continued on next page*

## High and Standard Option

In-Network benefits <i>(continued)</i>	You pay High Option	You pay Standard Option
<b>Inpatient hospital</b>		
Room and board, such as: <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate.  Note: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	Nothing (No deductible)	15% of the Plan allowance
Other hospital services and supplies: <ul style="list-style-type: none"> <li>• Services provided by a hospital</li> </ul>	10% of the Plan allowance  (\$100 per admission deductible applies)	15% of the Plan allowance
<b>Outpatient hospital</b>		
Services provided by a hospital including partial hospitalization or Intensive Day Treatment Programs.	10% of the Plan allowance	15% of the Plan allowance
<b>Emergency room – non-accidental injury</b>		
Outpatient services and supplies billed by a hospital for emergency room treatment  Note: We pay Hospital benefits if you are admitted.	10% of the Plan allowance	15% of the Plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Services we determine are not medically necessary</li> <li>• Marriage counseling</li> </ul>	<i>All charges</i>	<i>All charges</i>

### Precertification

To be eligible to receive these enhanced mental health and substance abuse benefits, you must follow the network authorization process:

- You must call Encompass at (888) 372-3190 to receive authorization for inpatient care and outpatient Intensive Day Treatment from a Network provider. They will authorize any covered treatment.
- You should call our Medical Management Department (800) 821-6136 to precertify benefits for psychological testing. Psychological testing claims will be denied if we determine the testing is not medically necessary.

### Network limitation

If you do not obtain precertification for inpatient care and outpatient intensive day treatment, we will decide whether the stay was medically necessary. If we determine the stay was medically necessary, we will pay the services less the \$500 penalty. If we determine that it was not medically necessary, we will only pay for any covered services that are otherwise payable on an outpatient basis. If you remain in the hospital beyond the days we approved and did not get the additional days precertified, we will pay inpatient benefits for the part of the admission that was medically necessary. See Section 3 for details.

Out-of Network benefits	You pay High Option	You pay Standard Option
<b>Out-of-Network mental health and substance abuse benefits</b>		
<ul style="list-style-type: none"> <li>• <b>Inpatient Hospital/Facility for treatment of mental health</b> <ul style="list-style-type: none"> <li>– 100-day limit per calendar year</li> <li>– Precertification required</li> </ul> </li> <li>• <b>Inpatient Hospital/Facility for treatment of alcoholism and drug abuse</b> <ul style="list-style-type: none"> <li>– 30-day maximum per lifetime.</li> <li>– Precertification required</li> </ul> </li> <li>• <b>Outpatient Hospital/Intensive Day Treatment Program for mental health/substance abuse</b> <ul style="list-style-type: none"> <li>– 60-day limit per calendar year</li> </ul> </li> </ul>	50% of the Plan allowance and any difference between our allowance and the billed amount; \$500 inpatient hospital and outpatient hospital/intensive day treatment deductible applies per person, per year	50% of the Plan allowance and any difference between our allowance and the billed amount; \$500 inpatient hospital and outpatient hospital/intensive day treatment deductible applies per person, per year
<ul style="list-style-type: none"> <li>• <b>Inpatient visits for psychotherapy</b> <ul style="list-style-type: none"> <li>– 100 inpatient visits limit per calendar year</li> </ul> </li> <li>• <b>Outpatient visits for psychotherapy and group sessions and psychological testing</b> <ul style="list-style-type: none"> <li>– 30 session limit per calendar year for treatment of mental health and substance abuse</li> </ul> </li> </ul>	50% of the Plan allowance and any difference between our allowance and the billed amount, \$350 calendar year deductible applies	50% of the Plan allowance and any difference between our allowance and the billed amount, \$450 calendar year deductible applies
<p><i>Not covered out-of-network:</i></p> <ul style="list-style-type: none"> <li>• <i>Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems</i></li> <li>• <i>Treatment for learning disabilities and mental retardation</i></li> <li>• <i>Telephone therapy</i></li> <li>• <i>Travel time to the member's home to conduct therapy</i></li> <li>• <i>Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs</i></li> <li>• <i>Marriage counseling</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

**Lifetime maximum** Out-of-network inpatient care for the treatment of alcoholism and drug abuse is limited to a 30-day maximum per lifetime.

**Precertification** The medical necessity of your admission to a hospital or other covered facility for mental health or substance abuse must be precertified. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits will be reduced. See Section 3 for details.

- Call Encompass at (888) 372-3190 to precertify.
- You should call our Medical Management Department (800) 821-6136 to precertify benefits for psychological testing. Psychological testing claims will be denied if we determine the testing is not medically necessary.

See these sections of the brochure for more valuable information about these benefits:

Section 3, *How you get care*, for information about catastrophic protection for these benefits.

Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

Section 5(f) Prescription drug benefits

**Important things you should keep in mind about these benefits and features you should be aware of:**

- We cover prescribed drugs and medications, as described in the chart beginning on page 55.
- 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.
- There is no calendar year deductible for prescription drugs.
- 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.
- Under the High Option plan, if Medicare is your primary insurance and you have both Medicare Part A & B coverage, you pay less for your prescriptions (see page 57).
- Based on manufacturer’s and FDA guidelines, the use of a certain medication may be limited as to its quantity, total dose, duration of therapy, age, gender or specific diagnosis. Since the prescription does not usually explain the reason the provider prescribed a medication, the requirement of any of these limits and/or prior authorization to confirm the intent of the prescriber may be appropriate.
- Some medications must be approved by GEHA and/or Medco before you may purchase them.
- If you need an extra supply of medications in emergency situations such as if you are called to active military duty or as a part of the government’s continuity of operations, you may receive an extra 30-day supply at retail or if you received a 90-day supply of a specific medication within the last thirty days, arrangements can be made for an additional 60 days to be dispensed through Medco By Mail. Call our office at (800) 821-6136 so that we can work with you to find the most cost effective and efficient manner of meeting your emergency prescription needs.
- Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, and a mail order form, questionnaire, and reply envelope.
- As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including names of your prescribing physicians, to any treating physician or dispensing pharmacies.
- **Who can write your prescription:** A licensed physician or a licensed dentist must write the prescription. For Medco By Mail prescriptions, the physician must be licensed in the United States. In addition, your mailing address must be within the United States or include an APO address.
- **Where you can obtain them:** You may fill the prescription at a participating network retail pharmacy, a non-network pharmacy, or through Medco By Mail. We pay a higher level of benefits when you use a network pharmacy. For medications you may take on a regular, long-term basis we pay a higher level of benefits through Medco By Mail.

Prescription drug benefits

**Covered medications and supplies**

- You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:
- Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not Covered*;
- Insulin;
- Needles and syringes for the administration of covered medications;
- Contraceptive drugs;
- Ostomy supplies (please include the manufacturer’s product number to ensure accurate fill of the product).

Note: A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written, when a Federally-approved generic drug is available unless substitution is prohibited by state law.

*Prescription drug benefits - continued on next page*

**Prescription drug benefits** *(continued)***High Option – three-tier drug benefit**

Under the **High Option**, we divide prescription drugs into three categories or tiers: generic, single-source brand name, and multi-source brand name. Multi-source brand name is not applicable to overseas prescription drugs. When an approved generic equivalent is available, that is the drug you will receive, unless you or your physician specifies that the prescription must be filled as written. When an approved generic equivalent is not available, you will pay the brand name single-source copayment. If an approved generic equivalent is available, but you or your physician specifies that the prescription must be filled as written, you will pay the \$5.00 copayment plus the difference in the cost of the generic drug and the brand name multi-source drug.

- **Generic drugs:** are chemically and therapeutically equivalent to the corresponding brand drug, but are available at a lower price. Equivalent generic products for brand name medications become available after a patent and other exclusivity rights for the brand expire. The Food and Drug Administration must approve all generic versions of a drug and assure that they meet strict standards for quality, strength and purity. The FDA requires that generic equivalent medications contain the same active ingredients and be equivalent in strength and dosage to brand name drugs. The main difference between a generic and its brand name drug is the cost of the product.
- **Single-source** brand name drugs are available from only one manufacturer and are patent-protected. No generic equivalent is available.
- **Multi-source** brand name drugs are available from more than one manufacturer and have a least one generic equivalent alternative available.

**Coordinating with other drug coverage**

If you also have drug coverage through another group health insurance plan and we are your secondary insurance, follow these procedures:

At participating pharmacies, do not present your GEHA drug card. Purchase your drug using the RX card issued by your primary insurance carrier. Then, mail your pharmacy receipt to GEHA for consideration of possible reimbursement. If your primary insurance does not provide an RX card, then purchase your drug and submit the bill to your primary insurance. When they have made payment, file the claims and the Explanation of Benefit (EOB) with GEHA for consideration of possible reimbursement. In any event, if you use GEHA's prescription drug card when another insurance is primary, you will be responsible for reimbursing us any amount in excess of our secondary benefit.

Drugs purchased at non-participating pharmacies should be submitted to our claims office (see page 109) along with the primary insurance EOB. We will accept either the drug receipts or a Medco drug claim form. **Submit these claims to GEHA, P.O. 4665, Independence, MO 64051-4665, when we are your secondary insurance.**

If another insurance is primary, you should use their drug benefit. If you elect to use Medco By Mail, Medco will bill you directly. Pay Medco the amount billed and submit the bill to your primary insurance. When your primary insurance makes payment, file the claim and their EOB to us (see page 109).

Should Medicare rules change on prescription drug coverage, we reserve the right to require you to use your Medicare coverage as the primary insurance for these drugs.

**Medco voluntary formulary**

Your prescription drug program includes a voluntary "formulary" feature. The Medco Drug Formulary is a list of selected FDA approved prescription medications reviewed by an independent group of distinguished health care professionals. Prescription drugs are subjected to rigorous clinical analysis from the standpoint of efficacy, safety, side effects, drug-to-drug interactions, dosage and cost-benefit in determining whether they are included on or excluded from the formulary.

A formulary is a list of commonly prescribed medications from which your physician may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other non-formulary medications, can help contain the increasing cost of prescription drug coverage without sacrificing quality. In many therapeutic categories, there are several drugs of similar effectiveness. Many doctors are often unaware of the significant variations in price among these similar drugs and, as a result, their prescribing decisions often do not consider cost. However, when the cost difference is brought to their attention, doctors will frequently prescribe the less costly medications.

Your physicians will be contacted to discuss their prescribing decision. No change in the medication prescribed will be made without your physicians' approval. Compliance with this formulary list is voluntary and there is no financial penalty for obtaining drugs not on the formulary list.

**Any rebates or savings received by the Plan on the cost of drugs purchased under this plan from drug manufacturers are credited to the health plan and are used to reduce health care costs.**

*Prescription drug benefits - continued on next page*

### Prescription drug benefits *(continued)*

#### Patient Safety

GEHA has several programs to promote patient safety. Through these programs, we work to ensure safe and appropriate quantities of medication are being dispensed. The result is improved care and safety for our members. Patient safety programs include:

- Prior approval – Approval must be obtained for certain prescription drugs and supplies before providing benefits for them.
- Quantity allowances – Specific allowances are in place for certain medications, based on manufacturer and FDA recommended guidelines.
- Pharmacy utilization – GEHA reserves the right to maximize your quality of care as it relates to the utilization of pharmacies.

GEHA will participate in other approved managed care programs, as deemed necessary, to insure patient safety.

#### How to use Medco network pharmacies (retail)

You may fill your prescription at any participating retail pharmacy. For the names of participating pharmacies, call (800) 551-7675 or visit [www.medco.com](http://www.medco.com). To receive maximum savings you must present your card at the time of each purchase, and your enrollment information must be current and correct. In most cases, you simply present the card together with the prescription to the pharmacist. Each purchase is limited to a 30-day supply. Any prescription purchased twice at retail, regardless of the quantity purchased is considered maintenance medication. We pay a higher level of benefits for maintenance medication through Medco By Mail.

Refills cannot be obtained until **75%** of the drug has been used. Refills for maintenance medications are not considered new prescriptions except when the doctor changes the strength or 180 days has elapsed since the previous purchase. As part of the administration of the prescription drug program, we reserve the right to maximize your quality of care as it relates to the utilization of pharmacies. Some medications may require prior approval by Medco or GEHA.

#### How to use Medco By Mail (mail order)

Through this service, you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, ostomy supplies, diabetic supplies and insulin, syringes and needles for covered injectable medications, and oral contraceptives. Some medications may not be available in a 90-day supply from Medco even though the prescription is for 90 days. Even though insulin, syringes, diabetic supplies and ostomy supplies do not require a physician's prescription, to obtain through Medco By Mail, you should obtain a prescription (including the product number for ostomy and insulin pump supplies) from your physician for a 90-day supply.

Some medications may require approval by Medco or GEHA. Not all drugs are available through Medco By Mail. In order to use Medco By Mail, your prescriptions must be written by a physician licensed in the United States. In addition, your mailing address must be within the United States or include an APO address.

Each enrollee will receive a kit that includes a brochure describing the Medco By Mail service, an order form, a questionnaire, and a return envelope.

**To order new prescriptions**, ask your doctor to prescribe needed medication for up to a 90-day supply, plus refills, if appropriate. Complete the Health, Allergy, & Medication Questionnaire the first time you order through this service. Complete the information on the Ordering Medication Form, enclose your prescription and the correct copayment.

Mail to: Medco

P.O. Box 30493

Tampa, FL 33630-3493

You should receive your medication within 14 days from the date you mail your prescription. You will also receive reorder instructions. If you have any questions or need an emergency consultation with a registered pharmacist, you may call Medco toll-free at (800) 551-7675 available 24 hours a day, 7 days a week except Thanksgiving and Christmas. Forms necessary for refills will be provided each time you receive a supply of medication from the service.

**Refilling your medication:** to be sure you never run short of your prescription medication, you should re-order on or after the refill date indicated on the refill slip or when you have approximately 14 days of medication left.

**To order by phone:** Call Member Services at (800) 551-7675. Have your refill slip with the prescription information ready.

**To order by mail:** Simply mail your refill slip and copayment in the return envelope.

**To order online:** Go to [www.geha.com/prescriptions/home\\_delivery.html](http://www.geha.com/prescriptions/home_delivery.html) then click on the link to Medco, or go to [www.medco.com](http://www.medco.com).

