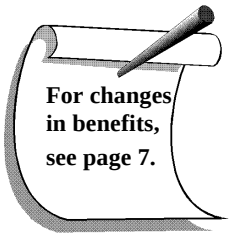
# Government Employees Hospital Association, Inc. Benefit Plan

**http://www.geha.com**

# 2001

## A fee-for-service plan with preferred provider organizations




**Sponsored and administered by:**
**Government Employees Hospital Association, Inc.**

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

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

**Membership dues:** There are no membership dues for the Year 2001.

**Enrollment codes for this Plan:**

**311 Self Only – High Option**
**312 Self and Family – High Option**
**314 Self Only – Standard Option**
**315 Self and Family – Standard Option**

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees Health Benefits Program

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# Introduction

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

This brochure describes the benefits of **Government Employees Hospital Association, Inc.** under our contract (CS 1063) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

# Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means GEHA.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

# 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 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.

**We also have Preferred Provider Organizations (PPO's):**

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. Contact us for the names of PPO providers and to verify their continued participation. For a list of PPO providers, visit our web site at www.geha.com or call (800) 296-0776. You can also reach our web page through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory.

We have entered into arrangements with Alliance PPO, Inc.; CAP; Community Care Network, Inc.; Healthlink; Private Healthcare Systems; PPO Oklahoma; PPO USA; Preferred Care Blue; SouthCare; FCHN; and United Payors & United Providers, Inc. (UP&UP), which are Preferred Providers or networks of hospitals and/or doctors in all states. The doctors and hospitals participating in these networks have agreed to provide services to Plan members. You always have the right to choose a PPO provider or a non-PPO provider for medical treatment.

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

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.

**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.

**Patients' Bill of Rights**

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

Government Employees Hospital Association, Inc. was founded in 1937 as the Railway Mail Hospital Association. For more than 60 years now, GEHA has provided health insurance benefits to federal employees and retirees.

GEHA is incorporated as a General Not-For-Profit Corporation pursuant to Chapter 355 of the Revised Statutes of the State of Missouri.

GEHA's Preferred Provider Organization includes more than 3,800 hospitals and more than 450,000 physician locations throughout the United States.

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

## Section 2. How we change for 2001

**Program-wide changes**

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our PPO network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling (800) 821-6136, **or** checking our website at www.geha.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.
- North Dakota is deleted from the list of states designated as medically underserved in 2001. See page 8 for information on medically underserved areas.

**Changes to this Plan**

- Your share of the non-Postal premium will increase by 10.3% for Self Only or 10.5% for Self and Family.
- GEHA will offer two plan options, a High Option and new Standard Option. Both options provide comprehensive benefits and access to GEHA's large provider network.
  - High Option is the plan we have offered for years: in general, you pay more in premium and less in out-of-pocket costs for copayments and coinsurance.
  - The Standard Option is new this year: in general, you pay a lower premium and share more of the costs for prescription drugs and other medical care.

  A comparison of the two options can be found in the benefits section of this brochure, pages 19 to 66.

**Change to High Option**

- *The following changes have been made to the way we cover mental health and substance abuse treatment.*
  - To qualify for network benefits, your treatment must be included in a treatment plan that we approve.
  - Room and Board charges for mental health and substance abuse treatment at a network hospital will be paid at 100%; related hospital miscellaneous expenses will be paid at 90%.
  - A separate $300 mental health calendar year deductible will apply to outpatient hospital charges and inpatient and outpatient physician charges at network providers.
  - Both network and out-of-network charges will apply to the mental health deductible.
  - After you meet the deductible, we pay 90% of your covered charges from network providers. You pay 10% of covered charges. This 10% coinsurance you pay applies toward your in-network $3,000 (Self and Family) or $2,500 (Self Only) mental health and substance abuse out-of-pocket maximum.
  - Office visits from network providers are subject to a $15 copayment (no deductible applies).

  Previously, all mental health and substance abuse benefits were paid at 50%. Benefits were paid for a limited number of days or visits. Physician services were subject to a combined medical/mental health calendar year deductible.
- Point of Service for Omaha, Nebraska has been eliminated.
- If you do not use a PPO provider, GEHA pays benefits based on the Plan Allowance for a service or supply in an area. This is determined primarily by using national databases of prevailing health care charges from Ingenix, including guides formerly published by the Health Insurance Association of America (HIAA) and Medical Data Research (MDR). For 2001, these guides will be applied at the 70$^{th}$ percentile.

