Government Employees Health Association, Inc. Benefit Plan

www.geha.com
(800) 821-6136

2015

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

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 14
- Summary of benefits: Page 115

Sponsored and administered by:

Government Employees Health 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 Health 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 2015.

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

ACCREDITED
HEALTH NETWORK
Connection Dental® Network

ACCREDITED
HEALTH UTILIZATION
MANAGEMENT

ACCREDITED
PHARMACY BENEFIT
& DRUG THERAPY
MANAGEMENT

URAC accreditation: Health Network Accredited for the Connection Dental® Network

URAC UM accreditation: InforMed for Health Utilization Management

URAC accreditation: Pharmacy Benefit & Drug Therapy Management

Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Government Employees Health Association, Inc. About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

Visit www.medicare.gov for personalized help,

Call (800) MEDICARE (800) 633-4227, TTY: (877) 486-2048.

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Introduction

This brochure describes the benefits of **Government Employees Health 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 Health Association, Inc. Customer service may be reached at (800) 821-6136 or through our website at www.geha.com. The address for the Government Employees Health Association, Inc. administrative offices is:

Government Employees Health 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, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on pages 13-14. Rates are shown at the end of this brochure.

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

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

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Government Employees Health 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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (800) 821-6136 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
(877) 499-7295
OR go to www.opm.gov/about-us/our-inspector-general
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 26 (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

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 reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. 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. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of avoidable complications and hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When an avoidable complication or "Never Event" occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct "Never Events", if you use Aetna Signature Administrators, Coventry Health Care of the Carolinas, Coventry Health Care of Georgia, Freedom Network, and HealthAmerica Pennsylvania providers. "Never Event" is defined by your claims administrator using national standards. Never Events are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

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

- **Minimum value standard**

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

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

See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

- Information on the FEHB Program and plans available to you;
- A health plan comparison tool;
- A list of agencies that participate in Employee Express;
- A link to Employee Express; and
- 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 Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family 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 of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

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

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including children of same-sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

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

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self 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 2015 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 2014 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits 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 website, www.opm.gov/healthcare-insurance.

- **Temporary Continuation of Coverage (TCC)**

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

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

- **Finding replacement coverage**

This Plan no longer offers its own non-FEHB plan for conversion purposes. If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at (800) 821-6136 or visit our website at www.geha.com.

- **Health Insurance Marketplace**

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

Section 1. How this plan works

This Plan 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 or a Standard Option.

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.

This Plan provides preventive services and screenings to you without any cost-sharing; you may choose any available primary care provider for adult and pediatric care, and visits for obstetrical or gynecological care do not require a referral.

General features of our High and Standard Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that we designate certain hospitals and other health care providers as "preferred providers." We assign you a "home network" based on the state where you live. Your home network is listed on your GEHA ID card. Please refer to the chart below to determine your home network.

Aetna Signature Administrators
Arizona, California, New York, New Jersey, Nevada, Oregon, and Washington
Coventry Health Care of the Carolinas, Inc.
North Carolina and South Carolina
Coventry Health Care of Georgia
Georgia
First Health
Florida and Texas
Freedom Network
E/S Kansas and W Missouri
HealthAmerica
Pennsylvania
Health Partners
Kansas
HealthLink
Illinois and E/S Missouri
Private Healthcare Systems
Arkansas, Connecticut, Hawaii, Indiana, Kentucky, Massachusetts, Maine, Michigan, New Hampshire, Rhode Island, and Vermont
UnitedHealthcare
Alabama, Alaska, Colorado, Delaware, Idaho, Iowa, Louisiana, Maryland, Minnesota, Mississippi, Montana, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Utah, Virginia, Washington DC, West Virginia, Wisconsin and Wyoming

The PPO organ/tissue transplant network for all members is LifeTrac. The PPO dialysis network for all members is the Preferred Outpatient Dialysis Network.

You have access to PPO providers inside and outside your home network. When you use a PPO provider in your home network, you are only responsible for the deductible, copayment, and coinsurance for covered charges. When you use a PPO provider that is outside your home network (in a GEHA network listed above but not printed on your GEHA ID card), GEHA will pay a PPO benefit based on a contracted rate, negotiated amount or a billed charge. You are still only responsible for the deductible, copayment, and coinsurance for covered charges. If you expect that you or a dependent will be residing outside of your home network for a temporary period of time, please contact GEHA for special assistance.

To find PPO providers, use the provider search tool on the geha.com website or call GEHA at (800) 296-0776. When you phone for an appointment, please remember to verify that the physician is still a PPO provider. GEHA 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.

You always have the right to choose a PPO provider or a non-PPO provider for medical treatment. When you see a provider not in the GEHA PPO network, GEHA will pay at the non-PPO level and you will pay a higher percentage of the cost.

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 up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians, hospitalists, neonatologists and pathologists who are not preferred providers at the preferred provider rate. In addition, providers outside the United States will be paid at the PPO level of benefits.

Georgia, North Carolina, Pennsylvania and South Carolina

We have entered into an agreement with Coventry Health Care, Inc. Coventry's open access health network will be available to our members. Benefits described above will be the same. You have the right to choose in network or out-of-network providers for your care. By receiving care from an in-network provider, you receive a higher level of benefit coverage. Also, in-network providers will file claims for you and are responsible for obtaining any needed precertifications required by the Plan. Out-of-network providers, unlike your in-network providers, are not obligated to obtain any needed certifications and therefore the member is responsible for obtaining the certification. In the local markets, Coventry is referred to as Coventry Health Care of the Carolinas, Inc., Coventry Health Care of Georgia and HealthAmerica Pennsylvania or HAPA. Members still call GEHA for all concerns or questions.

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.

We reserve the right to audit medical expenses to ensure that the provider's billed charges match the services that you received.

Health education resources

Our website at 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.

Your rights

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

- GEHA was founded in 1937 as the Railway Mail Hospital Association. For over 75 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 provider network includes nearly 6,500 hospitals and nearly 2 million in-network physician locations throughout the United States. In circumstances where there is limited access to network 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 website at www.geha.com.

Your medical and claims records are confidential

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

Section 2. Changes for 2015

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

Changes to this Plan

- CVS/caremark is the Plan's new pharmacy benefit manager. We will be using a new prescription drug formulary. Please read Section 5 (f) Prescription drug benefits so that you are aware of benefit changes and other important information that may affect you. The formulary and other information will be available to you on the CVS/caremark website.
- Certain drugs require prior authorization for medical necessity. These drugs are excluded from the formulary and we will not cover them unless we determine they are medically necessary based on objective clinical evidence. You are responsible for the full cost of drugs and services that we determine are not medically necessary (non-covered services). See page 72 for a list of drugs that require prior authorization for medical necessity.
- Step therapy is now required for certain specialty medications that your physician may prescribe for the following medical conditions: Multiple Sclerosis (MS), Rheumatoid Arthritis, Psoriatic Arthritis, Psoriasis, Ankylosing Spondylitis, Ulcerative Colitis and Crohn's disease. Step therapy requires you to use a Preferred drug before the pharmacist will dispense a Non-Preferred medication. Unless there are documented clinical reasons why you cannot take a Preferred drug, we will not cover the Non-Preferred medication and you will pay 100% of the prescription cost. We will not apply the cost of non-covered medication to your out-of-pocket maximum. See page 70 of Section 5(f) Prescription drug benefits.
- The generic copay does not apply to specialty medication. You are responsible paying the Preferred or Non-Preferred coinsurance for covered specialty drugs and medication. See Section 5(f) Prescription drug benefits.
- The CVS/caremark Mail Order Pharmacy is not a Medicare Part B provider for diabetic supplies. You may use a participating retail pharmacy that is willing to bill Medicare as primary in order to fill your diabetic supplies. See page 74.
- We no longer require step therapy for proton pump inhibitors (PPIs) or sleep aids and have removed the requirement from the brochure.

- Aetna Signature Administrators replaces the current PPO network in the following states: Arizona, California, New York, New Jersey, Nevada, Oregon, and Washington. See page 11.
- Covered adult routine preventive services include Hepatitis C screening and low dose CT lung cancer screening for individuals who satisfy criteria as established by the U. S. Preventive Services Task Force (USPSTF). See page 33.
- We have increased the cash rewards and merchandise incentives under the GEHA Health Rewards/Health Assessment Program. You may earn a $75 gift card for completing the health assessment and up to 175 points for completing a biometric screening and other targeted activities. See page 85.
- We no longer limit acupuncture to procedures performed by a licensed Medical Doctor or Doctor of Osteopathy. We cover acupuncture when performed by a licensed provider in the state where the service is rendered. See page 44.
- We have changed the subheading for Chiropractic to Manipulative Therapy. We cover manipulative therapy as shown in the brochure when performed by a licensed provider in the state where the service is rendered. See page 43.
- We no longer exclude Food and Drug Administration (FDA) approved sublingual allergy desensitization. See page 37.
- We cover diabetic shoes up to $150 per person per calendar year. See page 40.
- Generic Tamoxifen and Raloxifene are a covered preventive care service for women age 35 and over who have an increased risk for breast cancer according to USPSTF guidelines. See page 33.

Changes to our High Option only

- Your share of the non-postal premium will increase for 2015. See back cover.
- Prescription drugs now fall into three tiers of coverage which are: Tier 1 generic drugs, Tier 2 Preferred drugs and Tier 3 Non-Preferred drugs. When GEHA is primary, each 30-day supply from a retail pharmacy will cost you $10 generic, 25% up to $150 Preferred, or 40% up to $200 Non-Preferred. When Medicare A & B are primary, each 30-day supply from a retail pharmacy will cost you $10 generic, 20% Preferred up to $150 or 35% up to $200 Non-Preferred. Preferred or Non-Preferred coinsurance applies to specialty drugs and medication. See page 76 for your cost-sharing amounts when GEHA is primary. See page 77 for your cost sharing amounts when you have primary Medicare A&B.
- We have added Maintenance Choice to the prescription drug benefits. You may fill a 90-day supply of covered maintenance medication at a participating retail CVS pharmacy. See page 73 for details.
- You may obtain up to a 90-day supply of covered maintenance medication through the mail order program or at a retail CVS/pharmacy. When GEHA is primary, you pay $20 for generic drugs, 25% up to $350 maximum for Preferred drugs, and 40% up to $500 maximum for Non-Preferred drugs. When Medicare A and B are primary, you pay $15 for generic drugs, 15% up to $350 maximum for Preferred drugs, and 30% up to $500 maximum for Non-Preferred drugs. See page 76.
- The out-of-pocket maximum includes the deductible, copayments, and coinsurance that you pay for all covered essential health benefits as defined under the Affordable Care Act. The out-of-pocket maximum is $5,500 for PPO providers and $7,500 for Non-PPO providers per year. Covered PPO services count toward the Non-PPO maximum. Certain services do not apply to the out-of-pocket maximum (for example, precertification penalties, expenses that exceed the Plan allowance, non-covered services, etc.). Please see Section 4. Your costs for covered services for information on the out-of-pocket maximum.
- The Non-PPO coinsurance for non-accidental injury local ground ambulance transport has decreased from 25% to 10%. See pages 61 and 63.
- The benefit for hearing aids has increased. Previously, the Plan provided up to $500 per ear every five years. The new allowance is up to $2,000 in total every five years. See page 40.

Changes to our Standard Option only

- Your share of the non-Postal premium will increase. See back cover.
- The out-of-pocket maximum includes the deductible, copayments, and coinsurance that you pay for all covered essential health benefits as defined under the Affordable Care Act. The out-of-pocket maximum is $6,000 for PPO providers and $8,000 for Non-PPO providers per year. Covered PPO services count toward the Non-PPO maximum. Certain services do not apply to the out-of-pocket maximum (for example, precertification penalties, expenses that exceed the Plan allowance, non-covered services, etc.). Please see Section 4. Your costs for covered services for information on the out-of-pocket maximum.
- The Non-PPO coinsurance for non-accidental injury local ground ambulance transport has decreased from 35% to 15%. See pages 61 and 63.
- The benefit for hearing aids has increased. Previously, the Plan provided up to $500 per ear every five years. The new allowance is up to $1,000 in total every five years. See page 40.
- The PPO office visit copay will increase from $10 to $15 per visit to a primary care physician and from $25 to $30 per visit to a specialist. See Section 5(a) on page 31.

We have clarified the following:

- Your home PPO network appears on your identification card. When you use a PPO provider that is outside your home network (in a GEHA network but not the one printed on your GEHA ID card), we will pay a PPO benefit based on a contracted rate, negotiated amount, or a billed charge. See page 11.
- Non-routine colonoscopy is listed under covered diagnostic tests. See page 15.
- We bundle dialysis payments. Labs drawn during the week of dialysis treatments and drugs provided on the day of dialysis are part of the bundled dialysis payment for dialysis care. You have limited liability when you use a PPO provider. See page 37.
- When you have other primary coverage that pays for prescriptions, GEHA payment is based on the lesser of what GEHA would have paid in the absence of other primary coverage or the balance due after the primary carrier's payment. See page 73.
- You must see your PPO doctor for the specific purpose of routine preventive care in order for us to pay the visit in full and not apply the office visit copay. If you have a screening or blood test done during a visit to your doctor that is for medical reasons other than prevention, you will have to share in some of the cost. See page 34.
- We have added a definition for medical emergency. See page 62.
- We consider covered providers to be medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law. See page 16.
- We exclude benefits for oral implants and/or transplants, including for the treatment of accidental injury. See page 62.
- Residential Treatment Centers are covered facilities. Inpatient care at an RTC requires precertification. Failure to precertify will result in a penalty. We do not cover academic services or boarding schools. See page 66.
- Coverage for breast pumps is limited to one every two years with a physician's prescription. Members will receive an initial all-inclusive supply kit with the new pump. Two supplemental supply kits are allowed in a 12 month period. See page 42 for more information.
- Members must obtain prior authorization for compound drugs. See page 70.
- We have clarified preventive coverage and dosage strengths for aspirin, fluoride, iron, folic acid and vitamin D supplements. See page 71.
- Federal law prohibits the return of prescription medications after they are dispensed. See page 69.
- X-rays related to spinal subluxations or misalignments under Manipulative therapy are limited to $25 per person per calendar year. See page 43.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (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 website: 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 and who bills for the covered services. If you use our preferred providers, you will pay less.