*Prescription drug benefits - continued on next page*

<b>Prescription drug benefits (continued)</b>		
<b>Benefits Description</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<b>Note: The calendar year deductible does not apply to benefits in this Section.</b>		
<b>Covered medications and supplies – when GEHA is primary</b>		
<p><b>Medco Network Pharmacy (retail)</b></p> <p>All copayments are for up to a 30-day supply.</p> <p>A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when a Federally-approved generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance.</p> <p>Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills.</p> <p>Note: Medications to treat some severe and chronic medical conditions are not available at Medco participating retail pharmacies but are available through Medco Specialty Pharmacy program. See pages 28-29 for the categories of drugs in this program.</p>	<p>\$5 generic, 25% single-source brand name drugs up to a maximum of \$150 for up to a 30-day supply,</p> <p>\$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name drugs,</p> <p>If you choose a brand name drug for which a generic drug exists, you will pay the generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization.</p> <p>Initial fill not to exceed a 30-day supply, and the first refill. For all subsequent refills, you pay the greater of 50% or the amount described above.</p>	<p>\$5 generic 50% brand name</p> <p>Initial amount prescribed, for up to a 30-day supply</p>

*Prescription drug benefits – continued on next page*

## High and Standard Option

Prescription drug benefits <i>(continued)</i>	You pay High Option	You pay Standard Option
<p>Covered medications and supplies - when GEHA is primary - <i>continued</i></p> <p><b>Non-Network Retail</b></p> <p>If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to:</p> <p>Medco P.O. Box 14711 Lexington, KY 40512</p> <p>Your claim will be calculated on the coinsurance or the appropriate copayments. Reimbursement will be based on GEHA's costs had you used a participating pharmacy. You must submit original drug receipts.</p> <p>All copayments are for up to a 30-day supply.</p> <p>Note: When a claim is submitted for direct reimbursement of a compound medication, the pricing is based on the contractual Average Wholesale Price (AWP) cost of each active prescription component submitted. The professional fee and applicable sales tax are also included in the pricing.</p> <p>Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills.</p>	<p>\$5 generic, 25% single-source brand name drugs up to a maximum of \$150 for up to a 30-day supply, \$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name drugs, If you choose a brand name drug for which a generic drug exists, you will pay the generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization. (and any difference between our allowance and the cost of the drug) Initial fill not to exceed a 30-day supply, and the first refill. For all subsequent refills, you pay the greater of 50% or the amount described above.</p>	<p>\$5 generic 50% brand name  (and any difference between our allowance and the cost of the drug)</p>
<p><b>Medco By Mail</b></p> <p>All copayments are for up to a 90-day supply.</p> <p>A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when a Federally-approved generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance.</p> <p>Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills.</p>	<p>\$15 generic, 25% single-source brand name drugs up to a maximum of \$350 for up to a 90-day supply, \$15 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name drugs. If you choose a brand name drug for which a generic drug exists, you will pay the generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization.</p>	<p>\$15 generic 50% brand name</p>

*Prescription drug benefits – continued on next page*

Prescription drug benefits <i>(continued)</i>	You pay High Option	You pay Standard Option
<b>Covered medications and supplies – Medicare A &amp; B primary</b>		
<p><b>Medco Network Pharmacy (retail)</b></p> <p>All copayments are for up to a 30-day supply.</p> <p>A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written, (DAW) when a Federally-approved generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance.</p> <p>Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills.</p> <p>Note: Medications to treat some severe and chronic medical conditions are not available at Medco participating retail pharmacies but are available through Medco Specialty Pharmacy program. See pages 28-29 for the categories of drugs in this program.</p>	<p>\$5 generic,</p> <p>20% single-source brand name drugs up to a maximum of \$150 for up to a 30-day supply,</p> <p>\$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name drugs,</p> <p>If you choose a brand name drug for which a generic drug exists, you will pay the generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization.</p> <p>Initial fill not to exceed a 30-day supply, and the first refill. For all subsequent refills, you pay the greater of 50% or the amount described above.</p>	<p>\$5 generic</p> <p>50% brand name</p> <p>Initial amount prescribed, for up to a 30-day supply</p>

*Prescription drug benefits - continued on next page*

## High and Standard Option

Prescription drug benefits <i>(continued)</i>	You pay High Option	You pay Standard Option
<p>Covered medications and supplies – Medicare A &amp; B primary - <i>continued</i></p> <p><b>Non-Network Retail</b></p> <p>If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to:</p> <p>Medco P.O. Box 14711 Lexington, KY 40512</p> <p>Your claim will be calculated on the coinsurance or the appropriate copayments. Reimbursement will be based on GEHA's costs had you used a participating pharmacy. You must submit original drug receipts.</p> <p>All copayments are for up to a 30-day supply.</p> <p>Note: When a claim is submitted for direct reimbursement of a compound medication, the pricing is based on the contractual Average Wholesale Price (AWP) cost of each active prescription component submitted. The professional fee and applicable sales tax are also included in the pricing.</p> <p>Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills.</p>	<p>\$5 generic,</p> <p>20% single-source brand name drugs up to a maximum of \$150 for up to a 30-day supply,</p> <p>\$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name drugs,</p> <p>If you choose a brand name drug for which a generic drug exists, you will pay the generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization.</p> <p>(and any difference between our allowance and the cost of the drug)</p> <p>Initial fill not to exceed a 30-day supply, and the first refill. For all subsequent refills, you pay the greater of 50% or the amount described above and any difference between our allowance and the cost of the drug.</p>	<p>\$5 generic</p> <p>50% brand name</p> <p>(and any difference between our allowance and the cost of the drug)</p>
<p><b>Medco By Mail</b></p> <p>All copayments are for up to a 90-day supply.</p> <p>A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when a Federally-approved generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance.</p> <p>Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a \$4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills.</p>	<p>\$10 generic,</p> <p>15% single-source brand name drugs up to a maximum of \$350 for up to a 90-day supply,</p> <p>\$10 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name drugs.</p> <p>If you choose a brand name drug for which a generic drug exists, you will pay the generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization.</p>	<p>\$15 generic</p> <p>50% brand name</p>

*Prescription drug benefits - continued on next page*

<b>Prescription drug benefits (continued)</b>	<b>You pay High Option</b>	<b>You pay Standard Option</b>
<b>Non-covered medications and supplies</b>		
<p><i>The following medications and supplies are not covered under the GEHA health plan.</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them including enteral formula available without a prescription</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Drugs to aid in smoking cessation except those limited to the \$100 lifetime maximum as part of the smoking cessation benefit (see page 34). You may not obtain smoking cessation drugs with your Medco prescription card or through Medco By Mail. You must purchase these drugs and file the claim with us.</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Drugs which are investigational</i></li> <li>• <i>Drugs prescribed for weight loss</i></li> <li>• <i>Drugs to treat infertility</i></li> <li>• <i>Drugs to treat impotency</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

**Section 5(g) Special features**

<b>Special features</b>	<b>Description</b>
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue.</li> <li>• Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.</li> <li>• If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<b>Services for deaf and hearing impaired</b>	<p>TDD service is available at (800) 821-4833 for members who are hearing impaired.</p>
<b>High risk pregnancies</b>	<p>To participate in our enhanced maternity program, call (800) 821-6136 at any time as soon as you think you or your covered dependent may be pregnant. Early participation in the program guarantees you ongoing communication with a registered nurse throughout the pregnancy. Complimentary educational materials include the book “From Here to Maternity”.</p>

**Section 5(h) 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.
- There is no calendar year deductible for dental benefits.
- 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.

**Accidental injury benefit**

We cover restorative services and supplies necessary to promptly repair sound natural teeth. The need for these services must result from an accidental injury. The repair of accidental injury to sound natural teeth includes but is not limited to, expenses for X-rays, drugs, crowns, bridgework, inlays, and dentures. Masticating (biting or chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at 100% for charges incurred within 72 hours of an accident. Services incurred after 72 hours are paid at regular Plan benefits.

**Dental benefits**

Service	High Option Scheduled Allowance	High Option Scheduled Allowance	Standard Option Scheduled Allowance	Standard Option Scheduled Allowance
	We pay	You pay	We pay	You pay
Diagnostic and preventive services, limited to two visits per year including examination, prophylaxis (cleaning), X-rays of all types and fluoride treatment. Benefits are payable per visit not per service	\$22 per visit (maximum two visits per year)	All charges in excess of the scheduled amount listed to the left	50% up to the plan allowance for diagnostic and preventive services per year as follows:  Two examinations per person, per year;  Two prophylaxis (cleanings) per person, per year;  Two fluoride treatments per person, per year;  \$150 in allowed X-ray charges per person, per year (payable at 50%)	50% up to the plan allowance and all charges in excess of the plan allowance for diagnostic and preventive services
<b>Amalgam restorations</b> <b>Resin- Based Composite Restorations</b> <b>Gold Foil Restorations</b> <b>Inlay/Onlay Restorations</b>	\$21 One surface,  \$28 Two or more surfaces	All charges in excess of the scheduled amounts listed to the left	\$21 One surface,  \$28 Two or more surfaces	All charges in excess of the scheduled amounts listed to the left
<b>Simple Extractions</b>	\$21 Simple extraction	All charges in excess of the scheduled amount listed to the left	\$21 Simple extraction	All charges in excess of the scheduled amount listed to the left

**High Deductible Health Plan Benefits**

See pages 8-9 for how our benefits changed this year and page 135 for a benefits summary.

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## Section 5 High Deductible Health Plan 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 the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6, they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at (800) 821-6136 or at our Web site at [www.geha.com](http://www.geha.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 HRA based upon your eligibility.

With this Plan, preventive care is covered in full up to \$300 per adult per year. 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 76. 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.

- **Savings**

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

### **Health Savings Accounts (HSA)**

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 medical benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2006, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$60 per month for a Self Only enrollment or \$120 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$1,100 for Self Only or \$2,200 for Self and Family. See maximum contribution information on page 68. 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 HSA Bank™
- Your contributions to the HSA are tax deductible
- 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:** If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Instead, when you inform us of your coverage in an FSA, we will establish an HRA for you.

**Health Reimbursement Arrangements (HRA)**

If you aren't 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 2006, we will give you an HRA credit of \$720 per year for a Self Only enrollment and \$1,440 per year for a 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 GEHA
- 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?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS*

• **Preventive care**

The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., cancer screenings, cardiac screenings, and mammograms), well-child care, and child and adult immunizations. These services are covered at 100% up to \$300 per adult per year and are fully described in Section 5 *Preventive care*. Preventive care for children is covered at 100% and not subject to this limit. *You do not have to meet the deductible before using these services.*

This plan also provides vision care benefits through Avesis, Inc., and provides dental coverage. *You do not have to meet the deductible before using these services.*

The calendar year deductible does *not* apply to the following services:

- Supplemental vision care through Avesis Vision Care Plan;
- Dental benefits (50% of plan allowance for diagnostic and preventive services twice per year).

• **Traditional medical coverage**

After you have paid the Plan's deductible, we pay benefits under Traditional medical coverage described in Section 5. The Plan typically pays 85% for in-network and 70% for out-of-network care.

Covered services include:

- Medical services and supplies provided by physicians and other health care professionals
- Surgical and anesthesia services provided by physicians and other health care professionals
- Hospital services; other facility or ambulance services
- Emergency services/accidents
- Mental health and substance abuse benefits (an additional \$500 deductible applies for out-of-network non-PPO providers for inpatient hospital and outpatient hospital/intensive day treatment per person, limit of two per family, per calendar year)
- Prescription drug benefits (covered at 70%)

- **Catastrophic protection for out-of-pocket expenses** Your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$5,000 per person or \$10,000 per 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.
- **Health education resources and account management tools** HDHP Section 5(h) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

**Section 5 Savings – HSAs and HRAs**

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA</b>
<b>Administrator</b>	The Plan will establish an HSA for you with HSA Bank™ (P. O. Box 939, Sheboygan, WI 53082-0939, toll-free (866) 471-5964, <a href="http://www.hsabank.com">www.hsabank.com</a> ), this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS).	GEHA (P.O. Box 168, Independence, MO 64051-0168, toll-free (800) 821-6136, <a href="http://www.geha.com">www.geha.com</a> ) is the HRA fiduciary for this Plan.
<b>Fees</b>	Set-up fee is paid by the HDHP.  \$1.75 per month administrative fee charged by the fiduciary and taken out of the account balance until it reaches \$3,000.	None
<b>Eligibility</b>	<p>You must:</p> <ul style="list-style-type: none"> <li>• Enroll in this HDHP</li> <li>• Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage)</li> <li>• Not be enrolled in Medicare Part A or Part B</li> <li>• Not be claimed as a dependent on someone else’s tax return</li> <li>• Must not have received VA medical benefits in the last three months</li> <li>• Complete and return all banking paperwork.</li> </ul> <p>Eligibility for contributions is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment. If your eligibility changes mid year, please contact GEHA.</p>	<p>You must enroll in this HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.</p> <p>If you enroll in GEHA Health Savings Advantage (HDHP) and do not qualify for an HSA, we will establish an HRA for you.</p> <p>If your eligibility changes mid year, please contact GEHA.</p>
<b>Funding</b>	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.	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.
• <b>Self Only enrollment</b>	For 2006, a monthly premium pass through of \$60 will be made by the HDHP directly into your HSA each month.	For 2006, your HRA annual credit is \$720 (prorated for length of enrollment).
• <b>Self and Family enrollment</b>	For 2006, a monthly premium pass through of \$120 will be made by the HDHP directly into your HSA each month.	For 2006, your HRA annual credit is \$1440 (prorated for length of enrollment).

	<b>HSA</b>	<b>HRA</b>
<b>Contributions/credits</b>	<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 amount of the deductible, which is \$1,100 for Self Only or \$2,200 for Self and Family. This amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA.</p> <p>For each month you are eligible for HSA contributions, if you choose to contribute to your HSA:</p> <ul style="list-style-type: none"> <li>– The maximum allowable contribution is a combination of employee and employer funds up to the amount of the deductible of \$1,100 for Self Only or \$2,200 for Self and Family. To determine the maximum allowable contribution, take the amount of your deductible divided by 12, times the number of full months enrolled in the HDHP. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute.</li> <li>– 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).</li> <li>– HSAs earn tax-free interest (does not affect your annual maximum contribution).</li> <li>– Catch-up contribution discussed on page 71.</li> </ul>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.</p>
<b>• Self Only enrollment</b>	See above	You cannot contribute to the HRA.
<b>• Self and Family enrollment</b>	See above	You cannot contribute to the HRA.
<b>Access funds</b>	<p>You can access your HSA by the following methods:</p> <p>Debit card Withdrawal form Checks</p>	<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>

	<b>HSA</b>	<b>HRA</b>
<p><b>Distributions/withdrawals</b></p> <ul style="list-style-type: none"> <li>• <b>Medical</b></li> </ul>	<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>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</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 <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. 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"> <li>• <b>Non-medical</b></li> </ul>	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% 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 10% 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> <p>Medicare premiums are reimbursable.</p>
<p><b>Availability of funds</b></p>	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> <li>– Your enrollment in this HDHP is effective (effective date is determined by your agency in accordance with the event permitting the enrollment change).</li> <li>– 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.</li> <li>– The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.</li> </ul>	<p>The entire amount of your HRA will be available to you upon your enrollment in the HDHP.</p>
<p><b>Account owner</b></p>	<p>FEHB enrollee</p>	<p>HDHP</p>

**HDHP**

	<b>HSA</b>	<b>HRA</b>
<b>Portable</b>	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA.</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. Unused funds are forfeited.</p>
<b>Annual rollover</b>	<p>Yes, accumulates without a maximum cap.</p>	<p>Yes, accumulates without a maximum cap.</p>

**If you have an HSA**

**• Contributions**

All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), 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. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was effective after January 1, 2006, you would need to deduct 1/12 of the annual maximum contribution. Contact HSA Bank™ (P. O. Box 939, Sheboygan, WI 53082-0939, toll free (866) 471-5964 [www.hsabank.com](http://www.hsabank.com) for more details.

**• Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2006, you may contribute up to \$700 in catch-up contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at [www.ustreas.gov/offices/public-affairs/hsa/](http://www.ustreas.gov/offices/public-affairs/hsa/).

**• If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it 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, 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 any 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 Web site at [www.irs.gov](http://www.irs.gov) and click on “Forms and Publications”. Note: Although 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 10% 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. Just like a normal bank account, you cannot reimburse yourself for expenses that are greater than the balance in the account.

## 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 pages 67-70 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, and
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP.

## Section 5 Preventive care

**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
- Benefits in this Section are limited to \$300 per adult, per calendar year. Preventive care for children is not subject to this limit. The calendar year deductible does not apply to benefits in this Section. For other covered services not listed below see Section 5(a). Note: Preventive services in excess of the annual allowance of \$300 per adult would be applied to your calendar year deductible and payable under Traditional medical coverage benefits.
- There is no calendar year deductible for the dental benefits listed below.
- 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. If Medicare is your primary payer, GEHA will provide secondary benefits for covered charges. The high-deductible health plan deductible and coinsurance is not waived for Medicare members.
- The benefits listed below are for the charges billed by a hospital, physician, or other health care professional for your care.

Benefits Description	You pay
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**Note: The calendar year deductible does *not* apply to benefits in this Section.**

<b>Preventive care, adult</b>	
<p>Professional services such as:</p> <ul style="list-style-type: none"> <li>• Routine physical examinations</li> </ul> <p>Routine screenings, limited to:</p> <ul style="list-style-type: none"> <li>• Total blood cholesterol screenings</li> <li>• Chlamydial infection</li> <li>• Colorectal cancer screening, including                             <ul style="list-style-type: none"> <li>– Annual coverage of one fecal occult blood test for members age 40 and older</li> </ul> </li> </ul> <p>The following screenings at intervals recommended by the American Cancer Society:</p> <ul style="list-style-type: none"> <li>– Colonoscopy</li> <li>– Double contrast barium enema</li> <li>– Sigmoidoscopy</li> <li>• Prostate cancer screening                             <ul style="list-style-type: none"> <li>– Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older</li> </ul> </li> <li>• Routine Pap test                             <ul style="list-style-type: none"> <li>– Annual coverage of one Pap smear for women age 18 and older</li> </ul> </li> <li>• Routine mammogram                             <ul style="list-style-type: none"> <li>– Mammograms for diagnostic and/or routine screening</li> </ul> </li> <li>• Routine immunizations                             <ul style="list-style-type: none"> <li>– Tetanus-diphtheria (Td) booster</li> <li>– Influenza/Pneumococcal vaccines</li> </ul> </li> </ul>	<p>PPO: Nothing up to \$300 of the Plan allowance per person</p> <p>Non-PPO: Nothing up to \$300, except any difference between our Plan allowance and the billed amount</p>

<b>Preventive care, adult</b> <i>(continued)</i>	<b>You pay</b>
Professional services - <i>continued</i> <ul style="list-style-type: none"> <li>• Osteoporosis screening                             <ul style="list-style-type: none"> <li>– Bone density tests for osteoporosis screening as recommended by specialty organizations such as the U. S. Preventive Services Task Force or the National Osteoporosis Foundation</li> </ul> </li> </ul>	PPO: Nothing up to \$300 of the Plan allowance per person  Non-PPO: Nothing up to \$300, except any difference between our Plan allowance and the billed amount
<b>Preventive care, children</b>	
For dependent children under age 22: <ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Well-child care charges for routine examinations, immunizations and care</li> <li>• Initial examination of a newborn child covered under a family enrollment</li> </ul>	PPO: Nothing  Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount.
<i>Not Covered:</i> <ul style="list-style-type: none"> <li>• Professional fees for automated lab tests</li> </ul>	All charges

<b>Dental benefits</b>		
<b>Service</b>	<b>We pay (Scheduled Allowance)</b>	<b>You pay</b>
Diagnostic and preventive services, limited to two visits per year including examination, prophylaxis (cleaning), X-rays of all types and fluoride treatment. Benefits are payable per visit not per service	50% up to the Plan allowance for diagnostic and preventive services per year as follows: Two examinations per person, per year; Two prophylaxis (cleanings) per person, per year; Two fluoride treatments per person, per year; \$150 in allowed X-ray charges per person, per year (payable at 50%)	50% up to the Plan allowance and all charges in excess of the Plan allowance for diagnostic and preventive services
<b>Amalgam restorations</b> <b>Resin- Based Composite Restorations</b> <b>Gold Foil Restorations</b> <b>Inlay/Onlay Restorations</b>	\$21 One surface, \$28 Two or more surfaces	All charges in excess of the scheduled amounts listed to the left
<b>Simple Extractions</b>	\$21 Simple extraction	All charges in excess of the scheduled amount listed to the left

**Supplemental vision care**

Avesis Vision Care Plan (800) 672-7552

Using Avesis Incorporated:

- Avesis will process all claims

The following supplemental vision services are covered outside of the HDHP and are not subject to the plan deductible.

	<u>Examination</u>	<u>Spectacle Lenses</u>	<u>Frame</u>	<u>Contact Lenses</u>
<b>GEHA Plan</b>	12 months	12 months	24 months	12 months

	<u>In-Network</u>	<u>Out-of-Network</u>
<b><u>Eye Examination</u></b>	Covered in full after a \$10 exam copay	Reimbursed up to \$35
<b><u>Spectacle Lenses (pair)</u></b>		
<i>Standard Single Vision</i>	Covered in full after a \$10 materials copay	Reimbursed up to \$25
<i>Standard Bifocal</i>	Covered in full after a \$10 materials copay	Reimbursed up to \$40
<i>Standard Trifocal</i>	Covered in full after a \$10 materials copay	Reimbursed up to \$50
<i>Standard Lenticular</i>	Covered in full after a \$10 materials copay	Reimbursed up to \$80
<i>Progressive</i>	20% off U & C, minus \$50 allowance after a \$10 materials copay	Reimbursed up to \$40
<b><u>Lens Options</u></b>	Preferred Pricing (20% off retail)	No reimbursement
<b><u>Frame</u></b>	Covered in full after a \$10 materials copay with a \$35 or less wholesale value (approx. retail of \$75 to \$100)	Reimbursed up to \$45
<b><u>Contact Lenses</u></b>	<i>(In lieu of frame and spectacle lenses)</i>	
<i>Elective</i>	\$110 allowance after a \$10 materials copay	Reimbursed up to \$110
<i>Medically necessary</i>	Covered in full after a \$10 materials copay (excluding lenses covered under the Traditional medical coverage benefits)	Reimbursed up to \$250

**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.
- Preventive care is covered at 100% (see pages 73-75) up to the annual limit and is not subject to the calendar year deductible. After the annual limit on preventive care has been reached, additional preventive care is covered under Traditional medical coverage subject to the deductible.
- The deductible is \$1,100 per person or \$2,200 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to 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 \$5,000 per person or \$10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (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).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- 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...
<b>Deductible before Traditional medical coverage begins</b>	
The deductible applies to all benefits in this Section. When you receive covered services, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,100 per person or \$2,200 per 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.	<p>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.</p> <p>Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.</p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The calendar year deductible applies to all benefits in this Section. Note: Preventive services in excess of the annual allowance of \$300 per adult would be applied to your deductible and payable under Traditional medical coverage benefits. Non-covered charges and charges in excess of the plan allowable do not count toward the deductible.
- 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.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- The amounts listed below are for the charges billed by the physician or other health care professional for your care.
- 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. If Medicare is your primary payer, GEHA will provide secondary benefits for covered charges. The high-deductible health plan deductible and coinsurance are not waived for Medicare members.
- **YOU MUST GET PRECERTIFICATION OF CERTAIN OUTPATIENT IMAGING PROCEDURES. FAILURE TO DO SO WILL RESULT IN A MINIMUM OF \$100 PENALTY.** Please refer to precertification information in Section 3 to be sure which procedures require precertification. Penalties are not subject to the catastrophic limit.

Benefits Description	You pay After the calendar year deductible...
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• Routine physical examinations</li> <li>• Office medical consultations</li> <li>• Second surgical opinions</li> <li>• Emergency room physician care (non-accidental injury)</li> <li>• During a hospital stay</li> <li>• At home</li> <li>• In an urgent care center</li> </ul> Note: The facility charge for clinic or office visits is considered a part of the fee charged by the physician.	PPO: 15% of the Plan allowance  Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT Scans/MRI (outpatient requires precertification)</li> <li>• Double contrast barium enemas</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Professional fees for automated lab tests</li> </ul>	<p><i>All charges</i></p>
Preventive care, adult	
<p>Professional services such as:</p> <ul style="list-style-type: none"> <li>• Routine physical examinations</li> </ul> <p>Routine screenings, limited to:</p> <ul style="list-style-type: none"> <li>• Total blood cholesterol screenings</li> <li>• Chlamydial infection</li> <li>• Colorectal cancer screening, including                             <ul style="list-style-type: none"> <li>– Annual coverage of one fecal occult blood test for members age 40 and older</li> </ul> </li> </ul> <p>The following screenings at intervals recommended by the American Cancer Society:</p> <ul style="list-style-type: none"> <li>– Colonoscopy</li> <li>– Double contrast barium enema</li> <li>– Sigmoidoscopy</li> <li>• Prostate cancer screening                             <ul style="list-style-type: none"> <li>– Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older</li> </ul> </li> <li>• Routine Pap test                             <ul style="list-style-type: none"> <li>– Annual coverage of one Pap smear for women age 18 and older</li> </ul> </li> <li>• Routine mammogram                             <ul style="list-style-type: none"> <li>– Mammograms for diagnostic and/or routine screening</li> </ul> </li> <li>• Routine immunizations                             <ul style="list-style-type: none"> <li>– Tetanus-diphtheria (Td) booster</li> <li>– Influenza/Pneumococcal vaccines</li> </ul> </li> <li>• Osteoporosis screening                             <ul style="list-style-type: none"> <li>– Bone density tests for osteoporosis screening as recommended by specialty organizations such as the U. S. Preventive Services Task Force or the National Osteoporosis Foundation</li> </ul> </li> </ul>	<p>PPO: 15% of the Plan allowance (after the Preventive care limit of \$300)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (after the Preventive care limit of \$300)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Professional fees for automated lab tests</li> </ul>	<p><i>All charges</i></p>

<b>Preventive care, children</b>	<b>You pay</b>
<p>For dependent children under age 22:</p> <ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Well-child care charges for routine examinations, immunizations and care</li> <li>• Initial examination of a newborn child covered under a family enrollment</li> </ul>	<p>PPO: Nothing</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount.</p>
<p>Vision examinations, limited to:</p> <ul style="list-style-type: none"> <li>• Examinations for amblyopia and strabismus</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Professional fees for automated lab tests</i></li> </ul>	<p><i>All charges</i></p>
<b>Maternity care</b>	<b>You pay</b>
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> <li>• Physician care such as sonograms</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your doctor, or your hospital must precertify.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay.</li> <li>• We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. See Hospital benefits and Surgery benefits.</li> <li>• Circumcision is covered under Surgery benefits.</li> <li>• Approved fetal monitors are covered the same as other medical benefits for diagnostic and treatment services.</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Home uterine monitoring devices, unless preauthorized by our Medical Director.</i></li> <li>• <i>Charges 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 rape or incest.</i></li> <li>• <i>Charges for services and supplies incurred after termination of coverage.</i></li> </ul>	<p><i>All charges</i></p>

Family planning	You Pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures)</li> <li>• Surgically implanted contraceptives</li> <li>• Injectable contraceptive drugs (such as Depo provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Reversal of voluntary surgical sterilization</li> <li>• Genetic counseling</li> <li>• Preimplantation genetic diagnosis (PGD)</li> </ul>	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility, except as shown in <i>Not covered</i>.</p> <p>Note: Benefits are limited to a maximum of \$3,000 per calendar year per person.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Infertility services after voluntary sterilization</li> <li>• Fertility drugs</li> <li>• Preimplantation genetic diagnosis (PGD)</li> <li>• Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> <li>– artificial insemination</li> <li>– in vitro fertilization</li> <li>– embryo transfer and gamete intrafallopian transfer (GIFT)</li> <li>– intravaginal insemination (IVI)</li> <li>– intracervical insemination (ICI)</li> <li>– intrauterine insemination (IUI)</li> </ul> </li> <li>• Services and supplies related to ART procedures</li> <li>• Cost of donor sperm</li> <li>• Cost of donor egg</li> </ul>	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> <li>• Testing and treatment, including materials (such as allergy serum)</li> <li>• Allergy testing is limited to \$500 per person per calendar year</li> <li>• Allergy injections</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Clinical ecology and environmental medicine</li> <li>• Provocative food testing and sublingual allergy desensitization</li> </ul>	<p><i>All charges</i></p>

<b>Treatment therapies</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Antibiotic therapy</li> <li>• Outpatient cardiac rehabilitation</li> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 89.</p> <ul style="list-style-type: none"> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: GHT is covered under the prescription drug benefit. We only cover GHT when we preauthorize the treatment. Call (800) 821-6136 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Other services</i> under <i>How to get approval for...</i> in Section 3.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapies</li> </ul> <p>Note: Some medications required for treatment therapies may be available through Medco By Mail or a Medco participating pharmacy. Medications obtained from these sources are covered under the Prescription Drug Benefits.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Chelating therapy except for acute arsenic, gold or lead poisoning</i></li> <li>• <i>Maintenance cardiac rehabilitation</i></li> <li>• <i>Topical hyperbaric oxygen therapy</i></li> </ul>	<p><i>All charges</i></p>
<b>Physical and occupational therapies</b>	
<ul style="list-style-type: none"> <li>• 60 visits per calendar year for the combined services of the following: (One visit is two hours or less of physical or occupational therapy.)             <ul style="list-style-type: none"> <li>– qualified physical therapists and</li> <li>– qualified occupational therapists</li> </ul> </li> </ul> <p>Prior to beginning physical therapy treatments, you should contact our Medical Management Department, (800) 821-6136, to preauthorize benefits. Continuing physical therapy claims will be subject to concurrent review for medical necessity. Physical therapy claims will be denied if we determine the therapy is not medically necessary. Please preauthorize.</p> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and when a physician:</p> <ul style="list-style-type: none"> <li>• orders the care;</li> <li>• identifies the specific professional skills the patient requires and the medical necessity for skilled services; and</li> <li>• indicates the length of time the services are needed.</li> </ul> <p>Note: When you receive medically necessary physical or occupational therapy on an outpatient basis from a qualified professional therapist at a skilled nursing facility, your therapy is covered up to plan limits.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Physical and occupational therapies – continued on next page*