## 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 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.

### Where you get covered care

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

· **Covered providers**

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

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

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

**Medically underserved areas.** Note: In "medically underserved" areas, we cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are medically underserved. For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, and Wyoming.

· **Covered facilities**

Covered facilities include:

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

••Hospice

A facility which meets all of the following:

(1) primarily provides inpatient hospice care to terminally ill persons;

(2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;

(3) is supervised by a staff of M.D.'s or D.O.'s, at least one of whom must be on call at all times;

(4) provides 24 hour a day nursing services under the direction of an R.N. and has a full-time administrator; and

(5) provides an ongoing quality assurance program.

••Hospital

(1) an institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

(2) A medical institution which is operated pursuant to law, under the supervision of a staff of doctors, and with 24 hour a day nursing service, and which is primarily engaged in providing general inpatient care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or have such arrangements by contract or agreement; or

(3) An institution which is operated pursuant to law, under the supervision of a staff of doctors and with 24 hour a day nursing service and which provides services on the premises for the diagnosis, treatment, and care of persons with mental/substance abuse disorders and has for each patient a written treatment plan which must include diagnostic assessment of the patient and a description of the treatment to be rendered and provides for follow-up assessments by or under the direction of the supervising doctor.

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

## What you must do to get covered care

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

### Transitional Care:

**Specialty care:** If you have a chronic or disabling condition and lose access to your specialist because we:

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

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

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can

continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

**Hospital care.** We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 821-6136.

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

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

These provisions apply only to the benefits of the hospitalized person.

## How to Get Approval for…

### · Your hospital stay

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

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

**Warning:**

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

**How to precertify an admission:**

- For medical and surgical services, you, your representative, your doctor, or your hospital must call Intracorp before admission. The toll-free number is (800) 747-GEHA or (800) 747-4342 and is available 24 hours per day. (See page 53 for mental health/substance abuse precertification.)
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date, and phone number;

- Reason for hospitalization, proposed treatment, or surgery;
- Name and phone number of admitting doctor;
- Name of hospital or facility; and
- Number of planned days of confinement.

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

**Maternity care**

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

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

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

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

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:
  - for the part of the admission that was medically necessary, we will pay inpatient benefits, but
  - for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.
- If no one contacted us, we will decide whether the hospital stay was medically necessary.
  - If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
  - If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

**Exceptions:** You do not need precertification in these cases:

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

## · Other services

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

Physical and occupational therapy
Growth hormone therapy (GHT)
Surgical treatment of morbid obesity
Certain prescription drugs
Organ and tissue transplant procedures
Surgical correction of congenital anomalies
In-network Mental Health and Substance Abuse Benefits (refer to page 53)

## 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 when you receive services.

Example: When you see your PPO physician, under the High Option you pay a copayment of $15 per office visit.

· **Deductible**

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is $300 per person (High Option) or $450 per person (Standard Option). Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reaches $600 (High Option) or $900 (Standard Option).

- We also have a separate deductible for mental health and substance abuse treatment of $300 per person (High Option) or $450 per person (Standard Option). Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the mental health and substance abuse treatment deductible for family members reaches $600 (High Option) or $900 (Standard Option).

- There is also a separate $500 deductible, per person, per calendar year for out-of-network hospital inpatient and hospital outpatient/intensive day treatment under the Mental Health and Substance Abuse benefit.

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

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

· **Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. We will base this percentage on either the billed charge or the Plan Allowance, whichever is less.

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

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

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

**· Differences between our allowance and the bill**

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

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

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

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

| 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 out-of-pocket maximum for deductibles, coinsurance, and copayments

For those 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**

· $3,000 for Self and Family (High Option) or $3,500 (Standard Option) and $2,500 for Self Only (High Option) or $3,000 (Standard Option) 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**

· $4,000 for Self and Family (High Option) or $4,500 (Standard Option) and $3,500 for Self Only (High Option) or $4,000 (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.

Refer to pages 54 and 56 for separate in- and out-of-network out-of-pocket maximums for mental health and substance abuse.

Out-of-pocket expenses for this benefit are:

- The 10% (High Option) or 15% (Standard Option) you pay for PPO charges under medical services and supplies, surgical and anesthesia services and hospital, facility and ambulance services.
- The 25% (High Option) or 35% (Standard Option) you pay for Non-PPO charges under medical services and supplies, surgical and anesthesia services and hospital, facility and ambulance services.