- **Covered providers**

We provide benefits for the services of covered providers as required by Section 2706(a) of the Public Health Service Act (PHSA).

Under the Plan, we consider covered providers to be medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law.

These covered providers may include: a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.); chiropractor; nurse midwife; nurse anesthetist; audiologist; dentist; optometrist; licensed clinical social worker; licensed clinical psychologist; licensed professional counselor; licensed marriage and family therapist; podiatrist; speech, physical and occupational therapist; nurse practitioner/clinical specialist; nursing school administered clinic; physician assistant; registered nurse first assistants; certified surgical assistants; Christian Science practitioner, and a dietitian as long as they are providing covered services which fall within the scope of their state licensure or statutory certification.

The terms "doctor", "physician", "practitioner" or "professional provider" includes any provider when the covered service 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, and mental health/substance abuse providers.

Covered services must be provided in the state in which the practitioner is licensed or certified.

- **Covered facilities**

Covered facilities include:

- Freestanding ambulatory facility

1. 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.
2. Ambulatory Surgical Facilities in the state of California do not require a license if they are physician owned. To be covered these facilities must be accredited by one of the following: AAAHC (Accreditation Association for Ambulatory Health Care), AAAASF (American Association for Accreditation for Ambulatory Surgery Facilities), IMQ (Institute for Medical Quality) or JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

- Christian Science nursing organization/facilities that are accredited by The Commission for Accreditation of Christian Science Nursing Organization/Facilities Inc.
- 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.

- Skilled Nursing Facility licensed by the state or Medicare certified if the state does not license these facilities. See limitations on page 60.
- 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 acute 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 serviceson 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.

- Residential Treatment Center

1. A facility, under the supervision of mental health professionals, which provides services on the premises for the diagnosis, treatment, and care of persons with mental/substance abuse disorders;
2. Is licensed by the state as a Residential Treatment Center; and
3. Has facility accreditation by a national accrediting body

- **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 reasons 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 your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 821-6136. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

- **Inpatient hospital admission (including Skilled Nursing Facility, Long Term Acute Care, Rehab Facility or Residential Treatment Centers)**

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 requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay, Long Term Acute Care stay or Rehabilitation Facility stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

We will reduce our benefits for the Skilled Nursing Facility stay if no one contacts us for precertification. If the stay is not medically necessary we will not pay any 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 payor for the hospital stay; or
- Medicare Part A is the primary payor for the hospital stay.

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payor and you **do** need precertification.

- **How to precertify an admission to a hospital, Skilled Nursing Facility, Long Term Acute Care, Rehab Facility or Residential Treatment Centers**

  First, you, your representative, your physician or your hospital must call InforMed (Medical Management Service – IMMS) before admission or services requiring prior authorization are rendered. The toll-free number is (800) 242-1025. For admissions to Skilled Nursing Facilities, Long Term Acute Care Facilities, or Rehabilitation Facilities please call OrthoNet to precertify at (877) 304-4419. For all admissions except mental health/substance abuse in the state of Georgia, call Coventry Health Care of Georgia. The toll-free number is (800) 470-2004. For all admissions except mental health/substance abuse in the states of North Carolina and South Carolina, call Coventry Health Care of the Carolinas, Inc. The toll-free number is (800) 708-9355. For all admissions except mental health/substance abuse in the state of Pennsylvania, call HealthAmerica Pennsylvania. The toll-free number is (800) 755-1135. (For mental health/substance abuse precertification, call InforMed toll-free at (800) 242-1025.) See Section 5(e) *Mental health and substance abuse benefits.*

  Next, 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 days requested for hospital stay.

  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.

- **Non-urgent care claims**

  For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim.

  If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

- **Urgent care claims**

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

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (800) 821-6136. You may also call OPM's Health Insurance at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at (number). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admission* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for 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.

NICU cases

Confinements of infants in the neonatal care unit at any level must be reported to GEHA. GEHA, in collaboration with Alere, will review NICU cases, and assign a level of care based on the infant's acuity and consistent with TIOP (March of Dimes report Toward Improving the Outcome of Pregnancy), the 2004 AAP (American Academy of Pediatrics) statement regarding hospital levels of care and NUBC (National Uniform Billing Committee). The facility is notified of the assigned level of care at the time the case is first reviewed and when a change occurs. If the facility bills for a higher level of care than is approved, you will be responsible for the difference between the higher level of care charge and the lower approved level of care charge.

- **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. If you remain 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.

- **Other services that require prior approval**

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

- ACI (Autologous Cultured Chrondrocytes), also called Genzyme tissue repair (or Carticel) for knee cartilage damage;

- Abdominoplasty/ diastasis recti repair/ panniculectomy;
- Back/spine surgeries;
- Botox injections;
- Breast reconstruction except immediate reconstruction for diagnosis of cancer;
- Certain prescription drugs;
- Chronic dialysis provided at a dialysis unit, outpatient hospital facility or in the home;
- Coma stimulation;
- Cosmetic procedures including: blepharoplasty or any other type of eyelid surgery, brow lift, liposuction, and scar revision;
- Dialysis;
- Durable medical equipment (DME);
- ECT (electroconvulsive therapy);
- Epidural injections;
- Experimental/ investigation surgery or treatment;
- FACET injections;
- Genetic testing;
- Growth hormone therapy (GHT);
- Gynecomastia-cosmetic (see mammoplasty);
- High tech outpatient radiology/imaging;
- Injectable drugs for arthritis, psoriasis or hepatitis;
- Injectable hematopoietic drugs (drugs for anemia, low white blood count);
- Inpatient hospital mental health and substance abuse benefits, inpatient care at residential treatment centers and outpatient intensive day treatment;
- Intrathecal pump insertion for pain management (morphine pump, baclofen pump);
- Mammoplasty, reduction (unilateral/ bilateral);
- Mastectomy performed prophylactically;
- Morbid obesity surgeries;
- Non-Surgical outpatient cancer treatment, including chemotherapy and radiation (on-line precertification through www.eviti.com);
- Organ and tissue transplant procedures;
- Orthognathic surgery (jaw), including TMJ;
- Physical, occupational and speech therapy;
- Psychological testing;
- Rhinoplasty-no prior approval for septoplasty;
- Surgical correction of congenital anomalies;
- Surgical treatment of hyperhidrosis (benefits will not be approved unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful);
- Sympathectomy by thoracoscopy or laproscopy;
- Transplants, except kidney or cornea;
- UPPP Uvulopalatopharyngoplasty;
- Ventricular assistive device (VAD) including post hospital device supplies; and
- Other surgeries, as identified by the Plan.

- **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; and
- 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. Once you have received precertification approval, see below for scheduling services. The toll free number is (866) 879-8317. For the state of Georgia, call Coventry Health Care of Georgia. The toll-free number is (800) 470-2004. For the states of North Carolina and South Carolina, call Coventry Health Care of the Carolinas, Inc. The toll-free number is (800) 708-9355. For the state of Pennsylvania, call Health America Pennsylvania. The toll-free number is (800) 755-1135. Provide the following information: patient's name, plan identification number, birth date, requested procedure and clinical support for request, name and telephone number of ordering provider, and name of requested imaging facility.

After you obtain precertification from MedSolutions, you may be contacted by US Imaging. US Imaging offers a voluntary appointment scheduling program for your advanced diagnostic imaging tests. After your scan has been precertified, US Imaging will contact you, or you may call (877) 904-3877.

US Imaging does not schedule services for members with Medicare A& B primary or Medicare Part B only. US Imaging does not schedule services in states where GEHA contracts with the Coventry and Freedom provider networks.

Exceptions:

You do not need precertification in these cases:

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

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

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

If you disagree with our pre-service claims decision

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

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

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

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

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

  1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
  2. Ask you or your provider for more information.

     You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

     If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your costs for covered services

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

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.

Copayments

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

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

Note: If the billed amount or the Plan allowance that providers we contract with have agreed to accept as payment in full is less than your copayment, you pay the lower amount.

Cost-sharing

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

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 and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

- The calendar year deductible is $350 per person under High and 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 and Standard Option.
- We also have separate deductibles for:
  - A High Option per admission deductible of $100 per person (PPO) and $300 per person (non-PPO) for inpatient hospital services.

If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible ($350 per person under High and Standard Option) has been satisfied.

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

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

If your provider routinely waives your cost

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).

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at (800) 821-6136 or write to GEHA, P. O. Box 4665, Independence, MO 64051-4665.

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. For more information about out of area services, see We have a Preferred Provider Organization (PPO) in Section 1.

- **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/her 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, the physician can bill you for the $50 difference between our allowance and his/her 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.

EXAMPLE	PPO physician	Non-PPO physician
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
TOTAL YOU PAY	$10	$75

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

- $5,500 High Option or $6,000 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

- $7,500 High Option or $8,000 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 $350 (High and Standard Option) calendar year deductible;
- The $20 copayment for doctor's office visits (High Option); or the $15 copayment for primary care physician/$30 specialist office visits (Standard Option);
- The (High Option) $100 (PPO) or $300 (non-PPO) per in-hospital admission deductible;
- The $300 copayment (High Option) or $500 copayment (Standard Option) for Specialty Pharmacy medication not dispensed by our Specialty Pharmacy;
- 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, ambulance services and mental health and substance abuse services; and
- Coinsurance and copayments that you make for prescription drugs that we cover.

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;
- Expenses, in excess of plan limits, for dental and manipulative therapy;
- The cost for non-approved step therapy medication and drugs that we exclude;
- Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements (see Section 3); and
- The difference (High Option) between the cost of the generic and brand name medication.

Carryover

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

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

If we overpay you

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

When Government facilities bill us

Facilities of the Department of 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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High and Standard Option Benefits

See Section 2 for how our benefits changed this year. Pages 114-117 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

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 *Important things you should keep in mind about these benefits* at the beginning of the subsections. For more information about services, see *We have a Preferred Provider Organization (PPO)* in Section 1. 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 on our website at 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
  - Generic drugs: $10 copay at a retail pharmacy; $20 for non-Medicare mail order; $15 for Medicare at the mail order pharmacy
  - Within the provider network, 100% coverage for room and board and 90% for other hospital charges after the $100 per admission deductible. Precertification is required
  - Freedom to choose any doctor with extra savings when you see a preferred provider
- **Standard Option**
  - Affordable premiums
  - Low $15 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
  - Generic drugs: $10 copay at a retail pharmacy; $20 at the mail order pharmacy.
  - 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 and 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. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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 up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians, hospitalists, neonatologists and pathologists who are not preferred providers at the preferred provider rate.
- **YOU MUST GET PRECERTIFICATION FOR 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...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • Routine physical examinations • Office medical consultations • Second surgical opinions Note: See page 45 for coverage of Christian Science practitioners.	PPO: $20 copayment (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $15 copayment for office visits to primary care physicians; $30 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
• Emergency room physician care (non-accidental injury) • During a hospital stay • At home • Professional services of a physician at an urgent care facility	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