Physical and occupational therapies <i>(continued)</i>	You Pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Exercise programs</li> <li>• Long-term rehabilitative therapy</li> <li>• Hot and cold packs</li> </ul>	<p><i>All charges</i></p>
<b>Speech therapy</b>	
<ul style="list-style-type: none"> <li>• 30 visits per calendar year for the services of a qualified speech therapist. (One visit is two hours or less of speech therapy.)</li> </ul> <p>Note: We only cover speech therapy when a physician:</p> <ul style="list-style-type: none"> <li>• orders the care;</li> <li>• identifies the specific professional skills the patient requires and the medical necessity for skilled services; and</li> <li>• indicates the length of time the services are needed.</li> </ul> <p>Note: When you receive medically necessary speech therapy on an outpatient basis from a qualified speech therapist at a skilled nursing facility, your therapy is covered up to plan limits.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Computer devices to assist with communications</li> <li>• Computer programs of any type, including but not limited to those to assist with speech therapy</li> </ul>	<p><i>All charges</i></p>
<b>Hearing services (testing, treatment, and supplies)</b>	
<p>Diagnostic hearing tests performed by a M.D., D.O. or audiologist.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Hearing aids, testing and examinations for them</li> </ul>	<p><i>All charges</i></p>
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• First pair of contact lenses or ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury.</li> <li>• 30 outpatient vision therapy visits by an ophthalmologist or optometrist per person per lifetime.</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Computer programs of any type, including but not limited to those to assist with vision therapy</li> <li>• Eyeglasses or contact lenses and examinations for them, except for the supplemental vision plan</li> <li>• Radial keratotomy and other refractive surgeries</li> </ul>	<p><i>All charges</i></p>
<b>Foot care</b>	
<p>Routine foot care only when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Foot care - continued on next page  
HDHP Section 5(a)*

<b>Foot care (continued)</b>	<b>You Pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming of toenails or removal of corns, calluses, or similar routine treatment of conditions of the foot, except as stated above.</i></li> </ul>	<p><i>All charges</i></p>
<b>Orthopedic and prosthetic devices</b>	
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy.</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Surgical Procedures for coverage of the surgery to insert the device.</li> </ul> <p>Note: We will pay only for the cost of the standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Diabetic shoes</i></li> <li>• <i>Bioelectric, computer programmed prosthetic devices</i></li> </ul>	<p><i>All charges</i></p>
<b>Durable medical equipment (DME)</b>	
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ul style="list-style-type: none"> <li>• Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury);</li> <li>• Are medically necessary;</li> <li>• Are primarily and customarily used only for a medical purpose;</li> <li>• Are generally useful only to a person with an illness or injury;</li> <li>• Are designed for prolonged use; and</li> <li>• Serve a specific therapeutic purpose in the treatment of an illness or injury.</li> </ul> <p>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> <li>• Hospital beds;</li> <li>• Wheelchairs;</li> <li>• Crutches; and</li> <li>• Walkers.</li> </ul> <p>Note: Call us at (800) 821-6136 as soon as your physician prescribes this equipment. We will 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> <p>Note: Benefits for durable medical equipment are limited to \$10,000 per person, lifetime maximum.</p> <p>Note: We will pay only for the cost of the standard item. Coverage for specialty equipment such as all-terrain wheelchairs is limited to the cost of the standard equipment.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

<b>Durable medical equipment (DME) (continued)</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Computer devices to assist with communications</i></li> <li>• <i>Computer programs of any type</i></li> <li>• <i>Air purifiers, air conditioners, heating pads, cold therapy units, whirlpool bathing equipment, sun and heat lamps, exercise devices (even if ordered by a doctor), and other equipment that does not meet the definition of durable medical equipment (page 120)</i></li> <li>• <i>Lifts, such as seat, chair or van lifts</i></li> <li>• <i>Wigs</i></li> </ul>	<p><i>All charges</i></p>
<p><b>Home health services</b></p> <p>25 in-home visits per calendar year, not to exceed one visit up to two hours per day when:</p> <ul style="list-style-type: none"> <li>• A registered nurse (R.N.), or licensed practical nurse (L.P.N.) provides the services;</li> <li>• The attending physician orders the care;</li> <li>• The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and</li> <li>• The physician indicates the length of time the services are needed.</li> </ul> <p>Note: Covered services are based on our review for medical necessity.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;</i></li> <li>• <i>Custodial Care;</i></li> <li>• <i>Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;</i></li> <li>• <i>Inpatient private duty nursing.</i></li> </ul>	<p><i>All charges</i></p>
<p><b>Chiropractic</b></p> <p>Chiropractic services limited to:</p> <ul style="list-style-type: none"> <li>• 30 visits per calendar year for manipulation of the spine.</li> <li>• X-rays, used to detect and determine nerve interferences due to spinal subluxations or misalignments.</li> </ul> <p>Note: No other benefits for the services of a chiropractor are covered under any other provision of this Plan. In medically underserved areas, services of a chiropractor that are listed above are subject to the stated limitations. In medically underserved areas, services of a chiropractor that are within the scope of his/her license and are not listed above are eligible for regular Plan benefits.</p>	<p>PPO and Non-PPO</p> <p>All charges in excess of \$9 per visit</p> <p>All charges in excess of \$25 for X-rays of the spine</p> <p>Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Any treatment not specifically listed as covered;</i></li> <li>• <i>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.</i></li> </ul>	<p><i>All charges</i></p>

<b>Alternative treatments</b>	<b>You Pay</b>
<p>Acupuncture:</p> <p>Benefits are limited to 20 procedures per calendar year for medically necessary acupuncture treatments if performed by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.).</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other alternative treatments, including clinical ecology and environmental medicine</i></li> <li>• <i>Any treatment not specifically listed as covered</i></li> <li>• <i>Naturopathic services</i></li> </ul> <p><i>(Note: benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 10.)</i></p>	<p><i>All charges</i></p>
<b>Educational classes and programs</b>	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Smoking Cessation – Up to \$100 to aid in smoking cessation per person per lifetime, including related expenses such as drugs.</li> </ul>	<p>PPO: all charges in excess of \$100</p> <p>Non-PPO: all charges in excess of \$100</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 \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible 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.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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. If Medicare is your primary payer, GEHA will provide secondary benefits for covered charges. The high-deductible health plan deductible and coinsurance are not waived for Medicare members.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

**Surgical procedures**

A comprehensive range of services, such as:

- Operative procedures
- Treatment of fractures, including casting
- Normal pre- and post-operative care by the surgeon
- Correction of amblyopia and strabismus
- Endoscopy procedures
- Biopsy procedures
- Electroconvulsive therapy
- Removal of tumors and cysts
- Correction of congenital anomalies - limited to children under the age of 18 unless there is a functional deficit. (See Reconstructive surgery)
- Surgical treatment of obesity (bariatric surgery) is covered only if:
  - eligible enrollee is 18 or over,
  - clinical records support a body mass index of 40 or greater (or 35-40 when there is a co-morbid condition such as life-threatening cardiopulmonary problems or severe diabetes mellitus) for a period of six months,
  - documentation of failure to lower the body mass index by a medically supervised program of diet and exercise of at least six months duration.
- Insertion of internal prosthetic devices. See Orthopedic and prosthetic devices for device coverage information.
- Voluntary sterilization (e.g., Tubal ligation, Vasectomy)

PPO: 15% of the Plan allowance

Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

*Surgical procedures - continued on next page*

<b>Surgical procedures (continued)</b>	<b>You pay</b>
<p>A comprehensive range of services - <i>continued</i></p> <ul style="list-style-type: none"> <li>• Surgically implanted contraceptives</li> <li>• Intrauterine devices (IUDs)</li> <li>• Treatment of burns</li> <li>• Assistant surgeons are covered up to 20% of our allowance for the surgeon's charge for procedures when it is medically necessary to have an assistant surgeon.</li> </ul> <p>Note: Post-operative care is considered to be included in the fee charged for a surgical procedure by a doctor. Any additional fees charged by a doctor are not covered unless such charge is for an unrelated condition.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are:</p> <ul style="list-style-type: none"> <li>• For the primary procedure based on: <ul style="list-style-type: none"> <li>– Full Plan allowance</li> </ul> </li> <li>• For the secondary procedure(s) based on: <ul style="list-style-type: none"> <li>– One-half of the Plan allowance</li> </ul> </li> <li>• For the subsequent procedure(s) based on: <ul style="list-style-type: none"> <li>– 25% of the Plan allowance</li> </ul> </li> </ul> <p>Note: Multiple or bilateral surgical procedures performed through the same incision are “incidental” to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Services of a standby physician or surgeon</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<p><i>All charges</i></p>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member's appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm – limited to children under the age of 18 unless there is a functional deficit. Examples of congenital anomalies are: cleft lip; cleft palate; birth marks; and webbed fingers and toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance of breasts;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage)</li> </ul> </li> </ul> <p>Note: We pay for internal breast prostheses as hospital benefits if billed by a hospital. If included with the surgeon's bill, surgery benefits will apply.</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>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Reconstructive surgery – continued on next page*

Reconstructive surgery <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <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 if repair is initiated promptly or as soon as the member’s medical condition permits;</i></li> <li>• <i>Surgeries related to sex transformation or sexual dysfunction;</i></li> <li>• <i>Surgeries to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit;</i></li> <li>• <i>Charges for photographs to document physical conditions.</i></li> </ul>	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate;</li> <li>• Excision of cysts and incision of abscesses unrelated to tooth structure;</li> <li>• Extraction of impacted (unerupted or partially erupted) teeth;</li> <li>• Alveoloplasty, partial or radical removal of the lower jaw with bone graft;</li> <li>• Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues;</li> <li>• Open reduction of dislocations and excision, manipulation, aspiration or injection of temporomandibular joints;</li> <li>• Removal of foreign body, skin, subcutaneous areolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones and incision/excision of salivary glands and ducts;</li> <li>• Repair of traumatic wounds;</li> <li>• Incision of the sinus and repair of oral fistulas;</li> <li>• Surgical treatment of trigeminal neuralgia.</li> <li>• Repair of accidental injury to sound natural teeth such as: expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. Masticating (biting or chewing) incidents are not considered to be accidental injuries.</li> <li>• Orthognathic surgery but only for treatment of severe sleep apnea and only after conservative treatment of sleep apnea has failed. Orthognathic surgery for any other condition is not covered.</li> <li>• Other oral surgery procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants;</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Orthodontic treatment;</i></li> <li>• <i>Any oral or maxillofacial surgery not specifically listed as covered;</i></li> <li>• <i>Orthognathic surgery (except as outlined above for severe sleep apnea), even if necessary because of TMJ dysfunction or disorder.</i></li> </ul>	<p><i>All charges</i></p>

<b>Organ/tissue transplants</b>	<b>You pay</b>
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single or double lung transplants, limited to patients for the following end-stage pulmonary diseases: (1) pulmonary fibrosis, (2) primary pulmonary hypertension, (3) emphysema, or (4) cystic fibrosis</li> <li>• Pancreas (limited to patients whose condition is not treatable by insulin therapy)</li> <li>• Allogeneic bone marrow transplants – only for patients with Acute leukemia, Advanced Hodgkin’s lymphoma, Advanced non-Hodgkin’s lymphoma, Advanced neuroblastoma (limited to children over age one), Aplastic anemia, Chronic myelogenous leukemia, Infantile malignant osteopetrosis, Severe combined immunodeficiency, Thalassemia major, or Wiskott-Aldrich syndrome</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver, small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>• Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support - limited to patients with Acute lymphocytic, or non-lymphocytic leukemia, Advanced Hodgkin’s lymphoma, Advanced non-Hodgkin’s lymphoma, Advanced neuroblastoma (limited to children over age one), Breast cancer or Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors, Multiple myeloma or Epithelial ovarian cancer.</li> </ul> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated below. This benefit applies only if the recipient is covered by us and if the donor’s expenses are not otherwise covered.</p> <p>Transportation Benefit</p> <ul style="list-style-type: none"> <li>• We will also provide up to \$10,000 per covered transplant for transportation (mileage or airfare) to a plan designated facility and reasonable temporary living expenses (i.e. lodging and meals) for the recipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 100 miles from the designated transplant facility. Transportation benefits are payable for follow-up care up to one year following the transplant. The transportation benefit is not available for cornea or kidney transplants. You must contact Customer Service for what are considered reasonable temporary living expenses.</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

*Organ/tissue transplants – continued on next page*

<b>Organ/tissue transplants (continued)</b>	<b>You pay</b>
<p>Limited Benefits</p> <ul style="list-style-type: none"> <li>The process for preauthorizing organ transplants is more extensive than the normal precertification process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact our Medical Director so we can arrange to review the clinical results of the evaluation and determine if the proposed procedure meets our definition of “medically necessary” and is on the list of covered transplants. Coverage for the transplant must be authorized in advance, in writing by our Medical Director. (Cornea and kidney transplants do not require preauthorization by GEHA’s Medical Director.)</li> </ul>	
<ul style="list-style-type: none"> <li>We will pay for a second transplant evaluation recommended by a physician qualified to perform the transplant, if: the transplant diagnosis is covered and the physician is not associated or in practice with the physician who recommended and will perform the organ transplant. A third transplant evaluation is covered only if the second evaluation does not confirm the initial evaluation.</li> <li>The transplant must be performed at a Plan-designated organ transplant facility to receive maximum benefits.</li> <li>If benefits are limited to \$100,000 per transplant, included in the maximum are all charges for hospital, medical and surgical care incurred while the patient is hospitalized for a covered transplant surgery and subsequent complications related to the transplant. Outpatient expenses for chemotherapy and any process of obtaining stem cells or bone marrow associated with bone marrow transplant (stem cell support) are included in benefits limit of \$100,000 per transplant. Tandem bone marrow transplants approved as one treatment protocol are limited to \$100,000 when not performed at a Plan designated facility. Expenses for aftercare such as outpatient prescription drugs are not a part of the \$100,000 limit.</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>If prior approval is not obtained or a Plan-designated organ transplant facility is not used, our allowance will be limited for hospital and surgery expenses up to a maximum of \$100,000 per transplant. If we cannot refer a member in need of a transplant to a designated facility, the \$100,000 maximum will not apply.</p>
<ul style="list-style-type: none"> <li>Chemotherapy and procedures related to bone marrow transplantation must be performed only at a Plan-designated organ transplant facility to receive maximum benefits.</li> <li>Simultaneous transplants such as kidney/pancreas, heart/lung, heart/liver, are considered as one transplant procedure and are limited to \$100,000 when not performed at a Plan-designated organ transplant facility.</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Services or supplies for or related to surgical transplant procedures (including administration of high-dose chemotherapy) for artificial or human organ/tissue transplants not listed as specifically covered.</i></li> <li><i>Donor screening tests and donor search expenses, except those performed for the actual donor.</i></li> <li><i>Donor search expense for bone marrow transplants.</i></li> </ul>	<p><i>All charges</i></p>
<p><b>Anesthesia</b></p>	
<p>Professional fees for the administration of anesthesia in:</p> <ul style="list-style-type: none"> <li>Hospital (inpatient)</li> <li>Hospital outpatient department</li> <li>Ambulatory surgical center</li> <li>Office</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

## 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.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible 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.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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. If Medicare is your primary payer, GEHA will provide secondary benefits for covered charges. The high-deductible health plan deductible and coinsurance are not waived for Medicare members.
- 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 MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM \$500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification. Penalties are not subject to the catastrophic limit.

