Government Employees Health Association, Inc. Benefit Plan

(800) 821-6136

http://www.geha.com

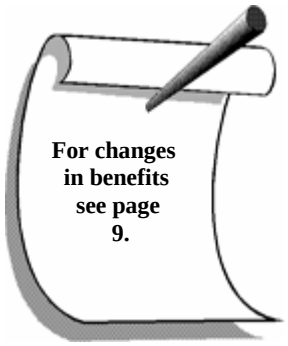
2012

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

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 2012.

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

URAC ACCREDITED HEALTH NETWORK

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT

NCQA HEDIS COMPLIANCE AUDIT AUDITED 2011

Joint Commission National Quality Approval

URAC accreditation: GEHA for Health Network

URAC UM accreditation: InforMed for Health Utilization Management

NCQA accreditation: Healthcare Effectiveness Data and Information Set (HEDIS) Audit

JCAHO accreditation: Medco for Home Care Pharmacy Dispensing Services

FEHB Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

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

RI 71-006

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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 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'll 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 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

Visit www.medicare.gov for personalized help,

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

Table of Contents

Introduction

This brochure describes the benefits of **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. 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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

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.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (800) 821-6136 and explain the situation.
  - If we do not resolve the issue:

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

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

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

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

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 Arizona Foundation for Medical Care, FCHN, Freedom Network, PPO USA®, Providence Preferred and SuperMed Network Preferred Providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.

Section 1. Facts about this fee-for-service Plan

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 is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

Questions regarding what protections apply may be directed to us at **www.geha.com.** You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

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 certain hospitals and other health care providers are "preferred providers". When you use our PPO providers, you will receive covered services at reduced cost. Government Employees Health Association, Inc. is solely responsible for the selection of PPO providers in your area. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact Government Employees Health Association, Inc. to request a PPO directory.

We have entered into arrangements with Arizona Foundation for Medical Care; Coventry Health Care of Georgia; FCHN in the state of Washington; First Health in the states of California, Florida and Texas; Freedom Network in the states of E/S Kansas and W Missouri; Health America Pennsylvania; Health Partners of Kansas; HealthLink in the states of Illinois and E/S Missouri; LifeTrac; MultiPlan in the states of New Jersey and New York; PPO USA® in the states of Alaska, Alabama, Iowa, Idaho, Louisiana, Minnesota, Mississippi, Montana, North Dakota, Nebraska, New Mexico, Nevada, South Dakota, Tennessee, Wisconsin, West Virginia, Wyoming; Private Healthcare Systems in the states of Arkansas, Connecticut, Hawaii, Indiana, Kentucky, Massachusetts, Maine, Michigan, New Hampshire, Rhode Island, Vermont; Providence Preferred in the state of Oregon; SuperMed Network in the state of Ohio; United Healthcare in the states of Colorado, Washington DC, Delaware, Maryland, Oklahoma, Utah, Virginia; and WellPath in the states of North Carolina and South Carolina which are Preferred Providers or networks of hospitals and/or doctors in all states. The doctors and hospitals participating in these networks have agreed to provide services to Plan members. You always have the right to choose a PPO provider or a non-PPO provider for medical treatment.

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

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians 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 Georgia, WellPath in the Carolinas and Health America 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.

Health education resources

Our Web site 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 Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Government Employees Health Association, Inc. was founded in 1937 as the Railway Mail Hospital Association. For 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 more than 4,700 hospitals and one 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 Web site 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. How we change for 2012

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

Program-wide changes

- South Carolina has been removed from the list of Medically Underserved Areas and Alaska added for 2012.
- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to this Plan

- Benefits are now available for nutritional counseling by a licensed or certified dietician, up to $250 per person per calendar year. (See page 39)
- Benefits are no longer excluded for separate charges of anesthesiologist for colonoscopy and upper endoscopy procedures. (See page 26)
- Benefits for home health visits by a registered nurse or a licensed practical nurse have been increased to 50 visits per person per calendar year. (See page 37)
- Benefits are now available for one pair of diabetic shoes per person per calendar year up to $150. (See page 35)
- If a drug exists that has an over the counter (OTC) equivalent the prescription drug will no longer be covered. (See page 69)
- A new program is now available. The GEHA Health Rewards earns rewards for you for activities to improve your health, including completion of an online health assessment. (See page 72)
- We have explained the procedures for coordinating benefits with your primary group health insurance under the prescription drug program with Medco when GEHA is secondary payer. (See pages 61-62)

Changes to our High Option only

- Your share of the non-Postal premium will increase 5% for Self Only and increase 5% for Self and Family. (See back cover)
- The pilot program to subsidize Medicare Part B premiums has been discontinued.

Changes to our Standard Option only

- Your share of the non-Postal premium will increase 7% for Self Only and increase 7% for Self and Family. (See back cover)

We have clarified the following:

- Prescription drug benefits will not be paid until drugs requiring preauthorization have been approved. (See page 60)
- Treatment therapies have been clarified to confirm this benefit applies to intravenous (IV) antibiotic therapy. (See page 30)
- We have clarified laboratory tests performed by an associated laboratory not participating in the Lab Card Program are subject to applicable deductibles and coinsurance. (See pages 26, 58, and 71)
- We have clarified we only cover facility services from a Hospital or a licensed residential treatment center (RTC) for substance abuse treatment. (See page 58)

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

A licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.). Other covered providers include a chiropractor, nurse midwife, nurse anesthetist, audiologist, dentist, optometrist, licensed clinical social worker, licensed clinical psychologist, 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 dietician with state licensure or statutory certification.

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved". For 2012, the states are: Alabama, Alaska, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, and Wyoming.

• 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 52.

- 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 services on the premises for the diagnosis, treatment, and care of persons with mental/substance abuse disorders and has for each patient a written treatment plan which must include diagnostic assessment of the patient and a description of the treatment to be rendered and provides for follow-up assessments by or under the direction of the supervising doctor.

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

- **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 or Rehabilitation Facility)

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
- 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 or Rehabilitation Facility

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 WellPath. 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 planned days of confinement.

We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

- **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) the end of the time frame, whichever is earlier.