Benefits Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI (outpatient requires precertification) • Ultrasound • Electrocardiogram and EEG • Non-routine colonoscopy	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.
Not covered: • *Professional fees for automated lab tests*	*All charges*	*All charges*
Lab Card, service of Quest Diagnostics	**High Option**	**Standard Option**
You may use this voluntary program for covered outpatient lab tests. You show your Lab Card Program identification card and tell your physician you would like to use the Lab Card benefit. If the physician draws the specimen, he/she can call (800) 646-7788 for pick up or you can go to an approved collection site and show your Lab Card along with the test requisition from your physician and have the specimen drawn there. Please Note: You must show your Lab Card each time you obtain lab work whether in the physician's office or collection site. To find an approved collection site near you, call (800) 646-7788 or visit www.geha.com.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance.
Preventive care, adult	**High Option**	**Standard Option**
We provide benefits for a comprehensive range of preventive care and professional services for adults age 22 and over, including the preventive services recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). Such as: • Age and gender appropriate annual preventive medical examination, which may include certain biometric screening measures (Body Mass Index (BMI), blood pressure, cholesterol tests, glucose and Hemoglobin A1c tests, colorectal cancer screening) performed or ordered by your doctor as part of that annual preventive medical examination. Annual routine screenings as recommended by USPSTF, such as: • Total blood cholesterol screenings • Chlamydial infection • Colorectal cancer screening, including - Annual coverage of one fecal occult blood test for members age 40 and older	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
- Sigmoidoscopy (surgeon and facility charges) - Colonoscopy (surgeon and facility charges) • Lung cancer screening - Low-dose computed tomography (LDCT), in adults ages 55 to 80, who have a 30 pack per year smoking history and currently smoke or have quit within the past 15 years • Hepatitis C virus infection screening for members at high risk for infection. • Prostate cancer screening - Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older Well woman care; including, but not limited to: • Routine Pap test - Annual coverage of one Pap smear for women age 18 and older • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Routine mammogram Note: 3D mammograms are not considered routine screening tests • Osteoporosis screening - Bone density tests for routine screening for women 65 or older or women 60 or older who are at increased risk Note: Aspirin, fluoride, iron, vitamin D, bowel prep, generic Raloxifene, generic Tamoxifen and folic acid with physician prescription are covered as preventive with the appropriate age/gender or dosage limits with no patient copay. See Section 5(f) *Prescription drug benefits.*	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Note: You must see your doctor for the specific purpose of preventive care in order to have the visit considered under this benefit. If you have a screening or blood test done during a visit to your doctor that is for medical reasons other than prevention, you will likely have to share in some of the cost. Note: Newly recommended services under the Act will be included as of the first day of the calendar year in which they are required to be covered under the Act. A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS: www.healthcare.gov/prevention; IOM: www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies/Recommendations.aspx; AAP: www2.aap.org/immunization/pediatricians/pediatricians.html; CDC: www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm		
Not covered: • *Professional fees for automated lab tests*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
For dependent children under age 22: • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, including one routine eye examination per person per calendar year, with child vision screening for amblyopia and strabismus, immunizations and care • Initial examination of a newborn child covered under a family enrollment Note: A complete list of preventive care services recommended under the USPSTF is available online at ww.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS: www.healthcare.gov/prevention; IOM: www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies/Recommendations.aspx; AAP: www2.aap.org/immunization/pediatricians/pediatricians.html; CDC: www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)
Not covered: • *Professional fees for automated lab tests*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Prenatal care • Delivery • Postnatal care • Physician care such as sonograms	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Maternity care (cont.)	**High Option**	**Standard Option**
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 21 for other circumstances, such as extended stays for you or your baby. • 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. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. See Hospital benefits (Section 5 (c)) and Surgery benefits (Section 5(b)).	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • Approved fetal monitors, skilled nursing services, intravenous/ infusion therapy, and injections are covered the same as other medical benefits for diagnostic and treatment services. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation.	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
• Breastfeeding support, supplies, and counseling for each birth Note: Refer to Section 5(a) under *Durable medical equipment (DME)* for obtaining breast pump and supplies.	PPO: Nothing (No deductible) Non PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount for support and counseling. All of the charges for breast pump and supplies not purchased from the Plan's DME provider	PPO: Nothing (No deductible) Non PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount for support and counseling. All of the charges for breast pump and supplies not purchased from the Plan's DME provider
Not covered: • *Home uterine monitoring devices, unless preauthorized by our Medical Director* • *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* • *Charges for services and supplies incurred after termination of coverage*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Contraceptive methods and counseling • Voluntary sterilizations • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the *Prescription drug benefits* in Section 5(f).	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilizations* • *Genetic counseling and genetic screening* • *Preimplantation genetic diagnosis (PGD)* • *Expenses for sperm collection and storage*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
• Diagnosis and treatment of infertility except as shown in *Not covered*	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
Not covered: • *Infertility services after voluntary sterilizations* • *Fertility drugs* • *Genetic counseling and genetic screening* • *Preimplantation genetic diagnosis (PGD)* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination* - *In vitro fertilization* - *Embryo transfer and gamete intrafallopian transfer (GIFT)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment, including materials (such as allergy serum) • Allergy testing is limited to 100 tests per person per calendar year. Note: Each individual test performed as part of a group or panel is counted individually against the 100 test limit. • Allergy injections	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
Not covered: • *Clinical ecology and environmental medicine* • *Provocative food testing* • *Non-FDA approved sublingual allergy desensitization drugs*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Antibiotic therapy – intravenous (IV)/Infusion (see *Note) • Outpatient cardiac rehabilitation • Chemotherapy and radiation therapy (precertification required) Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 54. • Dialysis – hemodialysis and peritoneal dialysis (precertification required) - GEHA has a Preferred Outpatient Dialysis Network - Labs drawn during the week of dialysis treatments and drugs provided on the day of dialysis are part of the bundled out of network dialysis payment • Intravenous (IV)/Infusion Therapy (see *Note) • Respiratory and inhalation therapies Note: Some medications required for treatment therapies may be available through CVS/caremark Mail Order Pharmacy or a CVS/caremark participating pharmacy. Medications obtained from these sources are covered under the *Prescription drug benefits* in Section 5 (f). *Note: Please refer to the *Specialty drug benefits* on pages 78-80.	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
Not covered: • *Chelating therapy except for acute arsenic, gold or lead poisoning* • *Maintenance cardiac rehabilitation* • *Topical hyperbaric oxygen therapy* • *Prolotherapy* • *Applied Behavior Analysis (ABA)*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Physical, Occupational, and Speech Therapy	**High Option**	**Standard Option**
• Up to 60 visits per person per calendar year for the combined services of the following: - Qualified physical therapists - Qualified occupational therapists - Qualified speech therapists	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
All physical, occupational, and speech therapy visits require preauthorization. Please make an evaluation visit, then contact OrthoNet by phone at (877) 304-4399 or fax a copy of the evaluation to OrthoNet at (877) 304-4398. Authorizations will be provided in blocks of time and progress reviewed prior to additional authorizations.		
To precertify physical, occupational, and/or speech therapy in Georgia, contact Coventry at (800) 470-2004. In North and South Carolina, contact Coventry Healthcare of the Carolinas, Inc. at (800) 708-9355. In Pennsylvania, contact HAPA at (800) 755-1135.		
Services must be ordered by a physician. Orders must include the specific professional skills the patient needs, the medical necessity for the therapy, and an anticipated length of time the services are needed.		
Authorizations for physical, occupational, and speech therapy are concurrent, based on medical necessity, and on-going therapy approval is based on measurable progress towards established treatment goals that are documented in the member's treatment record. Therapy must be therapeutic, consistent with medically-accepted standards of care, and not experimental, investigational, or solely educational in nature.		
Combined therapy visits may be used for rehabilitative therapy or habilitative therapy. • Rehabilitative: Therapy is initiated to restore bodily function when there has been a total or partial loss of bodily function due to illness, surgery, or injury. In order to make individual-specific authorization decisions, OrthoNet will review the treating provider's evaluation; including diagnosis, duration of member's symptoms (chronic vs acute), nature or severity of symptoms, timeframes for anticipated recovery or clinical milestones, and rehab potential. Where appropriate, OrthoNet will review standardized tools specific to the condition or affected body part; such as the Simple Shoulder Test, HSS Knee Score, Oswestry, and DASH.		

Physical, Occupational, and Speech Therapy - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Physical, Occupational, and Speech Therapy (cont.)	**High Option**	**Standard Option**
• Habilitative: Therapy is initiated to address a genetic, congenital, or early acquired disorder resulting in significant deficit of ADL, fine motor, or gross motor skills. Therapy services are provided to enhance functional status and is focused on developing skills that were never present. In order to make individual-specific authorizations decisions, OrthoNet will review the treating provider's evaluation; including diagnosis, duration of symptoms, nature or severity of symptoms, anticipated improvement in symptoms, anticipated timeframe for therapy. Evaluations must include standardized age-appropriate tests documenting a condition/ developmental delay resulting in ADL, fine motor or gross motor functionality. Progress in therapy is defined as measurable progress toward achieving realistic functional goals/life skills (Activities of Daily Living) within a predictable period of time toward a member's maximum potential. Note: When you receive therapy from a qualified therapist in the outpatient setting which is medically necessary and meets the criteria for rehabilitative or habilitative therapy, your therapy is covered up to the Plan limits.	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
Not covered: • *Exercise programs* • *Long-term rehabilitation therapy* • *Maintenance therapy—measurable improvement is not expected or progress is no longer demonstrated.* • *Hot and cold packs* • *Computer devices to assist with communication* • *Computer programs of any type, including, but not limited to those to assist with speech therapy* • *Hippotherapy* • *Services intended to teach or enhance Instrumental Activities of Daily Living (therapy to promote skills associated with independent living, such as shopping, using a phone, cleaning, laundry, preparing meals, managing medications, driving, or managing money/ finances)*	*All charges*	*All charges*
Hearing services (testing, treatment and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care children.* • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	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

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

Benefits Description	You pay After the calendar year deductible...	
Hearing services (testing, treatment and supplies) (cont.)	**High Option**	**Standard Option**
• External hearing aids Note: Benefit is payable per person every five years.	PPO: All charges in excess of $2000 (No deductible) Non-PPO: All charges in excess of $2000 (No deductible)	PPO: All charges in excess of $1000 (No deductible) Non-PPO: All charges in excess of $1000 (No deductible)
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment and supplies)	**High Option**	**Standard Option**
• First pair of contact lenses or standard ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury • Outpatient Vision therapy visits by an ophthalmologist or optometrist	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
Not covered: • *Computer programs of any type, including but not limited to those to assist with vision therapy* • *Eyeglasses or contact lenses and examinations for them except as shown above* • *Radial keratotomy and other refractive surgery* • *Special multifocal ocular implant lenses*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
• Routine foot care only when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: $20 copayment for the office visit (No deductible); plus 10% of the Plan allowance for other services performed during the visit Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $15 copayment for the office visit to primary care physicians; $30 copayment for office visits to specialists (No deductible); plus 15% of the Plan allowance for other services performed during the visit Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• Diabetic shoes are limited to $150 per person per calendar year	PPO: All charges in excess of $150 (No deductible) Non-PPO: All charges in excess of $150 (No deductible)	PPO: All charges in excess of $150 (No deductible) Non-PPO: All charges in excess of $150 (No deductible)

Foot care - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Foot care (cont.)	**High Option**	**Standard Option**
Not covered: • *Cutting, trimming of toenails or removal of corns, calluses, or similar routine treatment of conditions of the foot, except as stated above*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes; • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers and surgically implanted breast implant following mastectomy • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b*) Surgical procedures.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.* 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.	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
Not covered: • *Orthopedic and corrective shoes, arch supports,foot orthotics,heel pads and heel cups* • *Bioelectric, computer programmed prosthetic devices*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
Durable medical equipment (DME) is equipment and supplies that: - Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) - 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 - Serve a specific therapeutic purpose in the treatment of an illness or injury We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds	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

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• Wheelchairs • Crutches • Walkers Note: Call us at (800) 821-6136 to obtain a contract provider or PPO provider in your area. Your chosen provider should call for preauthorization. We may contact you to recommend a provider in your area to decrease your out of pocket expense. Note: Coverage for specialty equipment such as specialty wheelchairs and beds is limited to the cost of the standard care and is subject to a home evaluation. Note: Please see the definition for Medical Necessity, page 106. Note: Refer to Section 5(f) for glucose meter and diabetic supplies, page 70.	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
Breast Pump and supplies: • One double channel electric breast pump with double suction capability is purchased for breast-feeding patients with a physician's prescription every two years. A new prescription is required when requesting a new/replacement pump. Additional pumps may be obtained from the GEHA breast pump contracted provider at the member's expense. - There is no cost to the member when the designated pump is obtained through GEHA's breast pump contracted provider. You must obtain the breast pump and supplies from our contracted provider. - An initial all-inclusive supply kit is provided with a new pump order. Two supplemental supply kits are allowed in a 12 month period. Supplemental supply kits contain new tubing and canisters. All other requested supplies can be obtained from the GEHA contracted provider at the member's expense. Call (800) 482-1993 anytime in the last 2 months of pregnancy and submit your physician's order. The pump and supplies will be delivered within 1-5 business days.	PPO: Nothing (No deductible) Non PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount for support and counseling. All of the charges for breast pump and supplies not purchased from the Plan's DME provider	PPO: Nothing (No deductible) Non PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount for support and counseling. All of the charges for breast pump and supplies not purchased from the Plan's DME provider
Not covered: • *Computer devices to assist with communications* • *Computer programs of any type* • *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 (see page 105)* • *Lifts, such as seat, chair or van lifts* • *Wigs* • *Bone stimulators except for established non-union fractures* • *Devices or programs to eliminate bed wetting*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Home health services	**High Option**	**Standard Option**
50 in-home visits per person per calendar year, not to exceed one visit up to two hours per day when: • A registered nurse (R.N.) or a licensed practical nurse (L.P.N.) provides the services • The attending physician orders the care • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services • The physician indicates the length of time the services are needed Note: Covered services are based on our review for medical necessity. Note: Please refer to the *Specialty drug benefits* beginning on page 78 for information on benefits for home infusion therapies.	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
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care* • *Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption* • *Inpatient private duty nursing*	*All charges*	*All charges*
Manipulative Therapy	**High Option**	**Standard Option**
Manipulative Therapy services limited to: • 12 visits per person per calendar year for manipulation of the spine • Adjunctive procedures such as ultrasound, electrical muscle stimulation, and vibratory therapy • X-rays, used to detect and determine nerve interferences due to spinal subluxations or misalignments ($25 per person per calendar year)	PPO and Non-PPO: All charges in excess of $20 per visit (no deductible) All charges in excess of $25 for X-rays of the spine (no deductible)	PPO and Non-PPO: All charges in excess of $20 per visit (no deductible) All charges in excess of $25 for X-rays of the spine (no deductible)
Not covered: • *Any treatment not specifically listed as covered*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Alternative treatments	**High Option**	**Standard Option**
Acupuncture: • Benefits are limited to 20 procedures per person per calendar year for medically necessary acupuncture treatments for: - Anesthesia - Pain relief Christian Science Practitioners: • Benefits are limited to 50 sessions per person per calendar year Christian Science Facilities: • Nursing care and room and board in a facility accredited by the Commission for Accreditation of Christian Science Nursing Organizations up to 30 days per person per calendar year	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
Not covered: • *All other alternative treatments, including clinical ecology and environmental medicine* • *Any treatment not specifically listed as covered* • *Naturopathic services*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is limited to: • Tobacco Cessation – We cover counseling sessions including proactive telephone counseling, group counseling and individual counseling. Benefits are payable for up to two attempts per person per calendar year, with up to four counseling sessions per attempt. • In addition, we cover over-the-counter (with a physician's prescription) and prescription smoking cessation drugs approved by the FDA. The quantity of drugs reimbursed will be subject to recommended courses of treatment. You may obtain smoking cessation drugs with your CVS/caremark prescription card, through CVS/caremark Mail Order Pharmacy or a non-Network Retail pharmacy. (See 75 for filing instructions in Section 5(f) *Prescription drug benefits.*)	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount (No deductible)
• Diabetes Education – Provided by Certified Diabetes Educators or physician through a program certified by the American Diabetes Association up to $250 per person per calendar year	PPO: All charges in excess of $250 (No deductible) Non-PPO: All charges in excess of $250 (No deductible)	PPO: All charges in excess of $250 (No deductible) Non-PPO: All charges in excess of $250 (No deductible)