Benefits Description	You pay After the calendar year deductible...
<p><b>Inpatient hospital</b></p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> <p>Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate.</p> <p>Note: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms;</li> <li>• Prescribed drugs and medicines;</li> <li>• Diagnostic laboratory tests and X-rays;</li> <li>• Blood or blood plasma, if not donated or replaced;</li> <li>• Dressings, splints, casts, and sterile tray services;</li> <li>• Medical supplies and equipment, including oxygen;</li> <li>• Anesthetics, including nurse anesthetist services;</li> <li>• Take-home items;</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance</p>

*Inpatient hospital - continued on next page*

Inpatient hospital <i>(continued)</i>	You pay
<p>Other hospital services and supplies - <i>continued</i></p> <ul style="list-style-type: none"> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.</li> </ul> <p>Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance</p>
<p>Maternity Care – Inpatient Hospital</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify.</li> </ul> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Delivery room, recovery, and other treatment rooms;</li> <li>• Prescribed drugs and medicines;</li> <li>• Diagnostic laboratory tests and X-rays;</li> <li>• Blood or blood plasma, if not donated or replaced;</li> <li>• Dressings and sterile tray services;</li> <li>• Medical supplies and equipment, including oxygen;</li> <li>• Anesthetics, including nurse anesthetist services;</li> <li>• Take-home items;</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home;</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay;</li> <li>• We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment.</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>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.</i></li> <li>• <i>Custodial care; see definition.</i></li> <li>• <i>Non-covered facilities, such as nursing homes, schools</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> <li>• <i>Private nursing care</i></li> </ul>	<p><i>All charges</i></p>

<b>Outpatient hospital or ambulatory surgical center</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> <li>• Cardiac rehabilitation</li> </ul> <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>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Maintenance cardiac rehabilitation</i></li> </ul>	<p><i>All charges</i></p>
<p>Maternity Care – Outpatient Hospital</p> <ul style="list-style-type: none"> <li>• Delivery room, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia services</li> </ul>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<b>Extended care benefits/Skilled nursing care facility benefits</b>	
<p><i>No benefits</i></p>	<p><i>All charges</i></p>
<b>Hospice care</b>	
<p>Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan approved independent hospice administration.</p> <ul style="list-style-type: none"> <li>• We pay \$2,000 for hospice care on an outpatient basis.</li> <li>• We pay \$150 per day for room and board and care while an inpatient in a hospice up to a maximum of \$3,000.</li> </ul> <p>These benefits will be paid if the hospice care program begins after a person’s primary doctor certifies terminal illness and life expectancy of six months or less and any services or inpatient hospice stay that is part of the program is:</p> <ul style="list-style-type: none"> <li>• Provided while the person is covered by this Plan;</li> <li>• Ordered by the supervising doctor;</li> <li>• Charged by the hospice care program; and</li> <li>• Provided within six months from the date the person entered or re-entered (after a period of remission) a hospice care program.</li> </ul>	<p>PPO: 15% up to the Plan limits</p> <p>Non-PPO: 30% up to the Plan limits</p>

*Hospice care – continued on next page*

<b>Hospice care (continued)</b>	<b>You pay</b>
<p>Remission is the halt or actual reduction in the progression of illness resulting in discharge from a hospice care program with no further expenses incurred. A readmission within three months of a prior discharge is considered as the same period of care. A new period begins after three months from a prior discharge with maximum benefits available.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Charges incurred during a period of remission, charges incurred for treatment of a sickness or injury of a family member that are covered under another Plan provision, charges incurred for services rendered by a close relative, bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services.</li> </ul>	<p><i>All charges</i></p>
<b>Ambulance</b>	
<ul style="list-style-type: none"> <li>Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary).</li> <li>Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.</li> </ul>	<p>PPO: 15% up to the Plan allowance</p> <p>Non-PPO: 30% up to the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means.</li> </ul>	<p><i>All charges</i></p>

## 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 \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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. If Medicare is your primary payer, GEHA will provide secondary benefits for covered charges. The high-deductible health plan deductible and coinsurance are not waived for Medicare members.

**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.

Benefits Description	You pay After the calendar year deductible...
<b>Accidental injury</b>	
<ul style="list-style-type: none"> <li>• Non-surgical physician services and supplies</li> <li>• Related outpatient physician care</li> <li>• Surgical care</li> <li>• Treatment outside a hospital or in the outpatient/emergency room department of a hospital</li> </ul> <p>Note: Emergency room charges associated directly with an inpatient admission are considered “Other charges” under Inpatient Hospital Benefits (see pages 91-92) and are not part of this benefit, even though an accidental injury may be involved. This provision also applies to dental care required as a result of accidental injury to sound natural teeth. Masticating (chewing) incidents are not considered to be accidental injuries.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference between our allowance and the billed amount</p>
<b>Medical emergency</b>	
<p>Outpatient medical or surgical services and supplies billed by a hospital for emergency room treatment.</p> <p>Note: We pay hospital benefits if you are admitted.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<b>Ambulance</b>	
<ul style="list-style-type: none"> <li>• Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary).</li> </ul>	<p>PPO: 15% up to the Plan allowance</p> <p>Non-PPO: 30% up to the Plan allowance</p>

*Ambulance – continued on next page*

<b>Ambulance (continued)</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.</li> </ul>	<p>PPO: 15% up to the Plan allowance</p> <p>Non-PPO: 30% up to the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means.</li> </ul>	<p><i>All charges</i></p>

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

You may choose to get care In-Network or Out-of-Network. When you receive In-Network care, you must get our approval for inpatient hospital and intensive day treatment services. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- An additional calendar year deductible of \$500 for out-of-network non-PPO providers applies per person, limit of two per family, for inpatient hospital, and outpatient hospital/intensive day treatment for mental health and substance abuse benefits.
- 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. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. If Medicare is your primary payer, GEHA will provide secondary benefits for covered charges. The high-deductible health plan deductible and coinsurance are not waived for Medicare members.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS AND INTENSIVE DAY TREATMENT; FAILURE TO DO SO WILL RESULT IN A MINIMUM \$500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification. Penalties are not subject to the catastrophic limit.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 99.

Benefits Description	You pay After the calendar year deductible...
<b>In-Network benefits</b>	
Covered services for in-network providers.  Note: In-network inpatient hospital and outpatient intensive day treatment benefits are payable only when we determine the care is clinically appropriate to treat your condition and is precertified.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> <li>• Psychological tests (requires precertification)</li> <li>• Inpatient professional fees</li> <li>• Diagnostic tests</li> <li>• Laboratory tests to monitor the effect of drugs prescribed for your condition</li> </ul>	15% of the Plan allowance
<b>Inpatient hospital</b>	
Room and board, such as: <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul>	15% of the Plan allowance

*Inpatient hospital – continued on next page*

<b>Inpatient hospital (continued)</b>	<b>You pay</b>
<p>Room and board - <i>continued</i></p> <p>Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate.</p> <p>Note: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.</p> <p>Other hospital services and supplies:</p> <ul style="list-style-type: none"> <li>• Services provided by a hospital</li> </ul>	15% of the Plan allowance
<b>Outpatient hospital</b>	
<p>Services provided by a hospital including partial hospitalization or Intensive Day Treatment Programs</p>	15% of the Plan allowance
<b>Emergency room non-accidental injury</b>	
<p>Outpatient services and supplies billed by a hospital for emergency room treatment</p> <p>Note: We pay Hospital benefits if you are admitted.</p>	15% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Services we determine are not medically necessary</i></li> <li>• <i>Marriage counseling</i></li> </ul>	<i>All charges</i>

**Precertification**

To be eligible to receive these enhanced mental health and substance abuse benefits, you must follow the network authorization process:

- You must call Encompass at (888) 372-3190 to receive authorization for inpatient care and outpatient intensive day treatment from a Network provider. They will authorize any covered treatment.
- You should call our Medical Management Department (800) 821-6136 to precertify benefits for psychological testing. Psychological testing claims will be denied if we determine the testing is not medically necessary.

**Network limitation**

If you do not obtain precertification for inpatient care and outpatient intensive day treatment, we will decide whether the stay was medically necessary. If we determine the stay was medically necessary, we will pay the services less the \$500 penalty. If we determine that it was not medically necessary, we will only pay for any covered services that are otherwise payable on an outpatient basis. If you remain in the hospital beyond the days we approved and did not get the additional days precertified, we will pay inpatient benefits for the part of the admission that was medically necessary. See Section 3 for details.

<b>Out-of-Network benefits</b>	<b>You pay</b>
<b>Out-of-Network mental health and substance abuse benefits</b>	
<ul style="list-style-type: none"> <li>• <b>Inpatient Hospital/Facility for treatment of mental health</b> <ul style="list-style-type: none"> <li>– 100-day limit per calendar year.</li> <li>– Precertification required</li> </ul> </li> <li>• <b>Inpatient Hospital/Facility for treatment of alcoholism and drug abuse</b> <ul style="list-style-type: none"> <li>– 30-day maximum per lifetime</li> <li>– Precertification required</li> </ul> </li> <li>• <b>Outpatient Hospital/Intensive Day Treatment Program for mental health /substance abuse</b> <ul style="list-style-type: none"> <li>– 60-day limit per calendar year</li> </ul> </li> </ul>	50% of the Plan allowance and any difference between our allowance and the billed amount (after an additional \$500 calendar year deductible limited to two per family)
<ul style="list-style-type: none"> <li>• <b>Inpatient visits for psychotherapy</b> <ul style="list-style-type: none"> <li>– 100 inpatient visits limit per calendar year</li> </ul> </li> <li>• <b>Outpatient visits for psychotherapy and group sessions and psychological testing</b> <ul style="list-style-type: none"> <li>– 30 session limit per calendar year for treatment of mental health and substance abuse</li> </ul> </li> </ul>	50% of the Plan allowance and any difference between our allowance and the billed amount
<p><i>Not covered out-of-network:</i></p> <ul style="list-style-type: none"> <li>• <i>Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems</i></li> <li>• <i>Treatment for learning disabilities and mental retardation</i></li> <li>• <i>Telephone therapy</i></li> <li>• <i>Travel time to the member's home to conduct therapy</i></li> <li>• <i>Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staff</i></li> <li>• <i>Marriage counseling</i></li> </ul>	<i>All charges</i>

**Lifetime maximum**      Out-of-network inpatient care for the treatment of alcoholism and drug abuse is limited to a 30-day maximum per lifetime.

**Precertification**      The medical necessity of your admission to a hospital or other covered facility for mental health or substance abuse must be precertified. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits will be reduced. See Section 3 for details.

- Call Encompass at (888) 372-3190 to precertify.
- You should call our Medical Management Department (800) 821-6136 to precertify benefits for psychological testing. Psychological testing claims will be denied if we determine the testing is not medically necessary.

See these sections of the brochure for more valuable information about these benefits:  
 Section 3, *How you get care*, for information about catastrophic protection for these benefits.  
 Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

## 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 page 103.
- 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 \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The calendar year 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 for eligible medical expenses and 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. We will not waive the high-deductible health plan deductible and coinsurance for Medicare members.
- Based on manufacturer's and FDA guidelines, the use of a certain medication may be limited as to its quantity, total dose, duration of therapy, age, gender or specific diagnosis. Since the prescription does not usually explain the reason the provider prescribed a medication, the requirement of any of these limits and/or prior authorization to confirm the intent of the prescriber may be appropriate.
- Some medications must be approved by GEHA and/or Medco before you may purchase them.
- If you need an extra supply of medications in emergency situations such as if you are called to active military duty or as a part of the government's continuity of operations, you may receive an extra 30-day supply at retail or if you received a 90-day supply of a specific medication within the last 30 days, arrangements can be made for an additional 60 days to be dispensed through Medco By Mail. Call our office at (800) 821-6136 so that we can work with you to find the most cost effective and efficient manner of meeting your emergency prescription needs.
- Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, and a mail order form, questionnaire, and reply envelope.
- As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including names of your prescribing physicians, to any treating physician or dispensing pharmacies.
- **Who can write your prescription:** A licensed physician or a licensed dentist must write the prescription. For Medco By Mail prescriptions, the physician must be licensed in the United States. In addition, your mailing address must be within the United States or include an APO address.
- **Where you can obtain them:** You may fill the prescription at a participating network retail pharmacy, a non-network pharmacy, or through Medco By Mail. You can reduce your out-of-pocket expense if you use a participating network pharmacy or Medco By Mail. The difference between our allowance and the cost of the drug at a non-network pharmacy does not apply to the deductible or catastrophic limit.

### Prescription drug benefits

#### Covered medications and supplies

You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:

- Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not Covered*;
- Insulin;
- Needles and syringes for the administration of covered medications;
- Contraceptive drugs;
- Ostomy supplies (please include the manufacturer's product number to ensure accurate fill of the product).

Note: A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written, when a Federally-approved generic drug is available unless substitution is prohibited by state law.

*Prescription drug benefits – continued on next page*

**Prescription drug benefits** *(continued)*

**Coordinating with other drug coverage**

If you also have drug coverage through another group health insurance plan and we are your secondary insurance, follow these procedures:

At participating pharmacies, do not present your GEHA drug card. Purchase your drug using the RX card issued by your primary insurance carrier. Then, mail your pharmacy receipt to GEHA for consideration of possible reimbursement. If your primary insurance does not provide an RX card, then purchase your drug and submit the bill to your primary insurance. When they have made payment, file the claims and the Explanation of Benefit (EOB) with GEHA for consideration of possible reimbursement. In any event, if you use GEHA’s prescription drug card when another insurance is primary, you will be responsible for reimbursing us any amount in excess of our secondary benefit.