The following cannot be counted toward out-of-pocket expenses:

- The $300 (High Option) or $450 (Standard Option) calendar year deductible;
- The $15 copayment for doctor's office visits (High Option); or the $10 copayment for primary care physician/$25 specialist office visits (Standard Option);
- The $75 copayment for hospital emergency room expenses;
- 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 10-12)
- Expenses for prescription drugs purchased through retail or Mail Order Drug Program.

## When government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

## If we overpay you

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

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

Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. The following chart has more information about the limits.

### If you…

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

### Then, for your inpatient hospital care,

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

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

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

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

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

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

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

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services 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 our payment combined with Medicare's payment and the charge. Please see Section 9, Coordinating benefits with other coverage, for more information about how we coordinate benefits with Medicare.

Note: The 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 them to reduce their charges. If they do not, report them to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

## When you have a Medicare Private Contract

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

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

# Section 5. Benefits -- OVERVIEW

***(See page 7 for how our benefits changed this year and pages 92 and 93 for a benefits summary.)***

**NOTE**: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at (800) 821-6136 or at our website at www.geha.com.


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- Orthopedic and prosthetic devices
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## Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

**Here are some 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 deductibles are:

  **High Option:** $300 per person ($600 per family)

  **Standard Option:** $450 per person ($900 per family)

  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.
- 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, keep in mind that the professionals who provide services to you in a hospital, such as radiologists, emergency room physicians, anesthesiologists and pathologists, may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers.
- 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.

IMPORTANT

| Benefit Description | You pay<br>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** | **Standard Option** | **High Option** |
| Professional services of physicians<br>• In physician's office<br>• Routine physical examinations<br>• Office medical consultations<br>• Second surgical opinions | PPO: $10 copayment for office visits to primary care physicians; $25 copayment for office visits to specialists (No deductible)<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount. | PPO: $15 copayment (No deductible)<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| Professional services of physicians<br>• Emergency room physician care (non accidental injury)<br>• During a hospital stay<br>• At home | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |

| **Diagnostic and treatment services –** *Continued* | **You pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| **Lab, X-ray and other diagnostic tests** | | |
| Tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine pap tests<br>• Pathology<br>• X-rays<br>• Non-routine mammograms<br>• CAT Scans/MRI<br>• Ultrasound<br>• Electrocardiogram and EEG | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount<br>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: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount<br>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. |
| **Preventive care, adult** | | |
| Routine screenings:<br>• Cholesterol screenings<br>• Colorectal cancer screening<br>•• Annual coverage of one fecal occult blood test for members age 40 and older<br>•• Sigmoidoscopy<br>• Prostate cancer screening<br>•• Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older<br>• Cervical cancer screening<br>•• Annual coverage of one pap smear for women age 18 and older<br>• Breast cancer screening<br>•• Mammograms for diagnostic and/or routine screening | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |

| **Diagnostic and treatment services –** *Continued* | **You pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| **Preventive care, adult** | | |
| Routine Immunizations:<br>• Tetanus-diphtheria (Td) booster<br>• Influenza/Pneumococcal vaccines | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| **Preventive care, children** | | |
| For dependent children under age 22:<br>• Childhood immunizations recommended by the American Academy of Pediatrics and examinations done on the same day.<br>• For well-child care charges for routine examinations, immunizations and care.<br>• Initial examination of a newborn child covered under a family enrollment. | PPO: Nothing (No deductible)<br>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible) | PPO: Nothing (No deductible)<br>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible) |
| • Vision examinations, limited to:<br>•• Examinations for amblyopia and strabismus | PPO: $10 copayment for office visits to primary care physicians; $25 copayment for office visits to specialists (No deductible)<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount. | PPO: $15 copayment (No deductible)<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |

| Maternity Care | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Complete maternity (obstetrical) care, such as:<br>• Prenatal care<br>• Delivery<br>• Postnatal care<br>• Physician care such as non-routine sonograms. | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount. | PPO: Nothing (No deductible)<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| • Approved fetal monitors are covered the same as other medical benefits for diagnostic and treatment services<br>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount. | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Routine sonograms to determine fetal age, size or sex.*<br>• *Home uterine monitoring devices, unless preauthorized by our Medical Director.*<br>• *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.*<br>• *Charges for services and supplies incurred after termination of coverage.* | *All charges* | *All charges* |
| **Family planning** | | |
| • Voluntary sterilization<br>• Surgically implanted contraceptives<br>• Injectable contraceptive drugs<br>• Intrauterine devices (IUDs)<br>Note: We cover contraceptive drugs in Section 5(f). | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered: reversal of voluntary surgical sterilization, genetic counseling* | *All charges* | *All charges* |