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

- **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**

Some surgeries and procedures 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
- 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, browlift, liposuction, and scar revision
- Epidural injections
- Experimental/ investigation surgery or treatment
- FACET injections
- Genetic testing
- Growth hormone therapy (GHT)
- Gynecomastia-cosmetic (see mammoplasty)
- 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)
- Left ventricular assistive device (LVAD)
- Mammoplasty, reduction (unilateral/ bilateral)
- Mastectomy performed prophylactically
- Morbid obesity surgeries

- Multilevel artificial disc replacement
- Multilevel spinal surgeries
- Non-Surgical outpatient cancer treatment, including chemotherapy and radiation
- Organ and tissue transplant procedures
- Orthognathic surgery (jaw), including TMJ
- Physical, occupational and speech therapy
- Psychological testing
- Rhinoplasty-no prior approval for septoplasty
- Spinal fusion
- 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
- 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
- PET - Positron Emission Tomography

How to precertify a radiology/imaging procedure:

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

Exceptions:

You do not need precertification in these cases:

- You have another health insurance policy that is 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
- 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 a 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.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten 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:

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.

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.

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.

- **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

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

Non-PPO

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

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

- The $350 (High and Standard Option) calendar year deductible;
- The (High Option) $100 (PPO) or $300 (non-PPO) per in-hospital admission deductible;
- 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;
- For High Option member's, copayments and coinsurance for prescription drugs dispensed by Medco go toward a $4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills and the 70% coinsurance for non-preferred sleep aid drug; and
- For Standard Option member's, copayments and coinsurance for prescription drugs dispensed by Medco go toward a $6,000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollments) except for the 70% coinsurance for non-preferred sleep aid drugs.

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

- The $20 copayment for doctor's office visits (High Option); or the $10 copayment for primary care physician/$25 specialist office visits (Standard Option);
- Expenses in excess of our allowable amount or maximum benefit limitations;
- Expenses for well child care and immunizations;
- Expenses for dental and chiropractic care;
- Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements (see pages 12-16); and
- The $300 copayment (High Option) or $500 copayment (Standard Option) for Specialty Pharmacy medication not dispensed by Medco Specialty Pharmacy.

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.

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, coinsurance, or copayments 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 or copayment 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, copayments, and any balance up to 115% of the Medicare approved amount.

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

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

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

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

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.

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

High and Standard Option Benefits

See Section 2 for how our benefits changed this year. Pages 98-101 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.

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. Also read the *General exclusions* in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at (800) 821-6136 or at our Web site at www.geha.com.

Each option offers unique features.

- **High Option**
  - Extensive provider network
  - No requirement to choose a single doctor as your primary physician
  - No referral needed to see a specialist
  - $5 copay for generic prescription drugs
  - Within the provider network, 100% coverage for room and board and 90% for other hospital charges 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 $10 copay for office visits to any primary care physician including family or general practitioners, pediatricians, OB/GYN and medical internists
  - No requirement to choose a single doctor as your primary physician
  - No referral needed to see a specialist
  - $5 copay for generic prescription drugs
  - Preventive dental services covered at 50% without a deductible
  - Freedom to choose any doctor with extra savings when you see a preferred provider

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 per family) under the High 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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians 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 39 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: $10 copayment for office visits to primary care physicians; $25 copayment for office visits to specialists (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• 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

Lab, X-ray and other diagnostic tests	You pay	
	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) • Double contrast barium enemas • Ultrasound • Electrocardiogram and EEG	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		
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 the website at http://www.geha.com/more_benefits_programs/labcard.html.	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		
Professional services, such as: • Age and gender appropriate preventive medical examination Routine screenings, limited to: • Total blood cholesterol screenings • Chlamydial infection • Colorectal cancer screening, including – Annual coverage of one fecal occult blood test for members age 40 and older – Sigmoidoscopy (surgeon and facility charges) – Colonoscopy (surgeon and facility charges) • Prostate cancer screening – Annual coverage of one PSA (Prostate Specific Antigen) test for men 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

Preventive care, adult *(continued)*	**You pay**	
	High Option	**Standard Option**
Routine screenings, limited to – *continued* • Routine Pap test – Annual coverage of one Pap smear for women age 18 and older • Routine mammogram – Mammograms for diagnostic and/or routine screening • Osteoporosis screening – Bone density tests for routine screening for women 65 or older or women 60 or older who are at increased risk	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)
Not covered: • *Professional fees for automated lab* tests	*All charges*	*All charges*
Preventive care, children		
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, immunizations and care • Initial examination of a newborn child covered under a family enrollment	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)
Vision examinations, limited to: • Examinations for amblyopia and strabismus	PPO: $20 copayment (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $10 copayment for office visits to primary care physicians; $25 copayment for office visits to specialists (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Professional fees for automated lab tests*	*All charges*	*All charges*
Maternity care		
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Physician care such as sonograms Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby.	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

Maternity care *(continued)*	**You pay**	
	High Option	**Standard Option**
• 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
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*
Family planning		
A range of voluntary family planning services, limited to: • Voluntary sterilizations (see *Surgical procedures* Section 5(b)) • 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: 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

Family planning - continued on next page

Family planning *(continued)*	**You pay**	
	High Option	**Standard Option**
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		
• Diagnosis and treatment of infertility except as shown in *Not covered* Note: Benefits are limited to a maximum of $3,000 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: • *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*
Allergy care		
• Testing and treatment, including materials (such as allergy serum) • Allergy testing is limited to $500 per person per calendar year • 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 and sublingual allergy desensitization*	*All charges*	*All charges*

Treatment therapies	You pay	
	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 pages 44-45. • Dialysis – hemodialysis and peritoneal (precertification required) • Intravenous (IV)/Infusion Therapy (see *Note) • Respiratory and inhalation therapies Note: Some medications required for treatment therapies may be available through Medco Pharmacy (mail order) or a Medco 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 31-32 for benefits which apply to some categories of prescription drug treatment including Growth Hormone Therapy (GHT).	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*	*All charges*	*All charges*