Drugs purchased at non-participating pharmacies should be submitted to our claims office (see page 109) along with the primary insurance EOB. We will accept either the drug receipts or a Medco drug claim form. **Submit these claims to GEHA, P.O. 4665, Independence, MO 64051-4665, when we are your secondary insurance.**

If another insurance is primary, you should use their drug benefit. If you elect to use Medco By Mail, Medco will bill you directly. Pay Medco the amount billed and submit the bill to your primary insurance. When your primary insurance makes payment, file the claim and their EOB to us (see page 109).

Should Medicare rules change on prescription drug coverage, we reserve the right to require you to use your Medicare coverage as the primary insurance for these drugs.

**Medco voluntary formulary**

Your prescription drug program includes a voluntary “formulary” feature. The Medco Drug Formulary is a list of selected FDA approved prescription medications reviewed by an independent group of distinguished health care professionals. Prescription drugs are subjected to rigorous clinical analysis from the standpoint of efficacy, safety, side effects, drug-to-drug interactions, dosage and cost-benefit in determining whether they are included on or excluded from the formulary.

A formulary is a list of commonly prescribed medications from which your physician may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other non-formulary medications, can help contain the increasing cost of prescription drug coverage without sacrificing quality. In many therapeutic categories, there are several drugs of similar effectiveness. Many doctors are often unaware of the significant variations in price among these similar drugs and, as a result, their prescribing decisions often do not consider cost. However, when the cost difference is brought to their attention, doctors will frequently prescribe the less costly medications.

Your physicians will be contacted to discuss their prescribing decision. No change in the medication prescribed will be made without your physicians’ approval. Compliance with this formulary list is voluntary and there is no financial penalty for obtaining drugs not on the formulary list.

**Any rebates or savings received by the Plan on the cost of drugs purchased under this plan from drug manufacturers are credited to the health plan and are used to reduce health care costs.**

**Patient Safety**

GEHA has several programs to promote patient safety. Through these programs, we work to ensure safe and appropriate quantities of medication are being dispensed. The result is improved care and safety for our members. Patient safety programs include:

- Prior approval – Approval must be obtained for certain prescription drugs and supplies before providing benefits for them.
- Quantity allowances – Specific allowances are in place for certain medications, based on manufacturer and FDA recommended guidelines.
- Pharmacy utilization – GEHA reserves the right to maximize your quality of care as it relates to the utilization of pharmacies.

GEHA will participate in other approved managed care programs, as deemed necessary, to insure patient safety.

*Prescription drug benefits – continued on next page*

## Prescription drug benefits (*continued*)

### How to use Medco network pharmacies (retail)

You may fill your prescription at any participating retail pharmacy. For the names of participating pharmacies, call (800) 551-7675 or visit [www.medco.com](http://www.medco.com). To receive maximum savings you must present your card at the time of each purchase, and your enrollment information must be current and correct. In most cases, you simply present the card together with the prescription to the pharmacist. Each purchase is limited to a 30-day supply.

Refills cannot be obtained until **75%** of the drug has been used. As part of the administration of the prescription drug program, we reserve the right to maximize your quality of care as it relates to the utilization of pharmacies. Some medications may require prior approval by Medco or GEHA.

### How to use Medco By Mail (mail order)

Through this service, you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, ostomy supplies, diabetic supplies and insulin, syringes and needles for covered injectable medications, and oral contraceptives. Some medications may not be available in a 90-day supply from Medco even though the prescription is for 90 days. Even though insulin, syringes, diabetic supplies and ostomy supplies do not require a physician's prescription, to obtain through Medco By Mail you should obtain a prescription (including the product number for ostomy and insulin pump supplies) from your physician for a 90-day supply.

Some medications may require approval by Medco or GEHA. Not all drugs are available through Medco By Mail. In order to use Medco By Mail, your prescriptions must be written by a physician licensed in the United States. In addition, your mailing address must be within the United States or include an APO address.

Each enrollee will receive a kit that includes a brochure describing the Medco By Mail service, an order form, a questionnaire, and a return envelope.

**To order new prescriptions**, ask your doctor to prescribe needed medication for up to a 90-day supply, plus refills, if appropriate. Complete the Health, Allergy, & Medication Questionnaire the first time you order through this service. Complete the information on the Ordering Medication Form, enclose your prescription and the correct deductible and coinsurance.

Mail to: Medco  
P.O. Box 30493  
Tampa, FL 33630-3493

You should receive your medication within 14 days from the date you mail your prescription. You will also receive reorder instructions. If you have any questions or need an emergency consultation with a registered pharmacist, you may call Medco toll-free at (800) 551-7675 available 24 hours a day, 7 days a week except Thanksgiving and Christmas. Forms necessary for refills will be provided each time you receive a supply of medication from the service.

**Refilling your medication:** to be sure you never run short of your prescription medication, you should re-order on or after the refill date indicated on the refill slip or when you have approximately 14 days of medication left.

**To order by phone:** Call Member Services at (800) 551-7675. Have your refill slip with the prescription information ready.

**To order by mail:** Simply mail your refill slip and deductible and coinsurance in the return envelope.

**To order online:** Go to [www.geha.com/prescriptions/home\\_delivery.html](http://www.geha.com/prescriptions/home_delivery.html) then click on the link to Medco, or go to [www.medco.com](http://www.medco.com).

*Prescription drug benefits – continued on next page*

**Prescription drug benefits (continued)**

Benefits Description	You pay
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**Covered medications and supplies**

<p><b>Medco Network Pharmacy (retail)</b>                  All coinsurance is for up to a 30-day supply.                  A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when a Federally-approved generic drug is available.</p>	<p>30% of Plan allowance</p>
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<p><b>Non-Network Retail</b>                  If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to:                  Medco                  P.O. Box 14711                  Lexington, KY 40512                  Your claim will be calculated on the 30% coinsurance and the appropriate deductible. Reimbursement will be based on GEHA’s costs had you used a participating pharmacy. You must submit original drug receipts.                  All coinsurance is for up to a 30-day supply.                  Note: When a claim is submitted for direct reimbursement of a compound medication, the pricing is based on the contractual Average Wholesale Price (AWP) cost of each active prescription component submitted. The professional fee and applicable sales tax are also included in the pricing.</p>	<p>30% of network price                   (and any difference between our allowance and the cost of the drug)</p>
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<p><b>Medco By Mail</b>                  All coinsurance is for up to a 90-day supply.                  A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when a Federally-approved generic drug is available.</p>	<p>30% of Plan allowance</p>
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**Non-covered medications and supplies**

<p><i>The following medications and supplies are not covered under the GEHA health plan.</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them including enteral formula available without a prescription</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Drugs to aid in smoking cessation except those limited to the \$100 lifetime maximum as part of the smoking cessation benefit (see page 85). You may not obtain smoking cessation drugs with your Medco prescription card or through Medco By Mail. You must purchase these drugs and file the claim with us.</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Drugs which are investigational</i></li> <li>• <i>Drugs prescribed for weight loss</i></li> <li>• <i>Drugs to treat infertility</i></li> <li>• <i>Drugs to treat impotency</i></li> </ul>	<p><i>All charges</i></p>
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**Section 5(g) Special features**

<b>Special features</b>	<b>Description</b>
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue.</li> <li>• Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.</li> <li>• If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<b>Services for deaf and hearing impaired</b>	<p>TDD service is available at (800) 821-4833 for members who are hearing impaired.</p>
<b>High risk pregnancies</b>	<p>To participate in our enhanced maternity program, call (800) 821-6136 at any time as soon as you think you or your covered dependent may be pregnant. Early participation in the program guarantees you ongoing communication with a registered nurse throughout the pregnancy. Complimentary educational materials include the book “From Here to Maternity”.</p>

**Section 5(h) Health education resources and account management tools**

<b>Special features</b>	<b>Description</b>
<b>Health education resources</b>	<p>Visit our website at <a href="http://www.geha.com">www.geha.com</a> for the Health e-Report Newsletter.</p> <p>Visit our Wellness Center tab on our website at <a href="http://www.geha.com/wellness_center">www.geha.com/wellness_center</a> for information on:</p> <ul style="list-style-type: none"> <li>• General health topics</li> <li>• Links to health care news</li> <li>• Cancer and other specific diseases</li> <li>• Drugs / medication interactions</li> <li>• Kids health</li> <li>• Patient safety information</li> <li>• and several helpful website links.</li> </ul>
<b>Account management tools</b>	
<b>HSA</b>	<ul style="list-style-type: none"> <li>• You will receive a monthly statement from the HSA Bank™ outlining your account balance and activity for the month.</li> <li>• You may also access your account on-line at <a href="http://www.hsabank.com">www.hsabank.com</a>.</li> </ul>
<b>HRA</b>	<ul style="list-style-type: none"> <li>• Your HRA balance will be available on-line through <a href="http://www.geha.com">www.geha.com</a>.</li> <li>• Your balance will also be shown on your explanation of benefits (EOB form).</li> </ul>
<b>HDHP</b>	<ul style="list-style-type: none"> <li>• Complete claims payment history is available online through <a href="http://www.geha.com">www.geha.com</a>.</li> <li>• You will also receive an explanation of benefits (EOB) after every claim.</li> </ul>
<b>Consumer choice information</b>	<ul style="list-style-type: none"> <li>• If you have GEHA’s Health Savings Advantage<sup>SM</sup> HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at <a href="http://www.geha.com">www.geha.com</a>.</li> <li>• Pricing information for prescription drugs is available at <a href="http://www.medco.com">www.medco.com</a>.</li> <li>• Link to online pharmacy through Medco at <a href="http://www.medco.com">www.medco.com</a>.</li> <li>• Educational materials on the topics of HSAs, HRAs and HDHPs are available at <a href="http://www.geha.com">www.geha.com</a>.</li> </ul>
<b>Care support</b>	<ul style="list-style-type: none"> <li>• GEHA has a strong patient safety program. Pharmacy initiatives help ensure that members have fewer health complications related to prescription drugs. Disease management programs help our members with specific health conditions such as heart disease and diabetes. Medical case managers assist patients with high-risk pregnancies, durable medical equipment, transplants and other special needs.</li> <li>• Patient safety information is available on-line at <a href="http://www.geha.com/wellness_center/patient_safety.html">http://www.geha.com/wellness_center/patient_safety.html</a>.</li> </ul>

## Non-FEHB benefits available to Plan members

The benefits on pages 106 and 107 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.

### **Non-Covered Prescription Drugs**

**(800) 417-1893**

Certain prescription drugs not covered by GEHA's Prescription Drug Program are available to GEHA health plan members at a discount. If your physician writes a prescription for a non-covered drug to treat impotency or hair loss, you may purchase it through the Medco By Mail, paying 100% of the discounted amount. To order, complete the form called Ordering Medications from the Medco By Mail. Mail this form along with your prescription and check or credit card number to:

Medco  
P.O. Box 30493  
Tampa, FL 33630-3493

If paying by a check, please call first to obtain the cost of the medication. Full payment must be included with your order.

### **Online Shopping**

[www.medco.com](http://www.medco.com)

GEHA health plan members have access to special features offered on the Medco Web site, [www.medco.com](http://www.medco.com). On this Web site, you can refill mail order prescriptions and manage your mail order account. A new feature is online shopping for thousands of non-prescription drugstore products available from Family Meds. Items available include non-prescription medications, vitamins, herbal remedies and personal care products.

### **CONNECTION Hearing**

**(888) HEARING (432-7464)**

[www.HEARPO.com](http://www.HEARPO.com)

Free to all GEHA health plan option members, CONNECTION Hearing® offers cost savings on hearing aids and other hearing health needs at more than 4,800 credentialed hearing aid providers. The program provides testing, substantial discounts on all styles of hearing aids, programmable and digital hearing aids, discounts on repairs, a 60-day trial period with a money-back guarantee and unlimited first-year clinical visits at no charge to the patient. Program benefits are available to all GEHA health plan members, covered dependents, and parents and grandparents of members and spouses. Call the toll free number to receive a written referral to a provider in your area.

### **CONNECTION Vision**

**(800) 800-EYES (800-3937)**

[www.locateproviders.com](http://www.locateproviders.com)

Free to all GEHA health plan members and CONNECTION Dental *Plus*® members, CONNECTION Vision® offers cost savings at more than 12,000 eye care locations nationwide. This program is offered through Coast to Coast Vision. GEHA health plan members get discounts off the retail price of lenses, frames and specialty items such as tints, lightweight plastics and scratch-resistant coatings. Discounts are available for surgical procedures (including LASIK and PRK) not covered under the GEHA health plan. For discounts on mail-order contact lenses, call (800) 878-3901. Discounts for eye exams are offered at certain locations. These are announced when you call to locate the provider nearest you. To locate providers in your area, call (800) 800-EYES (800-3937) or visit [www.locateproviders.com](http://www.locateproviders.com).

### **CONNECTION Dental**

**(800) 296-0776**

[www.geha.com](http://www.geha.com)

Free to all GEHA health plan members, CONNECTION Dental® can reduce your costs for dental care. CONNECTION Dental is a network of approximately 37,000 participating dentists who have agreed to limit their charges to a reduced fee for GEHA health plan members. As a GEHA health plan member, you can take advantage of this program in addition to basic dental benefits provided under the GEHA health plan. Just show your CONNECTION ID card before you receive services. To find a participating CONNECTION Dental provider in your area, call (800) 296-0776 or visit [www.geha.com](http://www.geha.com) and click on Provider Search. Please confirm provider participation prior to your visit.

Available for an additional premium, CONNECTION Dental *Plus* is a supplemental dental plan that pays benefits for a wide variety of procedures, from cleanings and X-rays to crowns, dentures and orthodontia for children. This optional dental insurance is provided directly by GEHA. Certain waiting periods and limitations apply.

Enrollment is open to all federal employees, retirees and annuitants, including those who are not members of the GEHA health plan. When you also join the GEHA health plan, you pay a lower premium for CONNECTION Dental *Plus*. When you purchase CONNECTION Dental *Plus* you also have free access to GEHA's CONNECTION Vision program.