| Infertility services | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Diagnosis and treatment of infertility, except as excluded.<br>Note: Benefits are limited to a maximum of $3,000 per calendar year per person. | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Fertility drugs*<br>• *Assisted reproductive technology (ART) procedures, such as:*<br>•• *artificial insemination*<br>•• *in vitro fertilization*<br>•• *embryo transfer and GIFT*<br>•• *intravaginal insemination (IVI)*<br>•• *intracervical insemination (ICI)*<br>•• *intrauterine insemination (IUI)*<br>• *Services and supplies related to ART procedures.* | *All charges* | *All charges* |
| **Allergy care** | | |
| Allergy treatment and medically necessary allergy testing<br>Allergy testing is limited to $500 per person per calendar year. | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Clinical ecology and environmental medicine*<br>• *Provocative food testing and sublingual allergy desensitization* | *All charges* | *All charges* |

| Treatment therapies | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| • Antibiotic therapy<br>• Chemotherapy and radiation therapy<br>Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 37.<br>• Dialysis – Hemodialysis and peritoneal dialysis<br>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy<br>• Growth hormone therapy (GHT)<br>Note: – Call (800) 821-6136 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment.<br>• Respiratory and inhalation therapies<br>Note – Some medications required for treatment therapies may be available through the Mail Order Pharmacy or a PAID Participating Pharmacy. Medications obtained from these sources are covered under the Prescription Drug Benefits on pages 58-63. | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Chelation therapy except for acute arsenic, gold or lead poisoning* | *All charges* | *All charges* |

| Rehabilitative therapies | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| • Occupational and speech therapy –<br><br>Outpatient visits for any services provided by an occupational or speech therapist, when prescribed by a doctor and rendered by a qualified professional therapist, up to a combined total of 30 visits per person per calendar year.<br><br>Note: Speech therapy must be to restore functional speech when there has been a loss of attained functional speech due to illness or injury, such as stroke or brain trauma, and when therapy was rendered in accordance with a doctor's specific instructions as to the duration and type.<br><br>• Physical therapy –<br><br>Outpatient visits for physical therapy, when prescribed by a doctor and rendered by a qualified physical therapist, are available up to a total of 50 visits per calendar year.<br><br>Prior to beginning physical therapy treatments, you should contact our Medical Management Department, (800) 821-6136, to preauthorize benefits. Continuing physical therapy claims will be subject to concurrent review for medical necessity. Physical therapy claims will be denied if we determine the therapy is not medically necessary. Please preauthorize.<br><br>Note: When you receive medically necessary physical, speech 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.<br><br>• Vision therapy –<br><br>Outpatient visits for vision therapy provided by an ophthalmologist or optometrist are available up to a total of 30 visits per person, per lifetime.<br><br>Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or attained functional speech due to illness or injury and when a physician:<br><br>1) orders the care;<br><br>2) identifies the specific professional skills the patient requires and the medical necessity for skilled services; and<br><br>3) indicates the length of time the services are needed. | PPO: 15% of the Plan allowance<br><br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |

| **Rehabilitative therapies –** *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| *Not covered:*<br>• *Computer devices to assist with communications*<br>• *Computer programs of any type, including but not limited to those to assist with vision therapy or speech therapy.*<br>• *Exercise programs*<br>• *Rest cures* | *All charges* | *All charges* |
| **Hearing services (testing, treatment, and supplies)** | | |
| Diagnostic hearing tests performed by an MD or DO | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *hearing testing conducted by audiologists*<br>• *hearing aids, testing and examinations for them* | *All charges* | *All charges* |
| **Vision services (testing, treatment, and supplies)** | | |
| • First pair of contact lenses or ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury. | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Eyeglasses or contact lenses and examinations for them*<br>• *Radial keratotomy and other refractive surgery* | *All charges* | *All charges* |

| Foot care | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Routine foot care only when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. | PPO: $10 copayment for office visits 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.<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount. | PPO: $15 copayment for the office visit (No deductible) plus 10% of the Plan allowance for other services performed during the visit<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Cutting or 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** | | |
| • Artificial limbs and eyes; stump hose<br>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy<br>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Orthopedic and corrective shoes*<br>• *Arch supports*<br>• *Foot orthotics*<br>• *Heel pads and heel cups* | *All charges* | *All charges* |