Specialty drug benefits	You pay	
	High Option	**Standard Option**
Specialty medications are those used to treat some severe, chronic medical conditions and are usually administered by injection or infusion including, but not limited to, those in the following categories: See Section 5(f) *Prescription drug benefits* for additional pharmacy related information. • Hemophilia factor products such as Helixate FS, Recombinate; • Blood growth factors such as Aranesp, Leukine, Neupogen, Procrit, Promacta; • Medications for hyperparathyroidism such as Sensipar; • Growth Hormone medications such as Genotropin, Humatrope, Nutropin; • Immunoglobulin preparations such as Gammagard, Gammar-P, Vivaglobin; • Psoriasis medications such as Amevive; • Multiple Sclerosis medications such as Avonex, Betaseron, Rebif, Tysabri, Copaxone; • Hepatitis medications such as Intron A, Pegasys, Peg-Intron, Copegus, Rebetol, Ribavirin, Ribapak, Ribasphere; • Rheumatoid arthritis medications such as Kineret, Orencia, Enbrel and Humira. These drugs may also be indicated for other conditions. • Pulmonary medications such as Synagis (for RSV), Xolair (asthma), Pulmozyme and Tobi/inhaled tobramycin (for cystic fibrosis); • Aldurazyme and Naglazyme to treat Mucopolysaccharidosis; • Cerezyme to treat Gaucher's Disease; • Exjade as a blood modifier to treat iron overload; • Osteoporosis drug such as Forteo; • AIDS/HIV drug such as Fuzeon; • Orfadin for Hereditary Tyrosinemia; • Acromegaly drugs such as Octreotide and Sandostatin; • Pulmonary hypertension drugs such as Remodulin, Flolan, Tracleer and Ventavis, Letairis and Revatio; • Osteo-arthritis medications such as Synvisc, Supartz, Orthovisc, Hyalgan, Euflexxa; • Ophthalmic medications such as Lucentis (for macular degeneration); • Cancer medications such as Afinitor, Gleevec, Hycamtin, Nexavar, Revlimid, Sprycel, Sutent, Tarceva, Tasigna, Temodar, Thalomid, Tykerb and Zolinza; or infused medications, such as Herceptin, Erbitux, Rituxan; • Kuvan for Phenylketonuria (PKU); • Cystadane for Homocystinuria; and • Xenazine for Huntington's chorea.	**Medications dispensed by Medco Specialty Pharmacies:** **When GEHA is primary:** • 25% coinsurance up to a maximum of $150 for up to a 30-day supply • $350 maximum coinsurance for up to a 90-day supply **When Medicare is primary:** • 15% coinsurance up to a maximum of $150 for up to a 30-day supply • $350 maximum coinsurance for up to a 90-day supply If you choose a brand name specialty drug for which a generic drug exists, you will pay the 25% (non-Medicare)/15% (Medicare) 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:** • 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 Medco Specialty Pharmacies:** • 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 **Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals:** • 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 *(continued)*	**You pay**	
	High Option	**Standard Option**
Drugs in these categories are subject to the *Specialty drug benefits*. The medication examples provided above are not all inclusive. Call our customer service department at (800) 821-6136 to determine if other medications not listed apply to this benefit. Note: Coinsurance for medications dispensed by Medco Specialty Pharmacies go toward a $4,000 (High Option) or $6,000 (Standard Option) annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference in the cost of the generic and the brand multi-source specialty drugs.		
Non-Specialty Pharmacy retail purchase If Medco Specialty Pharmacies are not used and you purchase medications in the above categories through a retail pharmacy, you must submit your claim to: Medco P.O. Box 14711 Lexington, KY 40512 Reimbursement will be based on GEHA's costs had you used the Specialty Pharmacies. You must submit original drug receipts. Note: Coinsurance for medications dispensed at retail pharmacies go toward a $4,000 (High Option) or $6,000 (Standard Option) annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference in the cost of the generic and the brand multi-source specialty drugs.	**When GEHA is primary:** • $300 copayment per prescription fill and 25% of the Plan allowance (plus any difference between our allowance and the cost of the drug) Note: A separate copayment applies per prescription fill up to a 30-day supply. **When Medicare is primary:** • $300 copayment per prescription fill and 20% of the Plan allowance (and any difference between our allowance and the cost of the drug) Note: A separate copayment applies per prescription fill up to a 30-day supply. If you choose a brand name specialty drug for which a generic drug exists, you will pay the 25% (non-Medicare)/20% (Medicare) 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.	• $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.

Physical and occupational therapies	You pay	
	High Option	**Standard Option**
• 60 visits per person per calendar year for the combined services of the following: (One visit is two hours or less of physical or occupational therapy.) – Qualified physical therapists – Qualified occupational therapists All physical and occupational therapy visits require preauthorization. Please make an evaluation visit then contact OrthoNet by phone at (877) 304-4399 or fax to (877) 304-4398 a copy of the evaluation to OrthoNet. Authorizations will be provided in blocks of time and progress reviewed prior to additional authorizations. To precertify physical and occupational therapy in Georgia contact Coventry at (800) 470-2004. In North and South Carolina contact WellPath at (800) 708-9355. In Pennsylvania contact HAPA at (800) 755-1135. Authorizations for physical and occupational therapy are based on medical necessity. 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, measurements of joint motion or from standardized tools specific to the condition or affected body part (Simple Shoulder Test, HSS Knee Score, Oswestry, and DASH), and rehab potential. OrthoNet's on-going therapy management is concurrent and based on progress made in therapy. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and when a physician: – orders the care – identifies the specific professional skills the patient requires and the medical necessity for skilled services – indicates the length of time the services are needed Note: When you receive medically necessary physical or occupational therapy on an outpatient basis from a qualified professional therapist at a skilled nursing facility, your therapy is covered up to Plan limits.	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 rehabilitative therapy* • *Hot and cold packs*	*All charges*	*All charges*

Speech therapy	You pay	
	High Option	Standard Option
• 30 visits per person per calendar year for the services of a qualified speech therapist: (One visit is two hours or less of speech therapy.) Note: We only cover speech therapy when a physician: – orders the care – identifies the specific professional skills the patient requires and the medical necessity for skilled services – indicates the length of time the services are needed All speech therapy visits require preauthorization. Please make an evaluation visit, then contact OrthoNet by phone at (877) 304-4399 or fax to (877) 304-4398 a copy of the evaluation to OrthoNet. Authorizations will be provided in blocks of time and progress reviewed prior to additional authorizations. To precertify speech therapy in Georgia contact Coventry at (800) 470-2004. In North and South Carolina contact WellPath at (800) 708-9355. In Pennsylvania contact HAPA at (800) 755-1135. Authorization for speech therapy is based on medical necessity. In order to make individual-specific authorization decisions, OrthoNet will review the treating provider's evaluation; including diagnosis, duration of member's symptoms, nature or severity of symptoms, timeframes for anticipated recovery or clinical milestones, and rehab potential. OrthoNet's on-going therapy management is concurrent and based on progress made in therapy. Note: When you receive medically necessary speech therapy on an outpatient basis from a qualified speech therapist at a skilled nursing facility, your therapy is covered up to Plan limits.	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 devices to assist with communications* • *Computer programs of any type, including but not limited to those to assist with speech therapy*	*All charges*	*All charges*
Hearing services (testing, treatment and supplies)		
• 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