Educational classes and programs - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Nutritional Counseling – Provided by a dietician with state license or statutory certification. Nutritional counseling must be ordered by a physician	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

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 calendar year deductible is $350 per person ($700 per family) under the High and 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. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- 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 up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians, hospitalists, neonatologists and pathologists who are not preferred providers at the preferred provider rate.
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefits Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies - 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 at least one co-morbidity related to obesity). Applicable co-morbid conditions include the following:	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

Surgical procedures - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Type II diabetes mellitus (by American Diabetes Association diagnostic criteria). • Refractory hypertension (defined as blood pressure of 140 mmHg systolic and or 90 mmHg diastolic) despite medical treatment with maximal dose of three antihypertensive medications. • Refractory hyperlipidemia (acceptable levels of lipids unachievable with diet and maximum doses of lipid lowering medications). • Obesity–induced cardiomyopathy. • Clinically significant obstructive sleep apnea. • Severe arthopathy of the spine and or weight bearing joints (when obesity prohibits appropriate surgical management of joint dysfunction treatable but for obesity - Documentation of failure to lower the body mass index within the last 12 months through a medically supervised program of diet and exercise of at least 6 months duration. Note: Benefits are payable only for bariatric surgery which meets the above criteria. Bariatric surgery must be precertified. • Insertion of internal prosthetic devices (see Section 5(a) *Orthopedic and prosthetic devices* for device coverage information) • Treatment of burns • 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. Registered nurse first assistants and certified surgical assistants are covered up to 15% of our allowance for the surgeon's charge for the procedure if medically necessary to have an assistant surgeon. 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.	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
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure based on: - Full Plan allowance • For the secondary and subsequent procedures based on: - One-half of the Plan allowance 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.	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

Surgical procedures - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Note: Voluntary sterilizations, surgically implanted contraceptives, injectable contraceptive drugs (such as Depo provera), intrauterine devices (IUDs), and diaphragms are listed as covered under Section 5 (a) *Family planning.*	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
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician or surgeon* • *Routine treatment of conditions of the foot; see Foot care* • *Surgical treatment of hyperhidrosis unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm – 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. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses; and surgical bras and replacements (see Section 5(a) *Orthopedic and prosthetic devices* for coverage) 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. 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.	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

Reconstructive surgery - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated promptly or as soon as the member's condition permits* • *Surgeries related to sex transformation or sexual dysfunction* • *Surgeries to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit* • *Charges for photographs to document physical conditions*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate • Excision of cysts and incision of abscesses unrelated to tooth structure • Extraction of impacted (unerupted or partially erupted) teeth • Alveoloplasty, partial or radical removal of the lower jaw with bone graft • Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues • Open reduction of dislocations and excision, manipulation, aspiration or injection of temporomandibular joints • 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 • Repair of traumatic wounds • Incision of the sinus and repair of oral fistulas • Surgical treatment of trigeminal neuralgia • Repair of accidental injury to sound natural teeth such as: expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. We may review X-rays and/or treatment records in order to determine benefit coverage. 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 63). • Orthognathic surgery for the following conditions: - severe sleep apnea only after conservative treatment of sleep apnea has failed - cleft palate and Pierre Robin Syndrome - Orthognathic surgery for any other condition is not covered • Other oral surgery procedures that do not involve the teeth or their supporting structures	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

Oral and maxillofacial surgery - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
Not Covered: • *Oral implants and transplants; including for the treatment of accidental injury* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Orthodontic treatment* • *Any oral or maxillofacial surgery not specifically listed as covered* • *Orthognathic surgery, except as outlined above for severe sleep apnea, cleft palate and Pierre Robin Syndrome (even if necessary because of TMJ dysfunction or disorder)*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	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

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. Refer to *Other services* in Section 3 for prior authorization procedures. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, pure red cell aplasia) - Chronic myelogenous leukemia - Hemoglobinopathy - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria • Autologous transplants for: - Acute lymphocytic or non-lymphocytic - (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Neuroblastoma - Amyloidosis	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

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants not subject to review for medical necessity: • Allogeneic transplants for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis • Autologous transplants for: - Multiple myeloma - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, - Breast cancer - Epithelial ovarian cancer - Childhood rhabdomyosarcoma - Advanced Ewing sarcoma - Advanced Childhood kidney cancers - Mantle Cell (Non-Hodgkin lymphoma) - Waldenstrom's macroglobulinemia - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms)	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
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria	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

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	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
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	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
Donor expenses • We will cover donor screening tests and donor search expenses for up to four potential donors of organ/tissue transplants. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. 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.	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
Transportation Benefit • 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 only payable when GEHA is the primary payor. • 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.	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Limited Benefits • 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.)		
• 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. • The transplant must be performed at a Plan-designated organ transplant facility to receive maximum benefits. GEHA uses a defined transplantation network, which may be different than the Preferred Provider Network. • 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. All treatment within 120 days following the transplant is subject to the $100,000 limit except expenses for aftercare such as outpatient prescription drugs are not a part of the $100,000 limit.	PPO: $20 copayment (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount 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.	PPO: $15 copayment for office visits to primary care physicians; $30 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 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.
• Chemotherapy and procedures related to bone marrow transplantation must be performed only at a Plan-designated organ transplant facility to receive maximum benefits. • 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.	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

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Not covered: • *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* • *Donor screening tests and donor search expenses, except those listed above* • *Expenses for sperm collection and storage*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional fees for the administration of anesthesia in: • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office	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

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. We added "(calendar year deductible applies)". The calendar year deductible is $350 per person ($700 per family) under the High and 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. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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). See page 45 for coverage of a Christian Science facility.
- 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 up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians, hospitalists, neonatologists and pathologists who are not preferred providers at the preferred provider rate.
- Charges billed by a facility for implantable devices, surgical hardware, etc., are subject to the Plan allowance which is based on the provider's cost plus 20% with submitted invoice or two times the Medicare allowance with no invoice. Providers are encouraged to notify us on admission to determine benefits payable.
- When you receive hospital observation services, we apply outpatient benefits to covered services up to 48 hours. Inpatient benefits will apply only when your physician formally admits you to the hospital as an inpatient. It is your responsibility to ensure that we are contacted for precertification if you are admitted as an inpatient.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS INCLUDING OBSERVATION CARE EXCEEDING 48 HOURS. 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. Confinement which are not considered not medically necessary will not be covered. Penalties are not subject to the catastrophic limit.

Benefits Description	You pay	
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodation • General nursing care • Meals and special diets 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.	PPO: Nothing Non-PPO: Nothing	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance (calendar year deductible applies)
Other hospital services and supplies, such as: • Operating, recovery and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: Calendar year deductible applies.) 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.	PPO: 10% of the Plan allowance ($100 per admission deductible applies) Non-PPO: 25% of the Plan allowance ($300 per admission deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance (calendar year deductible applies)
Maternity care – Inpatient hospital Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 21 for other circumstances, such as extended stays for you or your baby. • 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.	PPO: Nothing Non-PPO: Nothing for room and board; 25% of the Plan allowance for other hospital services ($300 per admission deductible applies)	PPO: Nothing Non-PPO: 35% of the Plan allowance (calendar year deductible applies)

Inpatient hospital - continued on next page

Benefits Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Other hospital services and supplies, such as: • Delivery room, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: Calendar year deductible applies.) Note: We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay.	PPO: Nothing Non-PPO: Nothing for room and board; 25% of the Plan allowance for other hospital services ($300 per admission deductible applies)	PPO: Nothing Non-PPO: 35% of the Plan allowance (calendar year deductible applies)
Note: We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. Note: For facility care related to maternity, including care at birthing facilities, we will waive the per-admission copayment and pay for covered services in full when you use PPO providers. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation.	PPO: Nothing for room and board; 10% of the Plan allowance for other hospital services ($100 per admission deductible applies) Non-PPO: Nothing for room and board; 25% of the Plan allowance for other hospital services ($300 per admission deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance (calendar year deductible applies)
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting.* • *Custodial care; see definition* • *Non-covered facilities such as nursing homes, schools* • *Personal comfort items such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*

Benefits Description	You pay	
Outpatient hospital, clinic or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, observation, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood or blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, splints, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Cardiac rehabilitation • Observation care is covered up to a maximum of 48 hours as an outpatient hospital service, see Section 10. Note: Please refer to page 79 for information on benefits for *Specialty drug benefits* medications dispensed by hospitals. 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.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 25% of the Plan allowance (calendar year deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance (calendar year deductible applies)
Not covered: • *Maintenance cardiac rehabilitation*	*All charges*	*All charges*
Maternity care – Outpatient hospital • Delivery room, recovery, observation, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood or blood plasma, if not donated or replaced • Pre-surgical testing • Dressings and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia services Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation.	PPO: Nothing Non-PPO: 25% of the Plan allowance (calendar year deductible applies)	PPO: Nothing Non-PPO: 35% of the Plan allowance (calendar year deductible applies)

Benefits Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
• Inpatient confinement at a Skilled Nursing Facility for the first 14 days following transfer from acute inpatient confinement when skilled care is still required. Benefits limited to $700 per day. No other benefits are payable for inpatient skilled nursing facility charges. Note: Medicare Part A pays for the first 14 days of Skilled Nursing Facility confinements during a Medicare benefit period. No benefits are payable by us including during a readmission during the same benefit period as defined by Medicare.	Charges in excess of $700 per day All charges after 14 days	Charges in excess of $700 per day All charges after 14 days
Hospice care	**High Option**	**Standard Option**
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. • We pay up to $15,000 for hospice care provided in an outpatient setting or for room, board, and care while receiving hospice care in an inpatient setting. Services may include a combination of inpatient and outpatient care up to a maximum of $15,000. 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: • Provided while the person is covered by this Plan • Ordered by the supervising doctor • Charged by the hospice care program • Provided within six months from the date the person entered or re-entered (after a period of remission) a hospice care program 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.	PPO: Nothing up to the Plan limits (calendar year deductible applies) Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)	PPO: Nothing up to the Plan limits (calendar year deductible applies) Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)
Not covered: • *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*	*All charges*	*All charges*

Benefits Description	You pay	
Ambulance - accidental injury	**High Option**	**Standard Option**
Ambulance service within 72 hours of an accident is covered as follows: • 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) • 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.	PPO: Nothing up to the Plan allowance Non-PPO: Nothing up to the Plan allowance	PPO: Nothing up to the Plan allowance Non-PPO: Nothing up to the Plan allowance
Ambulance - non-accidental injury	**High Option**	**Standard Option**
• 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)	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
• 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.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Ambulance transportation when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 per family) under the High and 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. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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 up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians, hospitalists, neonatologists and pathologists who are not preferred providers at the preferred provider rate.

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.

What is a medical emergency?

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

Benefits Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury	**High Option**	**Standard Option**
If you receive care for your accidental injury within 72 hours, we cover: • Treatment outside a hospital or in the outpatient/emergency room department of a hospital or urgent care facility • Related outpatient physician care Note: Emergency room charges associated directly with an inpatient admission are considered "Other charges" under *Inpatient hospital benefits* (see page 58) 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.	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)

Accidental injury - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Accidental injury (cont.)	**High Option**	**Standard Option**
If you receive care for your accidental injury after 72 hours, we cover: • Non-surgical physician services and supplies • Surgical care Note: We pay hospital benefits if you are admitted.	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
Not covered: • *Oral implants and transplants; including for the treatment of accidental injury*	*All charges.*	*All charges.*
Medical emergency	**High Option**	**Standard Option**
• Outpatient medical or surgical services and supplies billed by a hospital for emergency room treatment or outpatient medical or surgical services and supplies billed by an urgent care facility. Note: We pay hospital benefits if you are admitted.	PPO: 10% of the Plan allowance Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
Ambulance - accidental injury	**High Option**	**Standard Option**
Ambulance service within 72 hours of an accident is covered as follows: • 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) • 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.	PPO: Nothing up to the Plan allowance (no deductible) Non-PPO: Nothing up to the Plan allowance (no deductible)	PPO: Nothing up to the Plan allowance (no deductible) Non-PPO: Nothing up to the Plan allowance (no deductible)
Ambulance - non-accidental injury	**High Option**	**Standard Option**
• 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)	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Ambulance - non-accidental injury - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Ambulance - non-accidental injury (cont.)	**High Option**	**Standard Option**
• 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	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Ambulance transportation when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means*	*All charges*	*All charges*

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

You may choose to get care In-Network or Out-of-Network.

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 and 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 of $100 (In-Network PPO) and $300 (Non-Network) for inpatient hospital services.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- When you receive hospital observation services, we apply outpatient benefits to covered services up to 48 hours. Inpatient benefits will apply only when your physician formally admits you to the hospital as an inpatient. It is your responsibility to ensure that we are contacted for precertification if you are admitted as an inpatient.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS INCLUDING OBSERVATION CARE EXCEEDING 48 HOURS, INPATIENT RESIDENTIAL TREATMENT CENTERS 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. Refer to requirements for covered facilities shown in Section 3. Penalties are not subject to the catastrophic limit.