| Durable medical equipment (DME) | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Durable medical equipment (DME) is equipment and supplies that:<br>1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury);<br>2. Are medically necessary;<br>3. Are primarily and customarily used only for a medical purpose;<br>4. Are generally useful only to a person with an illness or injury;<br>5. Are designed for prolonged use; and<br>6. Serve a specific therapeutic purpose in the treatment of an illness or injury.<br>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover:<br>• Hospital beds;<br>• Wheelchairs;<br>• Crutches; and<br>• Walkers.<br>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.<br>Note: Benefits for durable medical equipment are limited to $10,000 per person, lifetime maximum. | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Computer devices to assist with communications*<br>• *Computer programs of any type, including but not limited to those to assist with vision therapy or speech therapy*<br>• *Air purifiers, air conditioners, heating pads, 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 81)*<br>• *Lifts, such as seat, chair or van lifts*<br>• *Wigs* | *All charges* | *All charges* |

| Home health services | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| In-home services of a registered nurse (R.N.) and licensed practical nurse (L.P.N.) but not to exceed one visit up to two hours per day of skilled nursing care for up to a total of 25 visits per calendar year. Covered services are based on our review for medical necessity. | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Nursing care requested by, or for the convenience of, the patient or the patient's family;*<br>• *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;*<br>• *Custodial care;*<br>• *Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;.*<br>• *Inpatient private duty nursing;* | *All charges* | *All charges* |

| Alternative treatments | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Acupuncture<br>Benefits are limited to 20 procedures per calendar year for medically necessary acupuncture treatments if performed by a Medical Doctor (MD) or Doctor of Osteopathy (DO). | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| Chiropractic services<br>Benefits are limited to services that are within chiropractic scope of license, up to a maximum of 30 visits per calendar year and use of X-rays to detect and determine the presence or absence of nerve interferences due to spinal subluxations or misalignments up to a maximum of $25 per calendar year.<br>Note: Charges exceeding these amounts are not applied toward the calendar year deductible.<br>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:<br>All charges in excess of $9 per visit<br>All charges in excess of $25 for X-rays of the spine | PPO and Non-PPO:<br>All charges in excess of $9 per visit<br>All charges in excess of $25 for X-rays of the spine |
| *Not covered:*<br>· *All other alternative treatments, including clinical ecology and environmental medicine.*<br>• *Only the alternative treatments listed above are covered.* | *All charges* | *All charges* |
| **Educational classes and programs** | | |
| Coverage is limited to:<br>• Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.Only the alternative treatments listed above are covered. | PPO: all charges in excess of $100<br>Non-PPO: all charges in excess of $100 | PPO: all charges in excess of $100<br>Non-PPO: all charges in excess of $100 |

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

IMPORTANT

**Here are some 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 deductibles are:

  **High Option:** $300 per person ($600 per family)

  **Standard Option:** $450 per person ($900 per family)

  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.
- 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.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in a hospital, such as radiologists, emergency room physicians, anesthesiologists and pathologists, may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers.
- 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.

IMPORTANT

| Benefit Description | You pay<br>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** | **Standard Option** | **High Option** |
| • Operative procedures<br>• Treatment of fractures, including casting<br>• Normal pre- and post-operative care by the surgeon<br>• Correction of amblyopia and strabismus<br>• Endoscopy procedure<br>• Biopsy procedure<br>• Electroconvulsive therapy<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies (see Reconstructive surgery)<br>• Surgical treatment of morbid obesity – criteria regarding complications of obesity and body mass index must be met. Treatment must be precertified.<br>• Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information<br>• Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs)<br>• Treatment of burns<br>• Assistant surgeons- we cover up to 20% of our allowance for the surgeon's charge<br>• 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: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |

| **Surgical procedures –** *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are:<br>• For the primary procedure:<br>Full Plan allowance<br>• For the secondary procedure(s):<br>50% of the Plan allowance<br>• For the subsequent procedure(s):<br>25% of the Plan allowance<br>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: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount. |
| *Not covered:*<br>• *Reversal of voluntary sterilization*<br>• *Stand-by physicians and surgeons*<br>• *Routine treatment of conditions of the foot; see Foot care* | *All charges* | *All charges* |