Hearing services (testing, treatment and supplies) *(continued)*	You pay	
	High Option	**Standard Option**
• External hearing aids Note: Benefit is payable per person every five years	PPO: All charges in excess of $500 for each ear (No deductible) Non-PPO: All charges in excess of $500 for each ear (No deductible)	PPO: All charges in excess of $250 for each ear (No deductible) Non-PPO: All charges in excess of $250 for each ear (No deductible)
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment and supplies)		
• 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		
• 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: $10 copayment for the office visit to primary care physicians; $25 copayment for office visits to specialists (No deductible); plus 15% of the Plan allowance for other services performed during the visit Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• One pair of diabetic shoes per person per calendar year	PPO & Non-PPO: All charges in excess of $150 (No deductible)	PPO & Non-PPO: All charges in excess of $150 (No deductible)
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	You pay	
	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)		
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	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

Durable medical equipment (DME) *(continued)*	**You pay**	
	High Option	**Standard Option**
• Hospital beds • Wheelchairs • Crutches • Walkers Note: Call us at (800) 821-6136 as soon as your physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call. Note: We will pay only for the cost of the standard item. Coverage for specialty equipment such as all-terrain wheelchairs is limited to the cost of the standard equipment.	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 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 (page 87)* • *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*
Home health services		
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* on pages 31-32 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

Home health services - continued on next page

Home health services *(continued)*	You pay	
	High Option	**Standard Option**
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*
Chiropractic		
Chiropractic services limited to: • 12 visits per person per calendar year for manipulation of the spine • X-rays, used to detect and determine nerve interferences due to spinal subluxations or misalignments • $25 per person per calendar year for chiropractic X-rays Note: No other benefits for the services of a chiropractor are covered under any other provision of this Plan. In medically underserved areas, services of a chiropractor that are listed above are subject to the stated limitations. In medically underserved areas, services of a chiropractor that are within the scope of his/her license and are not listed above are eligible for regular Plan benefits.	PPO and Non-PPO: All charges in excess of $20 per visit All charges in excess of $25 for X-rays of the spine Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.	PPO and Non-PPO: All charges in excess of $20 per visit All charges in excess of $25 for X-rays of the spine Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.
Not covered: • *Any treatment not specifically listed as covered* • *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*	*All charges*	*All charges*
Alternative treatments		
Acupuncture: • Benefits are limited to 20 procedures per person per calendar year for medically necessary acupuncture treatments if performed by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) for: – Anesthesia – Pain relief	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

Alternative treatments – continued on next page

Alternative treatments *(continued)*	**You pay**	
	High Option	**Standard Option**
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* *(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 10.)*	*All charges*	*All charges*
Educational classes and programs		
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 Medco prescription card, through Medco Pharmacy (mail order) or a non-Network Retail pharmacy. (See page 65 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)
• Nutritional Counseling – Provided by a dietician with state license or statutory certification up to $250 per person per calendar year. Nutritional counseling must be ordered by a physician.	PPO & Non-PPO: All charges in excess of $250 (No deductible)	PPO & Non-PPO: All charges in excess of $250 (No deductible)

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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians 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*)	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

Surgical procedures *(continued)*	**You pay**	
	High Option	**Standard Option**
A comprehensive range of services - *continued* • Surgical treatment of obesity (bariatric surgery) is covered only if: – eligible enrollee is 18 or over – clinical records support a body mass index of 40 or greater (or 35-40 when there is a co-morbid condition such as life-threatening cardiopulmonary problems or severe diabetes mellitus) for a period of six months – documentation of failure to lower the body mass index by a medically supervised program within the last twelve months of diet and exercise of at least six months duration Note: Benefits are payable only for bariatric surgery which meets the above criteria and is performed at centers certified as "well qualified" by Centers for Medicare and Medicaid Services (CMS). Bariatric surgery must be precertified. • Insertion of internal prosthetic devices (see Section 5(a) *Orthopedic and prosthetic devices* for device coverage information) • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • 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

Surgical procedures *(continued)*	**You pay**	
	High Option	**Standard Option**
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		
• 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
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	You pay	
	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. 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 55). • 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
Not Covered: • *Oral implants and transplants* • *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	You pay	
	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 – Small intestine – Small intestine with the liver – Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral • Pancreas	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
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 – Advanced Hodgkin's lymphoma with reoccurrence (relapsed) – Advanced non-Hodgkin's lymphoma with reoccurrence (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	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

Organ/tissue transplants *(continue)*	You pay	
	High Option	**Standard Option**
• Allogeneic transplants for - *continued* – Myelodysplasia/Myelodysplastic syndromes – Severe combined immunodeficiency – Severe or very severe aplastic anemia – Amyloidosis – 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
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 transplants for – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Advanced Hodgkin's lymphoma with reoccurrence (relapsed) – Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) – Neuroblastoma – Amyloidosis • Autologous tandem transplants for – AL Amyloidosis – Multiple myeloma (de novo and treated) – Recurrent germ cell tumors (including testicular cancer) Blood or marrow stem cell transplants for: • 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	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

Organ/tissue transplants *(continued)*	You pay	
	High Option	**Standard Option**
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 reoccurrence (relapsed) – Advanced non-Hodgkin's lymphoma with reoccurrence (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 – 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 reoccurrence (relapsed) – Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) – Amyloidosis – Neuroblastoma Tandem transplants for covered transplants: Subject to medical necessity. We will cover donor screening tests and donor search expenses for up to four potential donors for bone marrow or stem cell transplants.	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

Organ/tissue transplants *(continued)*	**You pay**	
	High Option	**Standard Option**
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.		
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)
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.)		