<b>Covered Services</b>	<b>Calendar Year Deductible Per Person</b>	<b>Provider Participation</b>	<b>1<sup>st</sup> Year Benefit</b>	<b>2<sup>nd</sup> Year Benefit</b>	<b>3<sup>rd</sup> Year Benefit</b>
<b>Class A</b> Specified Diagnostic and Preventative	\$0	In-Network	100%	100%	100%
<b>Class A</b> Specified Diagnostic and Preventative	\$0	Out-of-Network	60%	80%	80%
Class B Other Diagnostic, Preventative, Restorative & Specified Oral Surgery	\$50	In-Network	70%	75%	80%
Class B Other Diagnostic, Preventative, Restorative & Specified Oral Surgery	\$50	Out-of-Network	50%	55%	60%
Class C Endodontics, Periodontics, Prosthodontics & Crowns, Inlays, Onlays	\$100	In-Network	0% 12 Month Waiting Period	40%	50%
Class C Endodontics, Periodontics, Prosthodontics & Crowns, Inlays, Onlays	\$100	Out-of-Network	0% 12 Month Waiting Period	30%	40%
<b>Class D</b> Orthodontics-Comprehensive Case (ages 6-17)	\$0	In-Network	0% 24 Month Waiting Period	0% 24 Month Waiting Period	\$50 per month
<b>Class D</b> Orthodontics-Comprehensive Case (ages 6-17)	\$0	Out-of-Network	0% 24 Month Waiting Period	0% 24 Month Waiting Period	\$25 per month

This is a partial summary of the terms, conditions and limitations of CONNECTION Dental *Plus*. To get an enrollment packet or more information on coverage and rates, please call CONNECTION Dental *Plus* at (800) 793-9335, or visit [www.geha.com](http://www.geha.com).

*Benefits described on pages 106 and 107 are not part of the FEHB contract or premium, and you cannot file a FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. The GEHA PPO copayment does not apply. GEHA does not guarantee that providers are available in all areas or that prices at a participating provider are lower than prices that may be available from a non-participating provider.*

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## Section 6 General exclusions – things we don't cover

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; sexual dysfunction or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits;
- Services or supplies for cosmetic purposes;
- Surgery to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit;
- Services or supplies not specifically listed as covered;
- Services or supplies not reasonably necessary for the diagnosis or treatment of an illness or injury, except for routine physical examinations and immunizations;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 18), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 19), or State premium taxes however applied;
- Charges in excess of the "Plan allowance" as defined on page 121;
- Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital;
- Inpatient private duty nursing;
- Stand-by physicians and surgeons;
- Clinical ecology and environmental medicine;
- Chelation therapy except for acute arsenic, gold, or lead poisoning;
- Treatment for impotency, even if there is an organic cause for impotency. (Exclusion applies to medical/surgical treatment as well as prescription drugs);
- Treatment other than surgery of temporomandibular joint dysfunction and disorders (TMJ);
- Computer devices to assist with communications;
- Computer programs of any type, including but not limited to those to assist with vision therapy or speech therapy;
- Weight loss programs;
- Home test kits including but not limited to HIV and drug home test kits; or
- Telephone consultations.

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## Section 7 Filing a claim for covered services

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### How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at (800) 821-6136, or at our Web site at [www.geha.com](http://www.geha.com).

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form.

Mail to: GEHA

P.O. Box 4665

Independence, MO 64051-4665

For claims questions and assistance, call us at (800) 821-6136.

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

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The 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:

- You must send a copy of the explanation of benefits (EOB) from any primary payer (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 and should include nursing notes.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not purchased through the prescription drug program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge. A copy of the physician's script must be included with prescription drugs purchased outside the United States.
- To control administrative costs, we will not issue benefit checks that do not exceed \$1.

### 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, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

**Overseas claims**

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send itemized bills that include an English translation. A copy of the physician's script must be included with prescription drugs purchased outside the United States. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. If possible, include a receipt showing the exchange rate on the date the claimed services were performed. Covered providers outside the United States will be paid at the PPO level of benefits. All overseas claims, including prescription drug reimbursement, should be submitted to: GEHA, Foreign Claims Department, P.O. Box 4665, Independence, MO 64051-4665.

**When we need more information**

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

## Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval. Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"> <li>a) Write to us within 6 months from the date of our decision; and</li> <li>b) Send your request to us at: GEHA, P.O. Box 4665, Independence, MO 64051-4665; and</li> <li>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li> <li>d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li> </ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"> <li>a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li> <li>b) Write to you and maintain our denial - go to step 4; or</li> <li>c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request - go to step 3.</li> </ol>
<b>3</b>	<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.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<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"> <li>• 90 days after the date of our letter upholding our initial decision; or</li> <li>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li> <li>• 120 days after we asked for additional information.</li> </ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p>

## The disputed claims process (continued)

	<p>Send OPM the following information:</p> <ul style="list-style-type: none"><li>• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li><li>• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li><li>• Copies of all letters you sent to us about the claim;</li><li>• Copies of all letters we sent to you about the claim; and</li><li>• Your daytime phone number and the best time to call.</li></ul> <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.</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>
<b>5</b>	<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 sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.</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> <p>You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.</p>

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (800) 821-6136 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

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## Section 9 Coordinating benefits with other coverage

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### When you have other health coverage or auto insurance

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

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

When we are the secondary payer, 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. There is no change in benefit limits or maximums when we are the secondary payer.

If your primary payer requires preauthorization or requires you use designated facilities for benefits to be approved, it is your responsibility to comply with these requirements. In addition you must file the claim to your primary payer within the required time period. If you fail to comply with any of these requirements and benefits are denied by the primary payer, we will pay secondary benefits based on an estimate of what the primary carrier would have paid if you followed their requirements.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

### What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). 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 third inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

### • Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 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 are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

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

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

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 probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at (800) 821-6136 or see our Web site at [www.geha.com](http://www.geha.com).

For members enrolled in High and Standard Option we waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

- **Inpatient hospital benefits:** If you are enrolled in Medicare Part A, we waive the deductible and coinsurance
- **Medical and surgery benefits and mental health/substance abuse care:** If you are enrolled in Medicare Part B, we waive the deductible and coinsurance. (There is no change in benefit limits or maximums for out-of-network mental health/substance abuse care.)
- **Office visits PPO providers:** If you are enrolled in Medicare Part B, we waive the copayments for PPO office visits.
- **Prescription drugs:** If you have Medicare Parts A and B, you will pay a copayment or coinsurance for drugs through Medco By Mail and at retail pharmacies as shown on pages 57-58.
- **Chiropractic benefits:** There is no change in benefit limits or maximums for chiropractic care when Medicare is primary. See page 33 for benefits.
- **Physical, speech and occupational therapy benefits:** There is no change in benefit limits or maximums for therapy when Medicare is primary.
- **We do NOT waive the \$300 (High Option) or \$500 (Standard Option) copayment for Specialty Pharmacy medications not dispensed by the Medco Specialty Pharmacy.**
- **We do NOT waive deductibles or coinsurance for Medicare members enrolled in the High-Deductible Health Plan.**

- **Private contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

If you enroll in a Medicare Advantage plan, the following options are available to you:

**This Plan and another plan's Medicare Advantage plan:** You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer 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.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
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...		✓ for 30-month coordination period
• This Plan was the primary payer before eligibility due to ESRD		
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
Have FEHB coverage on your own as an active employee or through a family member who is an active Employee		✓
Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

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

## **TRICARE and CHAMPVA**

TRICARE is the 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 the program.

## **Workers' Compensation**

We do not cover services that:

- You 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**

If GEHA pays benefits for an illness or injury for which you or your dependent are later compensated or reimbursed from another source, you must refund GEHA from any recovery you or your dependent obtain. All GEHA benefit payments in these circumstances are conditional, and remain subject to our contractual benefit limitations, exclusions, and maximums. By accepting these conditional benefits, you agree to the following:

- The covered person or his legal representative must contact GEHA's Subrogation Unit at (800) 821-4742, Ext. 5503 or 5735 as soon after the incident as possible and provide all requested information, including prompt disclosure of the terms of all settlements, judgments, or reimbursements. The covered person must sign any releases GEHA requires to obtain information about his or her claim from other sources.
- Include all benefits paid by GEHA in any claim for compensation you or your dependent assert against any tortfeasor, insurer, or other party for the injury or illness, and assign all proceeds recovered from any party, including your own and/or other insurance, to GEHA for up to the amount of the benefits paid.
- When benefits are payable under the plan in relation to the illness or injury, GEHA may, at its option:

Subrogate, that is, take over the covered person's right to receive payments from other parties. The covered person or his or her legal representative will transfer to GEHA any rights he or she may have to take legal action arising from the illness or injury to recover any sums paid on behalf of the covered person; or

Enforce its right to seek reimbursement, that is recover from the covered person, or his or her legal representative, any benefits paid from any payment the covered person is entitled to receive from other parties.

You must cooperate in doing what is reasonably necessary to assist us, and you must not take any action that may prejudice our rights to recover reimbursement.

- Reimburse GEHA on a first priority basis, in full up to the amount of benefits paid, out of any settlements, judgments, and/or recoveries that you obtain from any source, no matter how characterized, i.e., as “pain and suffering.” GEHA enforces this right of reimbursement by asserting a lien against any and all recoveries received, including first party Medpay, Personal Injury Protection, No-Fault coverage, Third-Party, and Uninsured and Underinsured coverage. GEHA’s lien consists of the total benefits paid to diagnose or treat the illness or injury. GEHA’s lien applies first, regardless of the “make whole” and “common fund” doctrines. No reduction of GEHA’s lien can occur without our written consent, including reduction for attorney fees and costs.
- Sign a Reimbursement Agreement if asked by GEHA to do so. However, a Reimbursement Agreement is not necessary to enforce our lien. We may delay processing of your claims until we receive a signed Reimbursement Agreement or Assignment of the proceeds of a claim.

GEHA’s lien extends to all related expenses incurred prior to the settlement or judgment date, even if those expenses were not submitted to GEHA for payment at the time you reimbursed GEHA. The lien remains the member’s obligation until it is satisfied in full. Failure to refund GEHA or cooperate with our reimbursement efforts may result in an overpayment that can be collected from you or any dependent.

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## Section 10 Definitions of terms we use in this brochure

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<b>Accidental injury</b>	An injury caused by an external force or element such as a blow or fall that requires immediate medical attention. Also included are animal bites, poisonings, and dental care required to repair injuries to sound natural teeth as a result of an accidental injury, not from biting or chewing.
<b>Admission</b>	The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.
<b>Assignment</b>	An authorization by an enrollee or spouse for the Plan to issue payment of benefits directly to the provider. The Plan reserves the right to pay the member directly for all covered services.
<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See pages 14-17.
<b>Congenital anomaly</b>	A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Plan may determine to be congenital anomalies. Surgical correction of congenital anomalies is limited to children under the age of 18 unless there is a functional deficit. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
<b>Cosmetic</b>	Any procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.
<b>Covered services</b>	Services we provide benefits for, as described in this brochure.
<b>Custodial care</b>	<p>Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:</p> <ul style="list-style-type: none"><li>• personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercise; dressing;</li><li>• homemaking, such as preparing meals or special diets;</li><li>• moving the patient;</li><li>• acting as companion or sitter;</li><li>• supervising medication that can usually be self administered; or</li><li>• treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.</li></ul> <p>The Carrier determines which services are custodial care. (Custodial care that lasts 90 days or more is sometimes known as long-term care.)</p>
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 14.

**Durable medical equipment**

Equipment and supplies that:

- are prescribed by your attending doctor;
- are medically necessary;
- are primarily and customarily used only for a medical purpose;
- are generally useful only to a person with an illness or injury;
- are designed for prolonged use; and
- serve a specific therapeutic purpose in the treatment of an illness or injury.

**Effective date**

The date the benefits described in this brochure are effective:

- January 1 for continuing enrollments and for all annuitant enrollments;
- the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during the open season for the first time; or
- for new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system

**Elective Surgery**

Any non-emergency surgical procedure that may be scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

**Expense**

An expense is "incurred" on the date the service or supply is rendered.

**Experimental or investigational services**

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Determination of experimental/investigational status may require review of appropriate government publications such as those of the National Institute of Health, National Cancer Institute, Agency for Health Care Policy and Research, Food and Drug Administration, and National Library of Medicine. Independent evaluation and opinion by Board Certified Physicians who are professors, associate professors, or assistant professors of medicine at recognized United States Medical Schools may be obtained for their expertise in subspecialty areas.

**Group health coverage**

Health care coverage that a member or covered dependent is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, dental or other health care services or supplies, including extension of any of these benefits through COBRA.

**Infertility**

The inability to conceive after a year of unprotected intercourse or the inability to carry a pregnancy to term.

<b>Intensive day treatment</b>	Outpatient treatment of mental conditions or substance abuse rendered at and billed by a facility which is accredited under the Hospital Accreditation Program of the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) or is licensed by the state as an outpatient day treatment program.
<b>Medical necessity</b>	<p>Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Plan determines</p> <ul style="list-style-type: none"> <li>• are appropriate to diagnose or treat the patient’s condition, illness or injury;</li> <li>• are consistent with standards of good medical practice in the United States;</li> <li>• are not primarily for the personal comfort or convenience of the patient, the family, or the provider,</li> <li>• are not a part of or associated with the scholastic education or vocational training of the patient; and</li> <li>• in the case of inpatient care, cannot be provided safely on an outpatient basis.</li> </ul> <p>The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.</p>
<b>Mental health/ Substance abuse</b>	Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by the Plan; or disorders listed in the ICD requiring treatment for abuse or dependence upon substances such as alcohol, narcotics, or hallucinogens.
<b>Plan allowance</b>	<p>Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our Plan allowance as follows:</p> <p>We consult standard industry guides, such as national databases of prevailing health care charges from Ingenix and Medical Data Resource. We use the 70th percentile. This means that out of every 100 reports, 30 charges billed may be more, but 70 charges will be the allowed amount or less. Charges determined in this way include, but are not limited to, ambulatory surgery centers, surgery, doctor’s services, physical therapy, speech therapy, occupational therapy, lab testing and X-ray expenses; and under the Standard Option diagnostic and preventive dental services.</p> <p>Plan allowance for prescription drugs is determined using average wholesale price data.</p> <p>Charges for some Plan allowances are stated in this brochure. These include limited benefits such as chiropractic care and routine dental care.</p> <p>Some Plan allowances may be submitted to medical consultants who recommend allowances based on special industry guidelines. We may also conduct independent surveys to determine the usual cost of a service or supply in a geographic area.</p> <p>If we negotiate a reduced fee amount on an individual claim for services or supplies which is lower than the Plan allowance, covered benefits will be limited to the negotiated amount. Your coinsurance will be based on the reduced fee amount. If you choose to use a provider other than the one we negotiated a reduction with, you will be responsible for the difference in these amounts.</p> <p>Our PPO allowances are negotiated with each provider who participates in the network. PPO allowances may be based on a standard reduction or on a negotiated fee schedule. For these allowances, the PPO provider has agreed to accept the negotiated reduction and you are not responsible for this discounted amount. In these instances, the benefit paid plus your coinsurance equals payment in full.</p> <p>For more information, see <i>Differences between our allowance and the bill</i> in Section 4.</p>

<b>Primary care physician</b>	For purposes of the office visit copayment for the Standard Option benefits, primary care physicians are individual doctors (M.D. or D.O.) whose medical practice is limited to Family/General Practice, Internal Medicine, Pediatrics/Adolescent Medicine or Obstetrics/Gynecology (OB/Gyn). Doctors listed in provider directories or advertisements under any other medical specialty or sub-specialty area (such as Internal Medicine doctors also listed under Cardiology or Geriatrics, or Pediatric sub-specialties such as Pediatric Allergy) are considered specialists, not primary care physicians. Chiropractors, eye doctors, dentists, audiologists, and mental health/substance abuse providers are not considered primary care physicians.
<b>Sound natural tooth</b>	Sound and Natural Tooth is a whole or properly restored tooth that has no condition that would weaken the tooth, or predispose it to injury, prior to the accident, such as decay, periodontal disease, or other impairments. For purposes of the Plan, damage to a restoration, such as a prosthetic crown or prosthetic dental appliances (i.e. bridgework), would not be covered as there is no injury to the natural tooth structure.
<b>Us/We</b>	Us and we refer to Government Employees Hospital Association, Inc.
<b>You</b>	You refers to the enrollee and each covered family member.