Benefits Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional Services	**High Option**	**Standard Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting (requires precertification)	PPO: $20 copayment per office visit (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $15 copayment per office visit (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

Professional Services - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Professional Services (cont.)	**High Option**	**Standard Option**
• Electroconvulsive therapy • Inpatient professional fees	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
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment (requires precertification)	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
Lab Card, service of Quest Diagnostics	**High Option**	**Standard Option**
You may use this voluntary program for covered outpatient lab tests. You show your Lab Card Program identification card and tell your physician you would like to use the Lab Card benefit. If the physician draws the specimen, he/she can call (800) 646-7788 for pick up or you can go to an approved collection site and show your Lab Card along with the test requisition from your physician and have the specimen drawn there. Please Note: You must show your Lab Card each time you obtain lab work whether in the physician's office or collection site. To find an approved collection site near you, call (800) 646-7788 or visit www.geha.com.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance.
Inpatient hospital and inpatient residential treatment centers (RTC)	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets 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 facility bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance

Inpatient hospital and inpatient residential treatment centers (RTC) - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Inpatient hospital and inpatient residential treatment centers (RTC) (cont.)	**High Option**	**Standard Option**
Other facility services and supplies: • Services provided by a hospital or residential treatment center (RTC) Note: We limit covered facilities for medically necessary substance abuse treatment to a hospital and/or RTC.	PPO: 10% of the Plan allowance ($100 per admission deductible applies) Non-PPO: 25% of the Plan allowance ($300 per admission deductible applies)	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance
Outpatient hospital	**High Option**	**Standard Option**
• Services such as partial hospitalization or intensive day treatment programs	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance
Emergency room - non-accidental injury	**High Option**	**Standard Option**
• Outpatient services and supplies billed by a hospital for emergency room treatment Note: We pay Hospital benefits if you are admitted.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance
Services we do not cover	**High Option**	**Standard Option**
Not covered: • *Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems* • *Treatment for learning disabilities and mental retardation* • *Telephone therapy, including therapy by remote video connection, such as Skype™* • *Travel time to the member's home to conduct therapy* • *Services rendered or billed by schools, half way houses, sober homes, or billed by their staff* • *Marriage counseling* • *Services that are not medically necessary* • *Applied Behavior Analysis (ABA)*	*All charges*	*All charges*

Precertification

To be eligible to receive full benefits for mental health and substance abuse, you must follow the authorization process:

- You must call InforMed at (800) 242-1025 to receive authorization for inpatient care and outpatient intensive day treatment. 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.

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.

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

- Section 4, *Your costs for covered services*, for information about catastrophic protection for these benefits; and
- 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 use a formulary that excludes coverage for certain medications unless we determine they are medically necessary. See page 72 for a list of drugs that require prior authorization for medical necessity.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Medication may be limited as to it's quantity, total dose, duration of therapy, age, gender or specific diagnosis. Prior approval/authorizations must be renewed periodically.
- There is no calendar year deductible for prescription drugs. Under the High Option plan copayments and coinsurance for prescription drugs go toward the annual PPO out-of-pocket limit except for the difference between the cost of the generic and brand name medication and the cost for non-approved step therapy medication. Under the Standard Option plan copayments and coinsurance for prescription drugs go toward the annual PPO out-of-pocket limit except for the cost for non-approved step therapy medication.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Some medications must be approved by GEHA and/or CVS/caremark before they are a covered benefit.
- 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 CVS/caremark Mail Order Pharmacy. Call GEHA Customer Service at (800) 821-6136 so 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, a mail order form, 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. CVS Caremark Specialty Pharmacy is the exclusive provider for specialty medications. You may contact the Specialty Pharmacy at (800) 237-2767.
- Step therapy applies to specialty medications that treat Rheumatoid Arthritis, Psoriatic Arthritis, Psoriasis, Ankylosing Spondylitis, Ulcerative Colitis, Crohn's Disease, and Multiple Sclerosis. Non-Preferred specialty drugs require prior approval.
- **Federal Law prohibits the return of prescription medications.** Medication cannot be returned to CVS caremark or retail pharmacies and you will be responsible for the cost. Be sure to check the cost of your medication before filling the prescription.

Prescription drug benefits

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

- **Drug coupon/copay cards:** We do not honor or coordinate benefits with drug coupon/copay cards. You are responsible for your copay or coinsurance as indicated in this brochure.
- **Who can write your prescription:** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication. 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, CVS/caremark Mail Order Pharmacy, or through a non-network pharmacy. 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 CVS/caremark Mail Order Pharmacy.

Prescription drug benefits - continued on next page

Prescription drug benefits (cont.)

There are important features you should be aware of – (*continued)*

- **How to obtain prior approval:** If you are filling a medication requiring a prior authorization for medical necessity please call (855) 240-0536, after January 1, 2015. At Mail, CVS/caremark will conduct the prior authorization for medical necessity review.
- **Step therapy applies to specialty medications that are used to treat certain conditions.** Step therapy requires you to use a preferred drug before the pharmacist dispenses a non-preferred medication. Non-preferred medications require prior approval. When you try to fill a non-preferred medication, the pharmacist will contact your physician to notify them of a preferred alternative. If the physician approves, a preferred medication will be dispensed for the applicable plan copayment. If the physician does not approve, an authorization review will be initiated to determine the medical necessity of the non-preferred drug. Unless there are documented clinical reasons why you cannot take the preferred drug, you may still obtain the non-preferred drug but you will be responsible for 100% of the cost, which will not apply to your annual out-of-pocket maximum. If the authorization for the non-preferred medication is approved, you will be responsible for the applicable plan copayment. Refer to the chart below for a list of the preferred and non-preferred medications. Preferred and non-preferred medications are subject to change.

Condition(s)	Preferred drugs	Non-Preferred drugs
Rheumatoid Arthritis, Psoriatic Arthritis, Psoriasis, Ankylosing Spondylitis, Ulcerative Colitis and Crohn's Disease	Enbrel & Humira	Actemra, Cimzia, Kineret, Orencia, Orencia SQ, Otezla, Remicade, Simponi, Simponi Aria, Stelara, Xeljanz
Multiple Sclerosis (MS)	Avonex, Copaxone, Extavia, Tecfidera, Gilenya	Betaseron, Aubagio, Tysabri

- **Compound Medication:** When a claim is submitted for online processing or direct reimbursement of a compound medication, the pricing is based on the contractual discounts plus a professional fee and any applicable sales tax. Pharmacies must submit all ingredients in a compound prescription as part of the claim for both online claims and paper claim submissions. At least one of the ingredients submitted with the compound Rx claim must require a physician's prescription in order to be covered by the plan. You are responsible for the appropriate brand name or generic copay or coinsurance based on the compound ingredients. Prior authorization may be required. Investigational drugs are not FDA approved. If the compound includes an investigational drug, the compound will not be covered.
  CVS/caremark can compound some medications. If the mail order pharmacy cannot accommodate your prescription, please consult your participating retail pharmacy. Ask your pharmacist to submit your claim electronically or "on-line". If the retail pharmacy is unable to submit the compound medication claim electronically to CVS/caremark, you will pay the full cost of the medication and submit the claim for reimbursement. Make sure that your pharmacist provides a list of the NDCs and quantity for every ingredient in the compound medication, and include this information on your claim. Mail the claim to CVS/caremark, P.O. Box 52136, Phoenix, AZ 85072-2136. Claim calculations and your copays or reimbursement for direct claims is performed using an industry standard reimbursement method for compounds.

Covered medications and supplies

You may purchase the following medications and supplies prescribed by a physician from either a retail 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;
- FDA approved contraceptive drugs and devices for women;
- Needles and syringes for the administration of covered medications.
- OneTouch blood glucose meter - provided at no charge by the manufacturer, thru the CVS/caremark Mail Order Pharmacy, call toll free: (877) 418-4746;
- Ostomy supplies (please include the manufacturer's product number to ensure accurate fill of the product);

Covered medications and supplies - continued on next page

Covered medications and supplies (cont.)

- GEHA members can go to a participating retail pharmacy to receive certain vaccinations. Influenza vaccine is commonly administered by retail pharmacies. Other vaccines, such as those for pneumococcal pneumonia (Pneumovax), varicella (Zostavax) and hepatitis B (Heptavax) may also be available through retail pharmacies.

  Members may call CVS/caremark at (844) 4-GEHARx or (844) 443-4279 to identify a participating vaccine pharmacy or go to www.caremark.com.

  GEHA members should check with the retail pharmacy to ensure availability of a pharmacist who can inject vaccines and availability of the vaccine product before going to the pharmacy. GEHA members should also ask retail pharmacies if there is an age requirement for vaccines that can be administered at that pharmacy.
- In addition, we will cover over-the-counter (with a physician's prescription) and prescription tobacco cessation drugs approved by the FDA. The quantity of drugs reimbursed will be subject to recommended courses of treatment. You may obtain tobacco cessation drugs with your GEHA ID card, through a participating network retail pharmacy, CVS/caremark Mail Order Pharmacy, or a non-network retail pharmacy (see page 75 for filing instructions).
- Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act, link to the website www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.
  - Aspirin –All single ingredient generic oral dosage forms ≤ 325 mg OTC only (requires a prescription) for prevention of CVD for individuals 45 years of age and older. Limit of 100 units per fill
  - Fluoride supplements - Single ingredient oral dosage forms ≤ 0.5mg with brand name and generic prescription products only for children 6 years of age and younger
  - Iron supplements - Single ingredient brand name and generic pediatric oral liquids– prescription or OTC (requires a prescription) for children age 6-12 months
  - Folic acid supplements - Single ingredient generic 0.4mg and 0.8mg tabs. OTC only (requires a prescription) for women 55 years of age and younger. Limit of 100 units per fill
  - Vitamin D products (Single entity vitamin D2 or D3 containing 1,000IU or less per dosage form, Combination products that also contain calcium (combination of two agents only for the combinations)) – Rx or OTC (requires a prescription) for indviduals age 65 and over
  - Generic tamoxifen and raloxifene - with prescription for women ages 35 and over for the prevention of breast cancer
  - Colorectal Cancer Prevention - Bowel Prep products - prescription only, brand name until generics become available, age 50-74 years
  - Women's Preventive Service - Contraceptives - oral, emergency, injectible, patch, barrier, and misc - brand name and generic Rx or OTC (requires a prescription). Women only and limits may apply
  - Immunizations: Vaccines; Childhood and Adult, Rx Only, coverage dependent on vaccine type
  - Smoking Cessation – gum, lozenge, patch, inhaler, spray and oral therapy, brand name and generic coverage, Rx and OTC (requires a prescription); day supply limits apply depending on therapy

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

CVS/caremark formulary

Your prescription drug program includes use of the CVS/caremark 2015 formulary which is developed by an independent panel of doctors and pharmacists who ensure the medications are clinically appropriate and cost-effective. In an effort to continue to help promote affordable and clinically appropriate products, there are a select number of drugs that are excluded from the formulary and not covered by the Plan. For these drugs, generics and/or alternative medications in the same drug class are readily available. If one of these excluded drugs is medically necessary, a prior authorization for medical necessity is required. We do not cover the drugs listed below unless we determine the medical necessity to treat a medical condition based on objective clinical data. Please refer to our website at www.geha.com for the most updated version that outlines formulary alternatives covered by the Plan.

Your physician may be contacted to discuss your prescriptions for drugs that are excluded by the Plan's formulary. No change in the medication prescribed will be made without your physician's approval.

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.

List of Drugs Requiring Prior Authorization for Medical Necessity

ACCU-CHEK STRIPS AND KITS +	FREESTYLE STRIPS AND KITS	OSENI
ACTOS	GENOTROPIN	OXYTROL
ADDERALL XR	GLUMETZA	PENNSAID
ADRENACLICK	*hecoria*	PLAVIX
ADVICOR	HUMALOG	PREVACID
AEROSPAN	HUMALOG MIX 50/50	PROTONIX
ALTOPREV	HUMALOG MIX 75/25	PROVENTIL HFA
ALVESCO	HUMULIN 70/30	QNASL
AMRIX	HUMULIN N	RAYOS
ANDROGEL	HUMULIN R	REBIF
APEXICON E	INTERMEZZO	RHINOCORT AQUA
APIDRA	JALYN	RIOMET
ARTHROTEC	KAZANO	ROZEREM
ASACOL HD	KOMBIGLYZE XR	SAIZEN
ATACAND	LASTACAFT	SUBOXONE FILM
ATACAND HCT	LESCOL XL	SYMBICORT
BECONASE AQ	LIPITOR	TESTIM
BREEZE 2 STRIPS AND KITS	LIPTRUZET	*testosterone gel*
BYETTA	LIVALO	TEVETEN
CONTOUR NEXT STRIPS AND KITS	LUNESTA	TEVETEN HCT
CONTOUR STRIPS AND KITS	LUMIGAN	TEV-TROPIN
DELZICOL	NAPRELAN	TOVIAZ
DETROL LA	NATESTO	TRICOR
DIOVAN HCT	NESINA	TUDORZA
DUEXIS	NORVASC	VALTREX
DYMISTA	NUTROPIN AQ	VENTOLIN HFA
EDARBI	OLUX-E	VERAMYST
EDARBYCLOR	OMNARIS	VIMOVO
EUFLEXXA	OMNITROPE	VOGELXO
FARXIGA	ONGLYZA	XOPENEX HFA
FLECTOR	ORTHOVISC	ZETONNA
FORTAMET		All other test strips that are not ONETOUCH brand name

High Option – prescription drug tiers

- Under the **High Option**, we divide prescription drugs into categories or tiers: generic, preferred, and non-preferred medications. When an approved generic equivalent is available, that is the drug you will receive, unless you or your physician specifies the prescription must be dispensed as written. When an approved generic equivalent is not available, you will pay the preferred or non-preferred applicable plan coinsurance. If an approved generic equivalent is available, but you or your physician specifies that the prescription must be dispensed as written with the brand name medication, you will pay the generic copayment plus the difference between the cost of the generic drug and the brand name drug dispensed. Your physician may request the brand name drug be approved through a medical necessity review. If your brand name drug is approved as medically necessary, your coinsurance will be the applicable brand name coinsurance.
- **Generic drugs** are chemically and therapeutically equivalent to the corresponding brand name 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 name expire. The Food and Drug Administration (FDA) 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.
- **Preferred drugs** are FDA approved prescription medications included on the Preferred Drug List developed by CVS/caremark. This list developed by an independent panel of doctors and pharmacists who ensure the medications are clinically appropriate and cost-effective. Selection criteria sources include but are not limited to: peer-reviewed literature; recognized compendia; consensus documents; nationally sanctioned guidelines and other publications of the National Institutes of Health, Agency for Healthcare Research and Quality, and other organizations or government agencies; drug labeling approved by the FDA; and input from medical specialty practitioners.
- **Non-Preferred drugs** are FDA approved prescription medications that are covered by GEHA, however they are not included on the CVS/caremark Preferred Drug List. Most commonly utilized medications have generic or preferred medications available.