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You pay	
	High Option	**Standard Option**
• 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 transplant 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 are 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: $10 copayment for office visits to primary care physicians; $25 copayment for office visits to specialists (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount 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
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		
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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or 5(b). See page 39 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 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.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefits Description	You pay	
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)

Inpatient hospital - continued on next page

Inpatient hospital *(continued)*	You pay	
	High Option	**Standard Option**
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 13 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. 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.) • 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)

Inpatient hospital - continued on next page

Inpatient hospital *(continued)*	**You pay**	
	High Option	**Standard Option**
Maternity Care – Inpatient Hospital – *continued* • 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*
Outpatient hospital, clinic or ambulatory surgical center		
• 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	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)

Outpatient hospital, clinic or ambulatory surgical center - continued on next page

Outpatient hospital, clinic or ambulatory surgical center *(continued)*	You pay	
	High Option	**Standard Option**
• Medical supplies, including oxygen • Anesthetics and anesthesia service • Cardiac rehabilitation Note: Please refer to pages 31-32 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)
Extended care benefits/Skilled nursing care facility benefits		
• 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	You pay	
	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*
Ambulance – accidental injury		
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).	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 – accidental injury - continued on next page

Ambulance – accidental injury *(continued)*	**You pay**	
	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: 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		
• 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: 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: • *Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means*	*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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians 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.

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 50) 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: Only the difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)
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

Medical emergency	You pay	
	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: 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
Ambulance – accidental injury		
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		
• 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: 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: • *Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means*	*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. You must get precertification for certain services. Cost-sharing and limitations for mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 per family) under the High 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 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT HOSPITAL SERVICES, INPATIENT RESIDENTIAL TREATMENT CENTERS AND OUTPATIENT INTENSIVE DAY TREATMENT.** Failure to do so will result in a minimum of $500 penalty. See the instructions after the benefits descriptions below.

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, or 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: $10 copayment per office visit (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• 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	You pay	
	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		
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 the website at http://www.geha.com/more_benefits_programs/labcard.html.	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)		
• 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
Other facility services and supplies: • Services provided by a hospital or residential treatment center (RTC) Note: We only cover treatment from a Hospital or a licensed RTC for substance abuse treatment.	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	You pay	
	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		
• 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
Mental health and substance abuse		
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* • *Travel time to the member's home to conduct therapy* • *Services rendered or billed by schools, or halfway houses or members of their staffs* • *Marriage counseling* • *Services that are not medically necessary*	*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.

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

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 64.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible for prescription drugs.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Under the High Option plan, if Medicare is your primary insurance and you have both Medicare Part A & B coverage, you pay less for your prescriptions (see pages 67-69).
- Based on manufacturer's and FDA guidelines, the use of a certain medication may be limited as to its quantity, total dose, duration of therapy, age, gender or specific diagnosis. Since the prescription does not usually explain the reason the provider prescribed a medication, the requirement of any of these limits and/or prior authorization to confirm the intent of the prescriber may be appropriate.
- Some medications must be approved by GEHA and/or Medco before 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 Medco Pharmacy (mail order). Call our office at (800) 821-6136 so that we can work with you to find the most cost effective and efficient manner of meeting your emergency prescription needs.
- Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/plan identification card, and a mail order form, questionnaire, and reply envelope.
- As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including names of your prescribing physicians, to any treating physician or dispensing pharmacies.
- **Who can write your prescription:** A licensed physician or a licensed dentist must write the prescription (physician assistants and nurse practitioners can prescribe in select states as state law allows). For Medco Pharmacy (mail order) prescriptions, the physician must be licensed in the United States. In addition, your mailing address must be within the United States or include an APO address.
- **Where you can obtain them**: You may fill the prescription at a participating network retail pharmacy, a non-network pharmacy, or through Medco 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 Medco Pharmacy.
- To help increase awareness, GEHA participates in programs to encourage the prescribing of generics and lower cost alternative preferred brand drugs. These programs may produce savings to you. These programs include generic drug awareness communications or prior approval. In situations where prior approval is required physicians are notified of lower cost preferred brand or generic alternatives. If physician approved, the more cost-effective medication will be dispensed. If the physician does not approve and prefers a non-preferred drug, a coverage review is initiated at mail service; at a retail pharmacy, to initiate the coverage review, the pharmacist, member, or physician would need to contact Medco. Medical necessity of non-preferred drug will be reviewed. Unless there are documented clinical reasons why the preferred drug cannot be used you may still obtain the non-preferred drug but you will be responsible for 70% of the cost of the non-preferred drug which will not apply to your annual out-of-pocket maximum.

Prescription drug benefits

Covered medications and supplies

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

- Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal Law of the United States require a physician's prescription for their purchase, except those listed as *Not covered;*

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

Covered medications and supplies *(continued)*

- Insulin;
- Needles and syringes for the administration of covered medications;
- Contraceptive drugs;
- Ostomy supplies (please include the manufacturer's product number to ensure accurate fill of the product); and
- 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 our Customer Service Department to identify a participating vaccine pharmacy or go to www. medco.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 vaccines can be administered for patients under the age of 18 in 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 Medco prescription card, through Medco Pharmacy (mail order), or a non-Network Retail pharmacy (See page 65 for filing instructions).

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

High Option – three-tier drug benefit

- Under the **High Option**, we divide prescription drugs into three categories or tiers: generic, single-source brand name, and multi-source brand name. Multi-source brand name is not applicable to overseas prescription drugs. When an approved generic equivalent is available, that is the drug you will receive, unless you or your physician specifies that the prescription must be filled as written. When an approved generic equivalent is not available, you will pay the brand name single-source copayment. If an approved generic equivalent is available, but you or your physician specifies that the prescription must be filled as written, you will pay the $5.00 copayment plus the difference in the cost of the generic drug and the brand name multi-source drug unless your physician has provided clinical necessity for the brand name drug which will require preauthorization.
- **Generic drugs** are chemically and therapeutically equivalent to the corresponding brand drug, but are available at a lower price. Equivalent generic products for brand name medications become available after a patent and other exclusivity rights for the brand expire. The Food and Drug Administration must approve all generic versions of a drug and assure that they meet strict standards for quality, strength and purity. The FDA requires that generic equivalent medications contain the same active ingredients and be equivalent in strength and dosage to brand name drugs. The main difference between a generic and its brand name drug is the cost of the product.
- **Single-source** brand name drugs are available from only one manufacturer and are patent-protected. No generic equivalent is available.
- **Multi-source** brand name drugs are available from more than one manufacturer and have at least one generic equivalent alternative available.

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 Rx 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 Rx card issued by your primary insurance carrier and pay any copay/coinsurance required by the primary insurance. Then, mail your pharmacy receipt to Medco for consideration of possible reimbursement through your GEHA, secondary benefit. Submit these claims to Medco, P.O. Box 14711, Lexington, KY 40512.