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## High Deductible Health Plan Definitions

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<b>Calendar year deductible</b>	There is one deductible for the entire plan year for covered services - medical, prescription, inpatient, outpatient, in-network mental health and chiropractic care - you must incur for almost all covered services and supplies before we start paying benefits.
<b>Catastrophic limit</b>	For those covered services with coinsurance, we pay 100% of our allowable amount for the remainder of the calendar year after your out-of-pocket-expenses for deductibles and coinsurance exceed \$5000 for self only coverage or \$10,000 for family coverage.
<b>Health Reimbursement Arrangement (HRA)</b>	Tax-free health plan deposits provided by us which allows you to accumulate savings for tax-free withdrawals for qualified medical expenses including your health plan deductible and other qualified out-of-pocket medical expenses.
<b>Health Savings Account (HSA)</b>	A tax-free account with monthly contributions made by us which earn interest for you to accumulate funds to help cover the deductible and other medical out-of-pocket expenses that roll over from year to year when not used for medical expenses. You have the option to make additional contributions to your account up to the maximum allowed by law.
<b>Premium contribution to HSA/HRA</b>	The portion of your monthly health plan premium that is deposited to your HSA each month based on your effective date of enrollment; or the portion of your health plan premium credited to your HRA which is available to you upon your enrollment in this Plan.

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## Section 11 FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

See [www.opm.gov/insure/health](http://www.opm.gov/insure/health) for enrollment as well as:

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

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, 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.

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

- **Children’s Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan’s Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn’t serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn’t serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 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 2005 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.

- **When you retire**

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

## **When you lose benefits**

- **When FEHB coverage ends**

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Spouse equity coverage** 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. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Web site, [www.opm.gov/insure](http://www.opm.gov/insure).
  
- **Temporary Continuation of Coverage (TCC)** If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from [www.opm.gov/insure](http://www.opm.gov/insure). It explains what you have to do to enroll.
  
- **Converting to individual coverage** You may convert to a non-FEHB individual policy if:

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.
  
- **Getting a Certificate of Group Health Plan Coverage** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

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

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## Section 12 Two Federal Programs complement FEHB benefits

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### Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

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

#### • What is an FSA

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

#### Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

#### • Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled for 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

**Online:** visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and click on Enroll.

- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

#### What is SHPS?

SHPS is a Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

- **Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDs accounts. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under the HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s). This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15. For example if you enrolled in FSAFEDS for the 2006 Plan Year, you will have until May 31, 2007 to submit claims for eligible expenses. [And, if your 2006 balance is not sufficient to reimburse you in full for eligible expenses incurred from January 1, 2007 through March 15, 2007, the unpaid balance will be paid out of your 2007 account if you re-enroll during Open season. If you do not re-enroll, you cannot be reimbursed in full for those expenses.]

The FSAFEDS Calculator at [www.FSAFEDS.com](http://www.FSAFEDS.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on pages 15-17 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this Plan, typical out-of-pocket expenses include: **\$350 calendar year deductible, \$20 PPO copay for covered office visits, \$5 copay for generic drugs/25% single-source brand name up to a maximum of \$150 for up to a 30-day supply; \$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand for up to a 30-day supply at retail for initial fill and first refill/subsequent fills you will pay the greater of 50% or amount described above, and \$15 generic/25% single-source brand name drugs up to a maximum of \$350 for up to a 90-day supply/\$15 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand drugs through Medco By Mail.**

Under the Standard Option of this Plan, typical out-of-pocket expenses include: **\$450 calendar year deductible, \$10 PPO copay for primary care physician or \$25 PPO copay for specialists for covered office visits, \$5 copay for generic drugs or 50% copay for brand name for up to a 30-day supply at retail, and \$15 copay for generic drugs/50% brand name for 90-day supply through Medco By Mail.**

Under the High Deductible Health Plan (HDHP), typical out-of-pocket expenses include: **\$1,100 for Self Only or \$2,200 for Self and Family calendar year deductible, 15% coinsurance for in-network providers, 30% coinsurance for out-of-network providers, for medical and surgical services, and 30% coinsurance for prescription drugs at retail pharmacies and through Medco By Mail.**

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at [www.irs.gov/pub/irs-pdf/p502.pdf](http://www.irs.gov/pub/irs-pdf/p502.pdf). The FSAFEDS Web site also has a comprehensive list of eligible expenses at [www.FSAFEDS.com/fsafeds/eligibleexpenses.asp](http://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp). If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

<b>Annual Tax Savings Example</b>	<b>With FSA</b>	<b>Without FSA</b>
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
<b>Your tax savings:</b>	<b>\$576</b>	<b>-\$0-</b>

**Note:** This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

**Paperless Reimbursement** – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

**Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal Tax Credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and download the [Dependent Care Tax Credit Worksheet](#) from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

• **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance during your period of coverage for the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

• **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.FSAFEDS.com](http://www.FSAFEDS.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time.

- E-mail: [FSAFEDS@shps.net](mailto:FSAFEDS@shps.net)
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

## **The Federal Long Term Care Insurance Program**

• **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

• **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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

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## Summary of benefits for the High Option of the Government Employees Hospital Association, Inc. 2006

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (\*) means the item is subject to the \$350 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

High Option Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		
<ul style="list-style-type: none"> <li>• Diagnostic and treatment services provided in the office</li> </ul>	PPO: \$20 copay per covered office visit and 10%* of other covered professional services including X-ray and lab  Non-PPO: 25%* of covered professional services	23-41
<b>Services provided by a hospital:</b>		
<ul style="list-style-type: none"> <li>• Inpatient</li> </ul>	PPO: Nothing for room and board, 10% of other hospital charges, inpatient \$100 per admission deductible applies  Non PPO: Nothing for room and board, 25% of other hospital charges, inpatient \$300 per admission deductible applies	42-44
<ul style="list-style-type: none"> <li>• Outpatient</li> </ul>	PPO: 10%* of other hospital charges  Non PPO: 25%* of other hospital charges	44-46
<b>Emergency benefits:</b>		
<ul style="list-style-type: none"> <li>• Accidental injury</li> </ul>	Nothing up to plan allowance of covered charges incurred within 72 hours of an accident	47-48
<ul style="list-style-type: none"> <li>• Medical emergency</li> </ul>	Regular benefits*	48
<b>Mental health and substance abuse treatment:</b>		
	In-Network: Regular cost sharing  Out-of-Network: Benefits are limited	49-51

*Summary of benefits for High Option - continued on next page*

**Summary of benefits for the High Option of the  
Government Employees Hospital Association, Inc. 2006 (continued)**

High Option Benefits (continued)	You pay	Page
<b>Prescription drugs:</b>		52-59
<ul style="list-style-type: none"> <li>• Retail pharmacy</li> </ul>	<p>Network pharmacy: Member pays \$5 for generic drugs/25% single-source brand name drugs up to a maximum of \$150 for up to a 30-day supply/\$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name for up to a 30-day supply for the initial fill and first refill. For subsequent refills, you pay the greater of 50% or the amount described above.</p> <p>Non-network pharmacy: Member pays \$5 for generic drugs/25% single-source brand name drugs up to a maximum of \$150 for up to a 30-day supply/\$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name drugs for up to a 30-day supply for the initial fill and first refill.</p> <p>Copayments and coinsurance go toward a \$4,000 annual prescription out-of-pocket except for the difference between the cost of the generic and brand multi-source drugs and the 50% coinsurance after the first two fills.</p> <p>For subsequent refills you pay the greater of 50% or the amount described above and any difference between our allowance and the cost of the drug.</p>	55-56
<ul style="list-style-type: none"> <li>• Mail Order</li> </ul>	<p>Member pays \$15 for generic drugs/25% single-source brand name drugs up to a maximum of \$350 for up to a 90-day supply/\$15 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name for a 90-day supply.</p> <p>Copayments and coinsurance go toward a \$4,000 annual prescription out-of-pocket except for the difference between the cost of the generic and brand multi-source drugs.</p>	56-58
<b>Dental care:</b>	Charges in excess of the scheduled amounts for diagnostic and preventive service, restorations, and extractions	61
<b>Special features:</b>	Flexible benefits option, services for deaf and hearing impaired, high-risk pregnancies	60
<b>Protection against catastrophic costs</b> (your catastrophic protection out-of-pocket maximum):	<p>Nothing after \$4,000 per year for PPO providers;</p> <p>Nothing after \$6,000 per year for Non-PPO providers. Some costs do not count toward this protection.</p>	15-16

## Summary of benefits for the Standard Option of the Government Employees Hospital Association, Inc. 2006

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (\*) means the item is subject to the \$450 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Standard Option Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		
<ul style="list-style-type: none"> <li>Diagnostic and treatment services provided in the office</li> </ul>	PPO: \$10 copay primary care physician; \$25 copay specialist for covered office visits and 15%* of other covered professional services including X-ray and lab  Non-PPO: 35%* of covered professional services	23-41
<b>Services provided by a hospital:</b>		
<ul style="list-style-type: none"> <li>Inpatient</li> </ul>	PPO: 15%* of covered hospital charges  Non PPO: 35%* of covered hospital charges	42-44
<ul style="list-style-type: none"> <li>Outpatient</li> </ul>	PPO: 15%* of covered hospital charges  Non PPO: 35%* of covered hospital charges	44-46
<b>Emergency benefits:</b>		
<ul style="list-style-type: none"> <li>Accidental injury</li> </ul>	Nothing up to plan allowance of covered charges incurred within 72 hours of an accident	47-48
<ul style="list-style-type: none"> <li>Medical emergency</li> </ul>	Regular benefits*	48
<b>Mental health and substance abuse treatment:</b>		
	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	49-51
<b>Prescription drugs:</b>		
<ul style="list-style-type: none"> <li>Retail pharmacy</li> </ul>	Network pharmacy: Member pays \$5 for generic drugs/50% brand name for up to 30-day supply.  Non-network pharmacy: Member pays \$5 for generic drugs/50% brand name and any difference between our allowance and the cost of the drug.	55-56
<ul style="list-style-type: none"> <li>Mail Order</li> </ul>	Member pays \$15 for generic drugs/50% brand name for 90-day supply	56-58
<b>Dental care:</b>		
	50% up to plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions	61
<b>Special features:</b>		
	Flexible benefits option, services for deaf and hearing impaired, high risk pregnancies	60
<b>Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):</b>		
	Nothing after \$5,000 per year for PPO providers; Nothing after \$7,000 per year for Non-PPO providers. Some costs do not count toward this protection	15-16

## Summary of benefits for the HDHP of the Government Employees Hospital Association, Inc. 2006

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

In 2006, for each month you are eligible for the HSA, we'll deposit \$60 per month for Self Only enrollment or \$120 per month for Self and Family enrollment to your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), we'll contribute up to \$720 for Self Only and \$1,440 for Self and Family annually when you are enrolled in the HDHP. The amount of your HRA (prorated for length of enrollment) will be available to you upon enrollment. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (\*) means the item is subject to the \$1,100 Self, \$2,200 Self and Family calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

HDHP Benefits	You pay	Page
<b>Medical/Surgical services provided by physicians:</b>		
<ul style="list-style-type: none"> <li>• Diagnostic and treatment services provided in the office</li> </ul>	PPO: 15%* for covered office visits and 15%* of other covered professional services including X-ray and lab Non-PPO: 30%* of covered professional services	73-90
<b>Services provided by a hospital:</b>		
<ul style="list-style-type: none"> <li>• Inpatient</li> </ul>	PPO: 15%* of covered hospital charges Non PPO: 30%* of covered hospital charges	91-92
<ul style="list-style-type: none"> <li>• Outpatient</li> </ul>	PPO: 15%* of covered hospital charges Non PPO: 30%* of covered hospital charges	93
<b>Emergency benefits:</b>		
<ul style="list-style-type: none"> <li>• Accidental injury</li> </ul>	Regular benefits*	95
<ul style="list-style-type: none"> <li>• Medical emergency</li> </ul>	Regular benefits*	95
<b>Mental health and substance abuse treatment:</b>		
	In-Network: Regular cost sharing* Out-of-Network: Benefits are limited*	97-99
<b>Prescription drugs:</b>		
<ul style="list-style-type: none"> <li>• Retail pharmacy</li> </ul>	Network pharmacy: Member pays 30%* for up to 30-day supply. Non-network pharmacy: Member pays 30%* and any difference between our allowance and the cost of the drug.	103
<ul style="list-style-type: none"> <li>• Mail Order</li> </ul>	Member pays 30%* for 90-day supply	103
<b>Dental care:</b>		
	50% up to plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions	74
<b>Special features:</b>		
	Flexible benefits option, services for deaf and hearing impaired, high-risk pregnancies	104
<b>Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):</b>		
	Nothing after \$5,000/Self Only or \$10,000/Self and Family enrollment per year; Some costs do not count toward this protection	16-17

## 2006 Rate Information for Government Employees Hospital Association, Inc. (GEHA) Benefit Plan

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

**Postal rates** apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Enrollment Code	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Postal Premium</i>	<i>Postal Premium</i>
		<u>Biweekly</u> Government Share	<u>Biweekly</u> Your Share	<u>Monthly</u> Government Share	<u>Monthly</u> Your Share	<u>Biweekly</u> USPS Share	<u>Biweekly</u> Your Share
High Option Self Only	311	\$139.18	\$94.40	\$301.56	\$204.53	\$164.31	\$69.27
High Option Self and Family	312	\$316.08	\$192.30	\$684.84	\$416.65	\$373.15	\$135.23
Standard Option Self Only	314	\$99.83	\$33.28	\$216.31	\$72.10	\$118.14	\$14.97
Standard Option Self and Family	315	\$226.87	\$75.62	\$491.55	\$163.85	\$268.46	\$34.03
HDHP Self Only	341	\$131.82	\$43.94	\$285.61	\$95.20	\$155.99	\$19.77
HDHP Self and Family	342	\$301.08	\$100.36	\$652.34	\$217.45	\$356.28	\$45.16