High Option Maintenance Choice

Maintenance Choice®lets you choose how to get 90-day supplies of your maintenance medications: through mail service or at a retail CVS/pharmacy. Either way, you pay mail service prices for 90-day supplies. After two retail 30-day prescription fills, members are required to use their mail service benefit. With the Maintenance Choice program, members can continue to use retail CVS/pharmacy locations to gain access to 90-day supply while accessing the mail order coinsurance under your plan. Maintenance Choice also allows members the ability to have their prescription transferred from the mail order service, to a retail CVS/pharmacy location if the member wants the experience of talking with pharmacy staff in person. If a member would like to get started with mail service for the first time, they can call the CVS/caremark Fast Start program and CVS/caremark will work with their physician to acquire a 90-day supply prescription to be filled through either the CVS/caremark Mail Order Pharmacy or their local retail CVS/pharmacy. The CVS/caremark Fast Start program can be reached at (800) 875-0867 or members can sign in or register at www.caremark.com/faststart once their plan year begins.

Coordinating with other drug coverage

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

If you obtain your prescription from a retail pharmacy using your primary insurance plan:

1. Present prescription ID cards from both your primary insurance plan and GEHA.
2. If able, the pharmacy will electronically process both your primary and secondary claims and the pharmacist will tell you if you have any remaining copay/coinsurance to pay.
3. If the pharmacy cannot electronically process the secondary claim, purchase your prescription using the prescription ID card issued by your primary insurance carrier and pay any copay/coinsurance required by the primary insurance. Then, mail your pharmacy receipt to CVS/caremark for consideration of possible reimbursement through your GEHA, secondary benefit. Submit these claims to CVS/caremark, PO Box 52136, Phoenix, AZ 85072-2136.

If you obtain your prescription from a mail service pharmacy using your primary insurance plan:

1. Purchase your prescription using the prescription ID card issued by your primary insurance carrier and pay any copay/coinsurance required by the primary insurance.
2. Then, mail your pharmacy receipt to CVS/caremark for consideration of possible reimbursement through your GEHA, secondary benefit. Submit these claims to CVS/caremark, PO Box 52136, Phoenix, AZ 85072-2136.

Coordinating with other drug coverage - continued on next page

Coordinating with other drug coverage (cont.)

If your primary insurance does not provide a prescription ID card:

1. Purchase your drug from the pharmacy and submit the bill to your primary insurance.
2. When the primary insurance has made payment, file the claims and the Explanation of Benefit (EOB) with CVS/caremark for consideration of possible reimbursement using your secondary benefit. Submit these claims to CVS/caremark, PO Box 52136, Phoenix, AZ 85072-2136.

In any event, if you use GEHA's prescription ID card when another insurance plan is primary, you will be responsible for reimbursing us any amount in excess of our secondary benefit. If another insurance plan is primary, you should use their drug benefit.

When coordination of benefits apply, reimbursement is based on GEHA's allowable. Our benefit payment will be based on the lesser of:

- what GEHA would have paid in the absence of other primary coverage
- or, the balance due after the primary carrier's payment.

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.

For Medicare Part B insurance coverage: If Medicare Part B is primary, discuss with the retail pharmacy the options to submit Medicare covered medications and supplies to allow Medicare to pay as the primary carrier. Prescriptions typically covered by Medicare Part B include diabetes supplies (test strips, meters), specific medications used to aid tissue acceptance from organ transplants, certain oral medications used to treat cancer, and ostomy supplies.

Retail - When using a retail pharmacy for eligible Medicare Part B medication or supplies, present the Medicare ID card. Request the retail pharmacy bill Medicare as primary. Most independent pharmacies and national chains are Medicare providers. To locate a retail pharmacy that is a Medicare Part B participating provider, visit the Medicare website at www.medicare.gov/supplier/home.asp or call Medicare Customer Service at (800) 633-4227.

Mail Order - To receive your Medicare Part B-eligible medications by mail, send your mail-order prescriptions to CVS/caremark. The CVS/caremark Mail Order Pharmacy will review the prescriptions to determine whether it could be eligible for Medicare Part B coverage and submit to Medicare if appropriate. Please note, the CVS/caremark Mail Order Pharmacy is not a Medicare Part B provider for diabetic supplies. You must use a retail pharmacy willing to bill Medicare as primary.

For Medicare Part D insurance coverage: GEHA supplements the coverage you get with your Medicare Part D prescription drug plan. Your Medicare drug plan provides your primary prescription drug benefit. GEHA provides your secondary prescription drug benefit. To ensure that you maximize your benefits, use a pharmacy in network for both the GEHA Plan and your Medicare Part D plan, and provide both prescription ID cards when filling a prescription allowing the pharmacy to coordinate coverage on your behalf.

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 ensure patient safety.

How to use CVS/caremark network pharmacies (retail)

You may fill your prescription at any participating retail pharmacy. To locate participating pharmacies, call CVS/caremark at (844) 4-GEHARX or (844) 443-4279 or visit www.caremark.com. To receive maximum savings you must present your prescription ID card at the time of each purchase, and your enrollment information must be current and correct. In most cases, you simply present the prescription ID card together with the prescription to the pharmacist.

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 12 months 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 CVS/caremark or GEHA.

How to use CVS/caremark (mail order)

Through this service, you may receive up to a 90-day supply per prescription 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 CVS/caremark Mail Order Pharmacy 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 CVS/caremark Mail Order Pharmacy 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 CVS/caremark or GEHA. Not all drugs are available through CVS/caremark. In order to use CVS/caremark Mail Order Pharmacy, 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.

To order new prescriptions, ask your physician to prescribe needed medication for up to a 90-day supply, plus refills, if appropriate. Complete the information on the Ordering Medication Form; enclose your prescription and the correct copayment.

Under regular circumstances, you should receive your medication within approximately 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 CVS/caremark toll-free at (844) 4-GEHARX or (844) 443-4279 available 24 hours a day, 7 days a week. Forms necessary for refills will be provided each time you receive a supply of medication.

Mail to: CVS/caremark
PO Box 94467
Palatine, IL 60094-4467

Fax: You can ask your physician to fax your prescriptions to CVS/caremark Mail Order Pharmacy. To do this, provide your physician with your ID number (located on your ID card) and ask him or her to fax the prescription to the CVS/caremark Mail Order Pharmacy fax number: (800) 378-0323.

Electronic transmission: You can ask your physician to transmit your prescriptions electronically to CVS/caremark Mail Order Pharmacy.

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 21 days of medication left.

To order by phone: Call Member Services at (844) 4-GEHARX or (844) 443-4279. 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.caremark.com.

Benefits Description	You pay	
Note: The calendar year deductible does not apply to benefits in this Section.		
Covered medications and supplies – when GEHA is primary	**High Option**	**Standard Option**
CVS/caremark Network Pharmacy (retail) All copayments are for up to a 30-day supply per prescription. 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 applicable plan coinsurance. Note: Medications to treat some severe and chronic medical conditions are only available through CVS/caremark Specialty Pharmacy. See pages 78-80 for the categories of drugs in this program.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Preferred: 25% up to a maximum of $150, for up to a 30-day supply Non-Preferred: 40% up to a maximum of $200, for up to a 30-day supply If you choose a brand name medication when a generic is available, you will be charged the generic copay plus the difference in cost between the brand name and the generic For the third and all subsequent refills of a maintenance medication, you pay the greater of 50% or the amount described above (except for Maintenance Choice).	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Brand name: 50% up to a maximum of $200, for up to a 30-day supply • Retail fills eligible for a greater than a 30-day supply will be subject to the 50% coinsurance up to the maximum of $500
Non-Network Retail If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to: CVS/caremark P.O. Box 52136 Phoenix, AZ 85072-2136 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. All copayments are for up to a 30-day supply per prescription.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Preferred: 25% up to a maximum of $150, for up to a 30-day supply Non-Preferred: 40% up to a maximum of $200, for up to a 30-day supply If you choose a brand name medication when a generic is available, you will be charged the generic copay plus the difference in cost between the brand name and the generic For the third and all subsequent refills of maintenance medication, you pay the greater of 50% or the amount described above	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Brand name: 50% up to a maximum of $200, for up to a 30-day supply • Retail fills eligible for a greater than a 30-day supply will be subject to the 50% coinsurance up to the maximum of $500 Plus any difference between our allowance and the cost of the drug
CVS/caremark (mail order) All copayments are for up to a 90-day supply per prescription.	Generic: $20 or the cost of the drug whichever is less Preferred: 25% up to a maximum of $350 for up to a 90-day supply	Generic: $20 or the cost of the drug whichever is less Brand name: 50% up to a maximum of $500 for up to a 90-day supply

Covered medications and supplies – when GEHA is primary - continued on next page

Benefits Description	You pay	
Covered medications and supplies – when GEHA is primary (cont.)	**High Option**	**Standard Option**
A generic equivalent will be dispensed unless you or your physician specifies the prescription be dispensed as written (DAW), when a generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance.	Generic: $20 or the cost of the drug whichever is less Preferred: 25% up to a maximum of $350 for up to a 90-day supply Non-Preferred: 40% up to a maximum of $500 for up to a 90-day supply If you choose a brand name medication when a generic is available, you will be charged the generic copay plus the difference in cost between the brand name and the generic Maintenance Choice lets you choose how to get a 90-day supply of your maintenance medications through mail service or at a CVS/pharmacy	Generic: $20 or the cost of the drug whichever is less Brand name: 50% up to a maximum of $500 for up to a 90-day supply
Covered medications and supplies – Medicare A & B primary	**High Option**	**Standard Option**
CVS/caremark Network Pharmacy (retail) All copayments are for up to a 30-day supply per prescription. A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written, (DAW) when a generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance. Note: Medications to treat some severe and chronic medical conditions are only available through CVS/caremark Specialty Pharmacy. See pages 78-80.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Preferred: 20% up to a maximum of $150 for up to a 30-day supply Non-Preferred: 35% up to a maximum of $200 for up to a 30-day supply If you choose a brand name medication when a generic is available, you will be charged the generic copay plus the difference in cost between the brand name and the generic For the third and all subsequent refills of maintenance medication, you pay the greater of 50% or the amount described above	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Brand name: 50% up to a maximum of $200 for up to a 30-day supply • Retail fills eligible for a greater than a 30-day supply will be subject to the 50% coinsurance up to the maximum of $500 Initial amount prescribed, for up to a 30-day supply
Non-Network Retail If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to:	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Preferred: 20% up to a maximum of $150 for up to a 30-day supply	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Brand name: 50% up to a maximum of $200 for up to a 30-day supply

Covered medications and supplies – Medicare A & B primary - continued on next page

Benefits Description	You pay	
Covered medications and supplies – Medicare A & B primary (cont.)	**High Option**	**Standard Option**
CVS/caremark P.O. Box 52136 Phoenix, AZ 85072-2136 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. All copayments are for up to a 30-day supply per prescription.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Preferred: 20% up to a maximum of $150 for up to a 30-day supply Non-Preferred: 35% up to a maximum of $200 for up to a 30-day supply If you choose a brand name medication when a generic is available, you will be charged the generic copay plus the difference in cost between the brand name and the generic	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Brand name: 50% up to a maximum of $200 for up to a 30-day supply • Retail fills eligible for a greater than a 30-day supply will be subject to the 50% coinsurance up to the maximum of $500 Plus any difference between our allowance and the cost of the drug.
CVS/caremark (mail order) All copayments are for up to a 90-day supply per prescription. 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.	Generic: $15 or the cost of the drug whichever is less Preferred: 15% up to a maximum of $350 for up to a 90-day supply Non-Preferred: 30% up to a maximum of $500 for up to a 90-day supply If you choose a brand name medication when a generic is available, you will be charged the generic copay plus the difference in cost between the brand name and the generic Maintenance Choice lets you choose how to get 90-day supplies of your maintenance medications through mail service or at a CVS/pharmacy store	Generic: $20 or the cost of the drug whichever is less Brand name: 50% up to a maximum of $500 for up to a 90-day supply

Specialty drug benefits	High Option	Standard Option
Specialty medications are biotech or biological drugs that are oral, injectable or infused, or may require special handling. To maximize patient safety, all specialty medications require prior authorization. These drugs are used in the treatment of severe, chronic medical conditions such as hemophilia, multiple sclerosis, hepatitis, cancer, rheumatoid arthritis, pulmonary hypertension, osteoarthritis, and immune deficiency.	**Medications dispensed by CVS/caremark Specialty Pharmacy:** **When GEHA is primary:** • Generic and Preferred medications: 25% up to a maximum of $150 for up to a 30-day supply, $350 maximum coinsurance for up to a 90-day supply	**Medications dispensed by CVS/caremark Specialty Pharmacy:** • 50% coinsurance up to a maximum of $200 for up to a 30-day supply • 50% coinsurance up to a maximum of $500 for up to a 90-day supply when appropriate