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

Coordinating with other drug coverage *(continued)*

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

1. Purchase your prescription using the Rx card issued by your primary insurance carrier and pay any copay/coinsurance required by the primary insurance.
2. Then, mail your pharmacy receipt to Medco for consideration of possible reimbursement through your GEHA, secondary benefit. Submit these claims to Medco, P.O. Box 14711, Lexington, KY 40512.

If your primary insurance does not provide an RX 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 Medco for consideration of possible reimbursement using your secondary benefit. Submit these claims to Medco, P.O. Box 14711, Lexington, KY 40512.

In any event if you use GEHA's prescription drug 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. If you elect to use GEHA's Medco Pharmacy (mail order), Medco will bill you directly for 100% of the claim amount. Medco may contact you to secure a form of payment. After you have paid Medco the amount billed, submit the bill to your primary insurance. When your primary insurance makes payment, file the claim and their EOB with Medco for consideration of possible reimbursement using your secondary benefit. Submit these claims to Medco, P.O. Box 14711, Lexington, KY 40512.

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 and/or Medco 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 and supplies by mail, send your mail-order prescriptions to Medco Pharmacy. Medco will review the prescriptions to determine whether it could be eligible for Medicare Part B coverage. Depending on the type of prescription, it will be forwarded to Liberty Medical or Accredo. You can also contact Liberty Medical directly at (866) 398-7164 to discuss your diabetes supplies.

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. You should have a prescription ID card from your Medicare Part D prescription drug plan and your GEHA ID card. To ensure that you get all the coverage you are entitled to receive, use a pharmacy in the networks for both the GEHA Plan and your Medicare Part D plan, and show both the Medicare Part D ID card and the GEHA ID card when filling a prescription so the pharmacy can coordinate coverage on your behalf.

Medco voluntary formulary

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

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

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

Medco voluntary formulary *(continued)*

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

Occasionally there may be exceptions, for additional details refer to page 60, *Important things you should keep in mind about these benefits and features you should be aware of*.

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

Patient Safety

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

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

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

How to use Medco network pharmacies (retail)

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

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

How to use Medco Pharmacy (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 Medco even though the prescription is for 90 days. Even though insulin, syringes, diabetic supplies and ostomy supplies do not require a physician's prescription, to obtain through Medco 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 Medco or GEHA. Not all drugs are available through Medco Pharmacy. In order to use Medco 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.

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

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

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

Fax: Or you can ask your physician to fax your prescriptions to Medco. To do this, provide your doctor with your ID number (located on your ID card) and ask him or her to call (888) 327-9791 for instructions on how to use Medco's fax service.

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

How to use Medco Pharmacy (mail order) *(continued)*

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

Electronic transmission: Or you can ask your physician to transmit your prescriptions electronically to Medco.

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

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

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

To order online: Go to http://www.geha.com/prescriptions/OnlinePharmacy.html then click on the link to Medco, or go to www.medco.com.

Benefits Description	You pay	
	High Option	Standard Option
Note: The calendar year deductible does not apply to benefits in this Section.		
Covered medications and supplies – when GEHA is primary		
Medco 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 brand name coinsurance. Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a $4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills and for the 70% coinsurance for non-preferred sleep aid drugs. Note: Under the Standard Option plan copayments and coinsurance for prescription drugs go toward a $6,000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs. Note: Medications to treat some severe and chronic medical conditions are not available at Medco participating retail pharmacies but are available through Medco Specialty Drug program. See pages 31-32 for the categories of drugs in this program.	Generic: $5 or the retail pharmacy's usual and customary cost of the drug whichever is less Single-source brand: 25% up to a maximum of $150 for up to a 30-day supply • Retail fills eligible for a greater than a 30-day supply will be subject to the 25% coinsurance up to the maximum of $350 Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the $5 generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization. When brand name drugs are approved over generic, your cost will be based on the brand name drug. Initial and first fill not to exceed a 30-day supply. For all subsequent refills, you pay the greater of 50% or the amount described above.	Generic: $5 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

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

Covered medications and supplies – when GEHA is primary	You pay	
	High Option	Standard Option
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: Medco P.O. Box 14711 Lexington, KY 40512 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. Note: 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. Recent regulations required a change in processing for compounds. The new standards, required by HIPAA, require pharmacies to submit all ingredients in a compound prescription as part of the claim for both online claims and paper claim submissions. Effective in 2011, pharmacies converted to the new industry standard changing from using the primary ingredient as the key to prescription claim pricing to use of all ingredients in the compound for prescription claim pricing. Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a $4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills and the 70% coinsurance for non-preferred sleep aid drugs. Note: Under the Standard Option plan copayments and coinsurance for prescription drugs go toward a $6,000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs.	Generic: $5 or the retail pharmacy's usual and customary cost of the drug whichever is less Single-source brand: 25% up to a maximum of $150 for up to a 30-day supply • Retail fills eligible for a greater than a 30-day supply will be subject to the 25% coinsurance up to the maximum of $350 Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the $5 generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization. Plus any difference between our allowance and the cost of the drug. Initial and first fill not to exceed a 30-day supply. For all subsequent refills, you pay the greater of 50% or the amount described above.	Generic: $5 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

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*		
Covered medications and supplies – when GEHA is primary	**You pay**	
	High Option	**Standard Option**
Medco Pharmacy (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. Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a $4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills and the 70% coinsurance for non-preferred sleep aid drugs. Note: Under the Standard Option plan copayments and coinsurance for prescription drugs go toward a $6,000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs.	Generic: $15 or the cost of the drug whichever is less Single-source brand: 25% up to a maximum of $350 for up to a 90-day supply Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the $15 generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization.	Generic: $15 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

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

Covered medications and supplies – Medicare A & B primary	You pay	
	High Option	**Standard Option**
Medco 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 brand name coinsurance. Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a $4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills and the 70% coinsurance for non-preferred sleep aid drugs. Note: Under the Standard Option plan copayments and coinsurance for prescription drugs go toward a $6,000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs. Note: Medications to treat some severe and chronic medical conditions are not available at Medco participating retail pharmacies but are available through Medco Specialty Drug program. See pages 31-32 for the categories of drugs in this program.	Generic: $5 or the retail pharmacy's usual and customary cost of the drug whichever is less Single-source brand: 20% up to a maximum of $150 for up to a 30-day supply • Retail fills eligible for a greater than a 30-day supply will be subject to the 20% coinsurance up to the maximum of $350 Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the $5 generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization. Initial and first fill not to exceed a 30-day supply. For all subsequent refills, you pay the greater of 50% or the amount described above.	Generic: $5 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

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

Covered medications and supplies – Medicare A & B primary	You pay	
	High Option	**Standard Option**
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: Medco P.O. Box 14711 Lexington, KY 40512 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. Note: 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. Recent regulations required a change in processing for compounds. The new standards, required by HIPAA, require pharmacies to submit all ingredients in a compound prescription as part of the claim for both online claims and paper claim submissions. Effective in 2011, pharmacies converted to the new industry standard changing from using the primary ingredient as the key to prescription claim pricing to use of all ingredients in the compound for prescription claim pricing. Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a $4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills and the 70% coinsurance for non-preferred sleep aid drugs. Note: Under the Standard Option plan copayments and coinsurance for prescription drugs go toward a $6,000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs.	Generic: $5 or the retail pharmacy's usual and customary cost of the drug whichever is less Single-source brand: 20% up to a maximum of $150 for up to a 30-day supply • Retail fills eligible for a greater than a 30-day supply will be subject to the 20% coinsurance up to the maximum of $350 Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the $5 generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization. Plus any difference between our allowance and the cost of the drug. Initial and first fill not to exceed a 30-day supply. For all subsequent refills, you pay the greater of 50% or the amount described above and any difference between our allowance and the cost of the drug.	Generic: $5 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.

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*		
Covered medications and supplies – Medicare A & B primary	**You pay**	
	High Option	**Standard Option**
Medco Pharmacy (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. Note: Under the High Option plan copayments and coinsurance for prescription drugs go toward a $4,000 annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference between the costs of the generic and brand multi-source drugs and the 50% coinsurance for retail drugs after the first two fills and the 70% coinsurance for non-preferred sleep aid drugs. Note: Under the Standard Option plan copayments and coinsurance for prescription drugs go toward a $6,000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs.	Generic: $10 or the cost of the drug whichever is less Single-source brand: 15% up to a maximum of $350 for up to a 90-day supply Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the $10 generic copay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization.	Generic: $15 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
Non-covered medications and supplies		
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* • *Medical supplies such as dressings and antiseptics* • *Drugs which are investigational* • *Drugs prescribed for weight loss* • *Drugs to treat infertility* • *Drugs to treat impotency* • *If a drug exists that has an over the counter (OTC) equivalent the prescription drug is not covered* *Note: Over the counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit with your Medco prescription card, through Medco Pharmacy (mail order) or a non-Network Retail pharmacy.* (See page 39)	*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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists, which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5(c) for *Inpatient hospital benefits*.

Accidental injury benefit

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

Dental benefit description

Dental Services	High Option Scheduled Allowance	High Option Scheduled Allowance	Standard Option Scheduled Allowance	Standard Option Scheduled Allowance
	We pay	You pay	We pay	You pay
Diagnostic and preventive services, 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
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

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	To participate in our enhanced maternity program, call (800) 821-6136 at any time as soon as you think you or your covered dependent may be pregnant. Early participation in the program guarantees you ongoing communication with a registered nurse throughout the pregnancy. Complimentary educational materials include the book "From Here to Maternity".
Lab Card	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 Assessment	Participate in GEHA Health Rewards and earn rewards for you for activities that improve your health. Start by completing an online health assessment at www.geha.com. GEHA Health Rewards is offered to GEHA members and spouses. For more information, including program details and rewards, go to www.geha.com and click on Member Web Services.
Personal Health Record	Our new Personal Health Record helps you track health conditions, allergies, medications and more. This program is voluntary and confidential. To access this tool, register for Member Web Services at www.geha.com and click on Health Toolbox.

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 **(800) 417-1893**

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

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

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

Online Shopping **www.medco.com**

GEHA health plan members have access to special features offered on the Medco Web site, www.medco.com. On this Web site, you can refill mail order prescriptions and manage your mail order account. A new feature is online shopping for thousands of consumer health products available from the *Medco Health Store*™. Items available include non-prescription medications and other health-related products that complement prescription drug care.

CONNECTION Hearing **(866) 211-6048** **www.HEARPO.com**

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 Amplifon HearPO. Use of this program can help maximize your hearing aid benefit dollars. Amplifon HearPO has over 2,350 locations, offering a variety of hearing aids and services. Plan highlights include:

- Significant discounts on hearing exams and services including a lowest price guarantee available to you and your family members;
- Three-year warranty covering repairs and one time loss and damage coverage;
- A complete line of hearing aids from eight leading hearing aid manufacturers;
- One-year follow-up care which includes cleaning, adjustment, and other hearing services;
- Financing options with up to 12 months no interest and 60 day, no risk trial period;
- One year of free hearing aid batteries mailed directly to your home (maximum of 80 cells per hearing aid); and
- Highest customer satisfaction ratings in the hearing aid industry.

Simply call **(866) 211-6048** to learn more about the hearing program.

CONNECTION'S Vision Powered by EyeMed **(877) 808-8538** **www.geha.com**

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 in the More Benefits & Programs section of the GEHA website at www.geha.com.

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 12 of this brochure, visit www.FSAFEDS.com, or call toll-free (877) FSAFEDS (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, discounts on the NutriSystem weight management program 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 83,000 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 and click on Provider Search. Please confirm provider participation prior to your visit.

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

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 25th 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.

Covered Services	Calendar Year Deductible Per Person	Provider Participation	We pay
Class A Specified Diagnostic and Preventative	$0	In-Network	100%
		Out-of-Network	80%
Class B Other Diagnostic, Preventative, Restorative & Specified Oral Surgery	$50	In-Network	80%
		Out-of-Network	70%
Class C Endodontics, Periodontics, Prosthodontics & Crowns, Inlays, Onlays	$100	In-Network	50%
		Out-of-Network	40%
Class D Orthodontics-Comprehensive Case (ages 6-17)	$0	In-Network	$50 per month
		Out-of-Network	$25 per month

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

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

Section 6. General exclusions – things we don't 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 *When you need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations; sexual dysfunction or sexual inadequacy.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, 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 20, doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 21), services, drugs or supplies related to avoidable complications and medical errors, Never event policies (see page 88) or State premium taxes however applied.
- Charges in excess of the "Plan allowance" as defined on pages 89-90.
- 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.
- Genetic counseling and genetic screening.
- Services, drugs, or supplies ordered or furnished by a non-covered provider.

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 Web site 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
- 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.

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.

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.
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.

The disputed claims process *(continued)*

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 sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. 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 sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

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 hasten 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.