Specialty drug benefits - continued on next page

Specialty drug benefits (cont.)	High Option	Standard Option
The CVS Caremark Specialty Pharmacy provides not only your specialty medicines, but also personalized pharmacy care management services. If you have questions, visit www.CVSCaremarkSpecialtyRx.com or call Specialty Customer Care toll-free at (800) 237-2767. Outpatient, non-surgical cancer treatments require precertification through eviti at www.eviti.com. Note: Specialty drugs require prior approval. See "How to obtain prior approval" on page 70. Note: Step therapy is required for specialty medication that treats certain medical conditions. See page 70 for a list of medical conditions and the list of Preferred and Non-Preferred drugs. We will not cover a non-Preferred drug unless it is medically necessary to treat your condition under the prior approval process.	**Medications dispensed by CVS/caremark Specialty Pharmacy:** **When GEHA is primary:** • Generic and Preferred medications: 25% up to a maximum of $150 for up to a 30-day supply, $350 maximum coinsurance for up to a 90-day supply • Non-Preferred medications: 40% up to a maximum of $200 for up to a 30-day supply $500 maximum coinsurance for up to a 90-day supply **When Medicare is primary:** • Generics and Preferred medications: 15% up to a maximum of $150 for up to a 30-day supply • Non-Preferred: 30% up to a maximum of $200 for up to a 30-day supply If you choose a brand name specialty drug for which a generic drug exists, you will pay the applicable coinsurance 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 specialty drug which will require preauthorization. **Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals, you pay after the calendar year deductible:** • PPO: $300 copayment per prescription fill and 10% of the Plan allowance • Non-PPO: $300 copayment per prescription fill and 25% of the Plan allowance • The $300 copayment per prescription fill does not apply to the out-of-pocket maximum Note: A separate copayment applies per prescription fill up to a 30-day supply.	**Medications dispensed by CVS/caremark Specialty Pharmacy:** • 50% coinsurance up to a maximum of $200 for up to a 30-day supply • 50% coinsurance up to a maximum of $500 for up to a 90-day supply when appropriate **Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals; you pay after the calendar year deductible::** • PPO: $500 copayment per prescription fill and 15% of the Plan allowance • Non-PPO: $500 copayment per prescription fill and 35% of the Plan allowance • The $500 copayment per prescription fill does not apply to the out-of-pocket maximum Note: A separate copayment applies per prescription fill up to a 30-day supply.

Specialty drug benefits - continued on next page

Specialty drug benefits (cont.)	High Option	Standard Option
Non-Specialty Pharmacy retail purchase If CVS/caremark Specialty Pharmacy is not used and you purchase a specialty medication through a retail pharmacy, you must submit your claim to: Government Employees Health Association, Inc, Attention: RX Program PO Box 4665 Independence MO 64051-4665 Reimbursement will be based on GEHA's costs had you used the specialty pharmacies. You must submit original drug receipts.	**When GEHA is primary:** • $300 copayment per prescription fill and: Generic and Preferred medications: 25% Non-Preferred medications: 40% You pay the difference between our allowance and the cost of the drug. If you choose a brand name specialty drug for which a generic drug exists, you will pay the applicable coinsurance 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 specialty drug which will require preauthorization. Note: A separate copayment applies per prescription fill up to a 30-day supply. **When Medicare is primary:** • $300 copayment per prescription fill and: Generics and Preferred medications: 20% Non-Preferred: 35% You pay the difference between our allowance and the cost of the drug. If you choose a brand name specialty drug for which a generic drug exists, you will pay the applicable coinsurance 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 specialty drug which will require preauthorization. Note: A separate copayment applies per prescription fill up to a 30-day supply.	• $500 copayment per prescription fill and 50% of the Plan allowance (plus any difference between our allowance and the cost of the drug) Note: A separate copayment applies per prescription fill up to a 30-day supply.

Non-covered medications and supplies	High Option	Standard Option
The following medications and supplies are not covered under the GEHA health plan: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements that do not require a prescription are not covered, including enteral formula available without a prescription* • *Nonprescription medicines not shown as covered* • *Medical supplies such as dressings and antiseptics* • *Drugs which are investigational* • *Drugs prescribed for weight loss* • *Drugs to treat infertility* • *Drugs to treat impotency* • *Certain prescription drugs that have an over-the-counter (OTC) equivalent drug are not covered* *Note: Over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation, through a participating network retail pharmacy, CVS/caremark Mail Order Pharmacy or a non-network retail pharmacy. See page 71.*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB plan will be First/Primary payor of any Benefit payments and your FEDVIP plan is secondary to your FEHB plan. See Section 9, *Coordinating benefits with other coverage*.
- 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. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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. We do not cover oral implants and transplants. 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 benefit description				
Dental Services	**High Option Scheduled Allowance We pay**	**High Option Scheduled Allowance You pay**	**Standard Option Scheduled Allowance We pay**	**Standard Option Scheduled Allowance You pay**
Diagnostic and preventive services, including examination, prophylaxis (cleaning), X-rays of all types and fluoride treatment	$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

Dental Services - continued on next page

Dental benefit description				
Dental Services (cont.)	**High Option Scheduled Allowance We pay**	**High Option Scheduled Allowance You pay**	**Standard Option Scheduled Allowance We pay**	**Standard Option Scheduled Allowance You pay**
Amalgam Restorations **Resin - Based Composite Restorations** **Gold Foil Restorations** **Inlay/Onlay Restorations**	$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
Simple Extractions	$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
Not covered: • *Oral implants and transplants are not covered, including for the treatment of accidental injury*	*Nothing*	*All charges*	*Nothing*	*All charges*

Section 5(h). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf and hearing impaired	TDD service is available at (800) 821-4833 for members who are hearing impaired.
High risk pregnancies	GEHA makes various maternity resources available to you or your covered dependent. Visit www.geha.com/maternity to order your packet on pregnancy and prenatal care.
Lab Card, service of Quest Diagnostics	The Lab Card Program gives you and your dependents the option of receiving 100% covered outpatient laboratory testing. Lab Card is an optional program. If you choose not to use Lab Card, you will not be penalized. You will simply pay the deductible, coinsurance or copay portion of your lab work. Lab Card does not replace your current healthcare benefits; it simply gives you and your dependents the option of receiving 100% coverage for outpatient laboratory testing. Please Note: You must show your Lab Card each time you obtain lab work whether in the physician's office or collection site. This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance. Lab Card covers most outpatient laboratory testing included in your health insurance plan, provided the tests have been ordered by a physician and you have asked for the Lab Card benefit and shown your Lab Card. Outpatient lab work includes: Blood testing (e.g., cholesterol, CBC), Urine testing (e.g., urinalysis), Cytology and pathology (e.g., pap smears, biopsies), Cultures (e.g., throat culture).

	Lab Card does not cover: Lab work ordered during hospitalization, lab work needed on an emergency (STAT) basis and time sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests, non-laboratory work such as mammography, X-ray, imaging and dental work.
Health Advice Line	Call the toll-free GEHA Health Advice Line number (888) 257-4342 and speak with a registered nurse – any time, 24 hours a day. The nurse can help you understand your symptoms and determine appropriate care for your needs. For example: Do you need emergency care? Should you make an appointment with your physician? Are there self-care techniques that you can apply at home? When you call the GEHA Health Advice Line, you can also choose to listen to recorded messages on more than 1,000 health topics.
Health Rewards/Health Assessment	Participate in GEHA Health Rewards program and earn rewards for activities that can improve your health. This program is available to two adults (member and/or dependent) for a family enrollment or one adult for self only enrollment. Your first step is completing an online health assessment. You will receive an individualized health report that can help you identify and address your health risks. This information is not shared with your employer. You will receive a $75 gift card after completing the health assessment. In addition, you will earn 100 points (equivalent to $100) by completing a biometric screening through Quest Diagnostics. You can earn up to an additional 75 points (equivalent to $75) by participating in any of the following activities: • Completion of on-line classes and tracking activity on www.onlifehealth.com, • Coaching for chronic conditions; such as high blood pressure, obesity, smoking cessation, or • Participation in a targeted health program (by invitation) The points you earn can be redeemed for health and wellness merchandise. Start by completing an online health assessment at www.onlifehealth.com (click Get Started, type GEHA when prompted to enter a key code). For more information, go to www.geha.com/rewards.
Obesity screening and management	GEHA offers a number of services and tools for weight management. • BMI calculation through on-line health risk assessment • Nutrition counseling (see Educational Classes and Programs, Section 5a) • Behavior change programs with coaching for members who qualify. • Discounts for gym memberships and other services through Connection Fitness. • Bariatric surgery, when medically necessary. Bariatric surgery must be precertified
Personal Health Record	Our Personal Health Record helps you track health conditions, allergies, medications and more. This program is voluntary and confidential. To access this tool, log in through your member dashboard at www.geha.com.

Non-FEHB benefits available to Plan members

The benefits in this Section are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at (800) 821-6136 or visit their website at www.geha.com.

Non-Covered Prescription Drugs	(844) 4-GEHARX or (844) 443-4279	

Certain erectile dysfunction 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 erectile dysfunction drug (except Levitra) to treat impotency, you may purchase it through the CVS/caremark Pharmacy (mail order), paying 100% of the discounted amount. To order, complete the form called CVS/caremark Mail Service Order Form. Mail this form along with your prescription and check or credit card number to:

CVS/caremark
P.O. Box 94467
Palatine, IL 60094-4467

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

CVS/caremark ExtraCare® Health Card		www.Caremark.com

GEHA's members can receive additional savings on OTC products through the CVS/caremark ExtraCare® Health Card. The ExtraCare® Health Card provides GEHA members with a 20% discount on thousands of CVS/pharmacy brand name health-related items at www.cvs.com or in any CVS/pharmacy stores nationwide. Through www.cvs.com, members can access extensive health information and resources in addition to customized deals and savings information, including any ExtraSavings™& ExtraBucks Rewards. Members also can turn their smartphone into a digital ExtraCare card with the CVS/pharmacy® application.

Connection Hearing®	(866) 211-6048	www.HearPO.com/geha

Free to all GEHA health plan option members and their families to include over age children, domestic partners, same sex spouses, parents, and grandparents, Connection Hearing® offers a discount hearing program through HearPO, an Amplifon company. Use of this program can help maximize your hearing aid benefit dollars.:

- Low price guarantee on hearing aids from ten leading hearing aid manufacturers;
- Continuous care – one year free follow-up, two years of free batteries, and a three-year warranty;
- 60 day, no risk trial period to ensure your satisfaction;
- Convenient locations near you;
- A patient care advocate will explain the HearPO process and assist in making the appointment with a hearing care professional.

Connection's Vision® Powered by EyeMed	(877) 808-8538	www.geha.com/vision

Free to all GEHA High or Standard Option Plan members, you receive vision exam coverage for no additional premium. Through Connection Vision powered by EyeMed, you and your covered family members each pay only $5 for an annual routine eye exam when you use a qualified EyeMed participating provider. Or, if you seek services from a non-participating provider, you can be reimbursed up to $45 for your annual eye exam.

At participating EyeMed locations, GEHA members also receive discounts off the retail price of lenses, frames, specialty items (such as tints, lightweight plastics, scratch-resistant coatings), as well as LASIK and PRK.

For a list of participating locations, select Connection Vision on the GEHA website at www.geha.com/vision.

You will receive a separate vision ID card from EyeMed to use for these services.

EyeMed will process all in-network claims systematically. Members will be responsible for copays at time of service. For out-of-network services, you will need to pay in full at the time of service and submit a copy of the itemized receipt with an out-of-network claim form for reimbursement to the following address:

EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

FSAFEDS Paperless Reimbursement Option	(877) 372-3337	www.FSAFEDS.com

FSAFEDS, in partnership with Government Employees Health Association, Inc. Benefit Plan, offers a Paperless Reimbursement option allowing you to be reimbursed from your FSAFEDS health care account without submitting a claim! When you receive services through Government Employees Health Association, Inc. Benefit Plan, your out-of-pocket liability – the amount of money you paid to your provider – will be sent automatically to FSAFEDS for processing. FSAFEDS will review your claims and reimburse you for any eligible out-of-pocket expenses – no need for a claim form or receipt! In many cases, you will receive your reimbursement before your doctor's bill is due! Reimbursement will be made directly from your FSAFEDS account to you via Electronic Funds Transfer.

See Section 11 of this brochure, visit www.FSAFEDS.com, or call toll-free (877) FSAFEDS (877) 372-3337 to learn more about how you can save money on your out-of-pocket health care expenses.

Connection Fitness®	(800) 294-1500	www.globalfit.com/geha

All GEHA health plan members can take advantage of special discounts available through our Connection Fitness® program by GlobalFit. This new program offers discounts on gym memberships at more than 10,000 health clubs nationwide, discounts on workout equipment and videos, and discounts on 12-week health coaching programs. Call GlobalFit or visit the GlobalFit website for more information.

Connection Dental®	(800) 296-0776	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 more than 91,000 provider locations. Participating providers have agreed to limit their charges to reduced fees for GEHA health plan members. As a GEHA health plan member, you can take advantage of this program in addition to receiving basic dental benefits provided under the GEHA health plan. To find a participating Connection Dental provider in your area, call (800) 296-0776 or visit www.geha.com. Please confirm provider participation prior to your visit.

CONNECTION Dental *Plus*®	(800)793-9335	www.geha.com/cdplus

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 current and former federal employees, retirees and annuitants, including those who are not members of the GEHA health plan. Parents can cover their unmarried dependent children up to their 26th birthday in this 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 Vision powered by EyeMed and Connection Hearing® by HearPO.

Section 6. General Exclusions - services, drugs and supplies we do not cover

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies 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 yourself, 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 non-covered facility, except that medically necessary prescription drugs and physical, occupational and speech 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 which 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 102), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare "limiting charge" (see page 103), services, drugs or supplies related to avoidable complications and medical errors, "Never Event" policies (see page 107) or State premium taxes however applied.
- Charges in excess of the "Plan allowance" as defined beginning on page 107.
- 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.
- Surgical treatment of hyperhidrosis unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful.
- 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.
- Telephone consultations and therapy (including consultations or therapy by remote video connection such as Skype™).
- Genetic counseling and genetic screening.
- Services, drugs, or supplies ordered or furnished by a non-covered provider.
- Applied Behavior Analysis (ABA)

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at (800) 821-6136, or at our website at www.geha.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 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 received overseas or when another group health plan is primary -- submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

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

Post-service claims procedures

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

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

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

Records

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the re-issuance 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 a completed Overseas Claim Form and the itemized bills to: GEHA, Foreign Claims Department, P.O. Box 4665, Independence, MO 64051-4665. Obtain Overseas Claim Forms from www.geha.com.

If you have questions about the processing of overseas claims, contact us at (877) 320-9469 or by email overseas@geha.com. 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.

When we need more information

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

Authorized Representative

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

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

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

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing GEHA, P.O. Box 4665, Independence, MO 64051-4665 or calling (800) 821-6136.

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

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

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: GEHA, P.O. Box 4665, Independence, MO 64051-4665; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; • Your daytime phone number and the best time to call; and • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to file a lawsuit. 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. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

	You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (800) 821-6136. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2, at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage or auto insurance

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

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

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

In certain circumstances when we are secondary, we will also take advantage of any provider discount arrangements your primary plan may have. When the primary plan allowance is less than our allowable, we will only make up the difference between the primary's plan payment and the amount the provider has agreed to accept as payment in full from the primary payor.

If your primary payor requires preauthorization or requires you use designated facilities or provider for benefits to be approved, it is your responsibility to comply with these requirements. In addition you must file the claim to your primary payor within the required time period. If you fail to comply with any of these requirements and benefits are denied by the primary payor, 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.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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/her legal representative must contact GEHA's Subrogation Unit at (800) 821-4742 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/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/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/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.

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

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

Clinical trials

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

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan ***does not*** cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan ***does not*** cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact (800) MEDICARE (800) 633-4227, TTY: (877) 486-2048 for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 100.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at (800) 772-1213, TTY: (800) 325-0778.

- **Should I enroll in Medicare?**

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

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

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

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

(Please refer to page 102 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (800) 821-6136 or see our website at www.geha.com.

For members enrolled in High and Standard Option we waive some costs if the Original Medicare Plan is your primary payor – 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.
- **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 CVS/caremark and at retail pharmacies as shown beginning on page 77.
- **Manipulative Therapy benefits**: There is no change in benefit limits or maximums for manipulative therapy care when Medicare is primary. See page 44 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 CVS/caremark Specialty Pharmacy.**
- If you obtain services from a non-Medicare provider, we will limit our payment to the coinsurance amount we would have paid after Original Medicare's payment based on our Plan allowable and the type of service you receive.

You can find more information about how our Plan coordinates benefits with Medicare as outlined in (*Medicare and GEHA*) at www.geha.com.

- **Tell us about your Medicare coverage**

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

- **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. Regardless of whether the physician requires you to sign an agreement, we will still limit our payment to the coinsurance amount we would have paid after Original Medicare's payment based on our Plan allowable and the type of service you receive. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at (800) MEDICARE (800) 633-4227, TTY: (877) 486-2048 or at www.medicare.gov.

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

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

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

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

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

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

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

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

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 payments you would be entitled to if you had Medicare. 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 and non-physician based care are 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 and coinsurance 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.
- The law prohibits a hospital from collecting more than the "equivalent Medicare 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 **not** in our PPO network,	your deductibles, coinsurance, and any balance up to the Medicare approved amount.
Does not participate with Medicare,	your deductibles, coinsurance, 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.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

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 the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of terms we use in this brochure

Accidental injury

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.

Admission

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.

Assignment

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.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

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

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. (see page 25)

Compound medications

A compound medication includes more than one ingredient and is custom made by a pharmacist according to your doctor's instructions. Compound prescriptions must contain a federal legend drug and the ingredients must be covered by the GEHA benefit.

Congenital anomaly

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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. (see Section 4, page 25)

Cosmetic

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.

Cost-sharing

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

Covered services

Services we provide benefits for, as described in this brochure.

Custodial care

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:

- Personal care such as help in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercise, and dressing;
- Homemaking, such as preparing meals or special diets;
- Moving the patient;
- Acting as companion or sitter;
- Supervising medication that can usually be self-administered; and
- 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.

The Carrier determines which services are custodial care. (Custodial care that lasts 90 days or more is sometimes known as long-term care.)

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. (see page 25)

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; or
- 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; and
- 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.

Health care professional

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

Infertility

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

Inpatient Care

Inpatient care is care rendered to a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even if it later develops that the patient can be safely discharged or transferred to another hospital and not actually use a hospital bed overnight. This Plan uses Milliman Care Guidelines to evaluate the appropriateness of observation services.

Intensive day treatment

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.

Medical necessity

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Plan determines:

- Are appropriate to diagnose or treat the patient's condition, illness or injury;
- Are consistent with **generally accepted standards of medical practice in the United States**.
  - Generally accepted standards of medical practice are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas, and any other relevant factors;
- Are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- Are not a part of or associated with the scholastic education or vocational training of the patient; or
- In the case of inpatient care, cannot be provided safely on an outpatient basis.

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

Mental health/substance abuse

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.

Never event policies

Federal or State policies that bar health care providers from charging patients for care that is attributable to certain avoidable complications or errors, such as wrong site surgery.

Observation care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. This Plan uses Milliman Care Guidelines to evaluate the appropriateness of observation services.

The Plan provides outpatient hospital benefits for observation care. If you are in the hospital for more than a few hours, confirm with your physician whether your stay is inpatient or outpatient so that you are aware of how your hospital claim will be processed.

Plan allowance

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:

PPO providers:

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.

Non-PPO providers:

To determine our non-PPO Plan allowance, we must first be provided an itemized bill that includes your diagnosis, the services or supplies you received, and the provider's charge for each, using the same types of standard codes, descriptions and other information required for processing by public health care plans like Medicare. If we are not provided the itemization of the services or supplies you received, we will assume they were equivalent to the level and extent of services and supplies typically provided by the providers or facilities most commonly used to treat other Plan members with the same principal diagnosis as yours. We will base these equivalent services on claims submitted
to the Plan by providers in the same geographic region or a combination of similar geographic regions across the United States.

Based on the itemization of services or supplies you received, we will determine the amount of the maximum non-PPO Plan allowance by applying the following rules, in order:

1. We consult standard industry guides, such as national databases of prevailing health care charges from FAIR Health or another identified data source, that are available for our use in a given state or geographic area. After the data supplier removes outliers from the claim data they collect, they group the remaining data by percentiles. We use the 70th percentile. This means that out of every 100 reports remaining after outliers were removed, 30 charges billed may be more, but 70 charges will be the allowed amount or less.

2. For services or supplies obtained in a state or geographic area where the above data source is unavailable for our use, and also for dialysis centers and outpatient dialysis performed at a hospital our non-PPO Plan allowance is two times the Medicare participating provider allowance for the service or supply in the geographic area in which it was performed or obtained. This Medicare-based allowance is not used for those services where Medicare sets a fixed national payment amount that does not vary geographically (such as blood draws). Medicare fee schedule information for physician services may be obtained at www.cms.hhs.gov/PFSlookup/.

   Note: Labs drawn during the week of dialysis treatments and drugs provided on the day of dialysis are part of the bundled dialysis payment.
3. Some Plan allowances may be submitted to medical consultants who recommend allowances based on standard industry relative value guidelines. For services or supplies for which Medicare does not provide an allowance amount, we may use the current fee schedule used by the federal Office of Workers Compensation (OWCP). OWCP fee schedule information may be obtained at www.dol.gov/OWCP/regs/feeschedule/fee.htm. For services or supplies that do not have a value currently established by public health care plans such as Medicare or Medicaid, or for implantable devices and surgical hardware, we may use medical consultants to determine an appropriate allowance. We may also conduct independent studies to determine the usual cost of a service or supply in a geographic area, or to establish allowances for services or supplies provided outside the United States.

Non-PPO Plan allowance amounts determined according to these guidelines include, but are not limited to, ambulatory surgery centers, dialysis centers, surgery, doctor's services, physical therapy, occupational therapy, speech therapy, lab testing and X-ray expenses, implantable devices and surgical hardware; and under the Standard Option, diagnostic and preventive dental services. For more information about the source of the data we are currently using you may call us at (800) 821-6136.

Plan allowance for prescription drugs is determined using Average Wholesale Price or other industry-standard reference price data.

Charges for some Plan allowances are stated in this brochure. These include limited benefits such as manipulative therapy care and routine dental care.

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.

To estimate our maximum Plan allowance for a non-PPO provider before you receive services from them, call us at (800) 821-6136.

For more information, see *Differences between our allowance and the bill* in Section 4.

Post-service claims

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

Pre-service claims

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

Primary care physician

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, obstetrics/gynecology (OB/Gyn) or geriatrics, psychiatrists, licensed clinical psychologists, licensed clinical social worker, licensed professional counselors or licensed marriage and family therapists. 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 pediatric sub-specialties such as pediatric allergy) are considered specialists, not primary care physicians. Chiropractors, eye doctors, dentists and audiologists, are not considered primary care physicians.

Sound natural tooth

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 appliance (i.e., bridgework), would not be covered as there is no injury to the natural tooth structure.

Specialty Medication

Specialty medications are biotech or biological drugs that are oral, injectable or infused, or may require special handling. To maximize patient safety, all specialty medications require prior authorization. These drugs are used in the treatment of severe, chronic medical conditions such as hemophilia, multiple sclerosis, hepatitis, cancer, rheumatoid arthritis, pulmonary hypertension, osteoarthritis, and immune deficiency.

Urgent care claims

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at (800) 821-6136. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and we refer to Government Employees Health Association, Inc.

You

You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

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

Important information about three Federal programs that complement the FEHB Program

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

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money.

Annuitants are not eligible to enroll.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

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

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.

Vision Insurance

All Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM websites at www.opm.gov/dental and www.opm.gov/vision. These sites also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call (877) 888-3337, TTY: (877) 889-5680.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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

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

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Summary of benefits for the High Option of the Government Employees Health Association, Inc. 2015

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
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $20 copay per covered office visit and 10%* of the covered professional services including X-ray and lab Non-PPO: 25%* of covered professional services	31 - 55
Services provided by a hospital:		
• Inpatient	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	56 - 58
• Outpatient	PPO: 10%* of other hospital charges Non PPO: 25%* of other hospital charges	59 - 60
Emergency benefits:		
• Accidental injury	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident	62 - 63
• Medical emergency	Regular benefits*	63
Mental health and substance abuse treatment:	Regular cost-sharing*	65 - 68
Prescription drugs:		69 - 81
• Retail pharmacy	Network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/ 25% preferred drugs for up to a maximum of $150 for up to a 30-day supply/40% non-preferred drugs for up to a maximum of $200 for up to a 30-day supply/$10 plus the difference in cost between the brand name and the generic 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 (except for Maintenance Choice).	76 - 77

High Option Benefits	You pay	Page
• Retail pharmacy *(continued)*	Non-network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/25% preferred drugs for up to a maximum of $150 for up to a 30-day supply/40% non-preferred drugs for up to a maximum of $200 for up to a 30-day supply /$10 plus the difference in cost between the brand name and the generic 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 and any difference between our allowance and the cost of the drug. Copayments and coinsurance go toward a $5,500 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic and the coinsurance for non-preferred step therapy medications.	76 - 77
• Mail order	Member pays lesser of $20 or the cost of the drug for generic drugs/25% preferred drugs for up to a maximum of $350 for up to a 90-day supply/40% non-preferred drugs for up to a maximum of $500 for up to a 90-day supply /$20 plus the difference in cost between the brand name and the generic for up to a 90-day supply Copayments and coinsurance go toward a $5,500 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic and the coinsurance for non-preferred step therapy medications.	76
Dental care:	Charges in excess of the scheduled amounts for diagnostic and preventive service, restorations, and extractions	82
Special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, Health Advice Line, Health Assessment and Personal Health Record	84 - 85
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $5,5000 per year for PPO providers Nothing after $7,500 per year for Non-PPO providers Some costs do not count toward this protection	26

Summary of benefits for the Standard Option of the Government Employees Health Association, Inc. 2015

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.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $15 copay primary care physician; $30 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	31 - 55
Services provided by a hospital:		
• Inpatient	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	56 - 58
• Outpatient	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	59 - 60
Emergency benefits:		
• Accidental injury	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident	62 - 63
• Medical emergency	Regular benefits*	63
Mental health and substance abuse treatment:	Regular cost-sharing*	56 - 68
Prescription drugs:		69 - 81
• Retail pharmacy	Network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/50% brand name for up to a maximum of $200 for up to a 30-day supply Non-network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/50% brand name for up to a maximum of $200 for up to a 30-day supply and any difference between our allowance and the cost of the drug. Copayments and coinsurance for prescription drugs go toward a $6,000 annual out-of-pocket limit (for Self Only or Self and Family enrollment) except for for the coinsurance for non-preferred step therapy medications.	76 - 77

Standard Option Benefits	You pay	Page
• Mail order	Member pays lesser of $20 or the cost of the drug for generic drugs/50% brand name for up to a maximum of $500 for up to a 90-day supply Copayments and coinsurance for prescription drugs go toward a $6,000 annual out-of-pocket limit (for Self Only or Self and Family enrollment) except for the coinsurance for non-preferred step therapy medications.	76
Dental care:	50% up to Plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions	82
Special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, Health Advice Line, Health Assessment and Personal Health Record	84 - 85
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $6,000 per year for PPO providers Nothing after $8,000 per year for Non-PPO providers Some costs do not count toward this protection	26

2015 Rate Information

For 2015 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.