Section 9. Coordinating benefits with 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' guidelines.

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.

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact (800) MEDICARE (800) 633-4227, TTY: (877) 486-2048 for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 82.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at (800) 772-1213, TTY: (800) 325-0778. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 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 20 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 Web site 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 Medco Pharmacy and at retail pharmacies as shown beginning on page 67.
- **Chiropractic benefits:** There is no change in benefit limits or maximums for chiropractic care when Medicare is primary. See page 38 for benefits.
- **Physical, speech and occupational therapy benefits:** There is no change in benefit limits or maximums for therapy when Medicare is primary.
- **We do NOT waive the $300 (High Option) or $500 (Standard Option) copayment for Specialty Pharmacy medications not dispensed by the Medco Specialty Pharmacy.**
- 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, but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

When we are the primary 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.

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

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.

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

- 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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. (see pages 17-19)

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. The Medco Pharmacy can compound many medications. However, if the Medco 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 Medco, you will pay the full cost of the medication and submit a direct 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 Medco, P.O. Box 14711, Lexington, KY 40512. Claim calculations and your copays or reimbursement for direct claims is performed using an industry standard reimbursement method for compounds. The industry standard changed in 2011 from use of the primary ingredient as the key to the prescription claim pricing to use of all ingredients in the compound for prescription claim pricing.

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 pages 17-19)

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
- 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 17)

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
- 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
- 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.

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 standards of good medical practice in the United States
- Are not primarily for the personal comfort or convenience of the patient, the family, or the provider
- Are not a part of or associated with the scholastic education or vocational training of the patient
- 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**.**

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:

For 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.

For 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/.

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

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
- 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) 821-8136. 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. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

See www.opm.gov/insure/health for enrollment information as well as:

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

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal 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
- 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 your employing or retirement office authorizes coverage for. 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.

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

You can find additional information at www.opm.gov/insure.

- **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 2012 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 2011 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), or a conversion policy (a non-FEHB individual policy).

- **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 Web site, www.opm.gov/insure.

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

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

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

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

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

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

Section 12. Other Federal Programs

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. The result can be a discount of 20% to more than 40% on services/products you 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 $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin products, 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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **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 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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) 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 and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. 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 24-month waiting period for dependent children up to age 19.

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 website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call (866) 717-5826, TTY: (866) 561-1604.

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

Summary of benefits for the High Option of the Government Employees Health Association, Inc. 2012

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 other covered professional services including X-ray and lab Non-PPO: 25%* of covered professional services	25-48
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	49-51
• Outpatient	PPO: 10%* of other hospital charges Non PPO: 25%* of other hospital charges	51-52
Emergency benefits:		
• Accidental injury	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident.	55
• Medical emergency	Regular benefits*	56
Mental health and substance abuse treatment:	Regular cost-sharing*	57-59
Prescription drugs:		60-69
• Retail pharmacy	Network pharmacy: Member pays lesser of $5 or pharmacy's usual and customary cost for generic drugs/25% single-source brand name drugs for up to a maximum of $150 for up to a 30-day supply/$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name for up to a 30-day supply for the initial fill and first refill. For subsequent refills, you pay the greater of 50% or the amount described above.	64-65 & 67-68

Retail pharmacy - continued on next page

Summary of benefits for the High Option of the Government Employees Health Association, Inc. 2012 *(continued)*

High Option Benefits	You pay	Page
• Retail pharmacy - *continued*	Non-network pharmacy: Member pays lesser of $5 or pharmacy's usual and customary cost for generic drugs/25% single-source brand name drugs for up to a maximum of $150 for up to a 30-day supply/$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name drugs for up to a 30-day supply for the initial fill and first refill. 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 $4,000 annual prescription out-of-pocket except for the difference between the cost of the generic and brand multi-source drugs and the 50% coinsurance after the first two fills and the 70% coinsurance for non-preferred sleep aid drugs.	64-65 & 67-68
• Mail Order	Member pays lesser of $15 or the cost of the drug for generic drugs/25% single-source brand name drugs for up to a maximum of $350 for up to a 90-day supply/$15 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name for up to a 90-day supply. Copayments and coinsurance go toward a $4,000 annual prescription out-of-pocket except for the difference between the cost of the generic and brand multi-source drugs and the 70% coinsurance for non-preferred sleep aid drugs.	66, 69
Dental care:	Charges in excess of the scheduled amounts for diagnostic and preventive service, restorations, and extractions	70
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.	71-72
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $4,000 per year for PPO providers Nothing after $6,000 per year for Non-PPO providers Some costs do not count toward this protection.	18-19

Summary of benefits for the Standard Option of the Government Employees Health Association, Inc. 2012

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: $10 copay primary care physician; $25 copay specialist for covered office visits and 15%* of other covered professional services including X-ray and lab Non-PPO: 35%* of covered professional services	25-48
Services provided by a hospital:		
• Inpatient	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	49-51
• Outpatient	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	51-52
Emergency benefits:		
• Accidental injury	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident.	55
• Medical emergency	Regular benefits*	56
Mental health and substance abuse treatment:	Regular cost-sharing*	57-59
Prescription drugs:		60-69
• Retail pharmacy	Network pharmacy: Member pays lesser of $5 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 $5 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 prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs.	64-65 & 67-68

Summary of benefits for the Standard Option of the Government Employees Health Association, Inc. 2012 *(continued)*

Standard Option Benefits	You pay	Page
• Mail Order	Member pays lesser of $15 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 prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs.	66, 69
Dental care:	50% up to Plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions.	70
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.	71-72
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $5,000 per year for PPO providers Nothing after $7,000 per year for Non-PPO providers Some costs do not count toward this protection.	18-19

2012 Rate Information for Government Employees Health Association, Inc. (GEHA) Benefit Plan

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

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and non-career employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:
Human Resources Shared Service Center
(877) 477-3273, option 5
TTY: (866) 260-7507

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	**311**	**$185.75**	**$85.40**	**$402.46**	**$185.03**	**$64.77**	**$62.19**
High Option Self and Family	**312**	**$414.35**	**$202.33**	**$897.76**	**$438.38**	**$156.29**	**$150.53**
Standard Option Self Only	**314**	**$128.39**	**$42.79**	**$278.17**	**$92.72**	**$28.24**	**$26.53**
Standard Option Self and Family	**315**	**$291.97**	**$97.32**	**$632.60**	**$210.86**	**$64.23**	**$60.34**