| Reconstructive surgery | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| • Surgery to correct a functional defect<br>• Surgery to correct a condition caused by injury or illness if:<br>  •• the condition produced a major effect on the member's appearance and<br>  •• the condition can reasonably be expected to be corrected by such surgery<br>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: cleft lip; cleft palate; birth marks; and webbed fingers and toes.<br>• All stages of breast reconstruction surgery following a mastectomy, such as:<br>  •• surgery to produce a symmetrical appearance on the other breast;<br>  •• treatment of any physical complications, such as lymphedemas;<br>  •• breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage) | PPO: 15% of the Plan allowance<br><br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| 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.<br><br>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. | | |
| *Not covered:*<br>• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated promptly or as soon as the member's medical condition permits.*<br>• *Surgeries related to sex transformation or sexual dysfunction* | *All charges* | *All charges* |

| Oral and maxillofacial surgery | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Oral surgical procedures, limited to:<br>• Reduction of fractures of the jaw or facial bones;<br>• Surgical correction of cleft lip or cleft palate;<br>• Excision of cysts and incision of abscesses unrelated to tooth structure;<br>• Extraction of impacted (unerupted or partially erupted) teeth;<br>• Alveoloplasty, partial or radical removal of the lower jaw with bone graft;<br>• Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues;<br>• Open reduction of dislocations and excision, manipulation, aspiration or injection of temporo-mandibular joints;<br>• 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;<br>• Repair of traumatic wounds;<br>• Incision of the sinus and repair of oral fistulas;<br>• Surgical treatment of trigeminal neuralgia;<br>• Repair of accidental injury to sound natural teeth (including, but 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 (see page 48). | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Oral implants and transplants*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*<br>• *Orthodontic treatment*<br>• *Any oral or maxillofacial surgery not specifically listed as covered*<br>• *Orthognathic surgery, even if necessary because of TMJ dysfunction or disorder.* | *All charges* | *All charges* |

| Organ/tissue transplants | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Limited to:<br>• Cornea<br>• Heart<br>• Heart/lung<br>• Kidney<br>• Kidney/Pancreas<br>• Liver<br>• Lung: Single or double lung transplants, limited to patients for the following end-stage pulmonary diseases: (1) Primary fibrosis, (2) Primary pulmonary hypertension, (3) Emphysema, or (4) cystic fibrosis.<br>• Pancreas (limited to patients whose condition is not treatable by insulin therapy)<br>• Allogeneic bone marrow transplants – only for patients with Acute leukemia, Advanced Hodgkin's lymphoma, Advanced non-Hodgkin's lymphoma, Advanced neurblastoma (limited to children over age one), Aplastic anemia, Chronic myelogenous leukemia, Infantile malignant osteopetrosis, Severe combined immunodeficiency, Thalassemia major, or Wiskott-Aldrich syndrome;<br>• Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support - limited to patients with Acute lymphocytic, or non-lymphocytic leukemia, Advanced Hodgkin's lymphoma, Advanced non-Hodgkin's lymphoma, Advanced neuroblastoma (limited to children over age one), Breast cancer or Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors, Multiple myeloma or Epithelial ovarian cancer. | PPO: 15% of the Plan allowance<br><br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |

| **Organ/tissue transplants –** *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| 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.<br><br>Transportation benefit<br><br>We will also provide up to $10,000 per covered transplant for transportation (mileage or airfare) to a plan designated facility and reasonable temporary living expenses (i.e. lodging and meals) for the recipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 100 miles from the designated transplant facility. Transportation benefits are payable for follow-up care up to one year following the transplant. The transportation benefit is not available for cornea or kidney transplants. You must contact Customer Service for what are considered reasonable temporary living expenses. | PPO: 15% of the Plan allowance<br><br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| Limitations<br><br>• The process for preauthorizing organ transplants is more extensive that 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. | | |

| **Organ/tissue transplants –** *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High 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. | PPO: $10 copayment for office visits to primary care physicians; $25 copayment for office visits to specialists (no deductible)<br><br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount. | PPO: $15 copayment (no deductible)<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount |
| • The transplant must be performed at a Plan-designated organ transplant facility to receive maximum benefits.<br><br>• 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 autologous bone marrow transplant (autologous stem cell support) are included in benefits limit of $100,000 per transplant. Expenses for aftercare such as outpatient prescription drugs are not a part of the $100,000 limit. | If prior approval is not obtained or a Plan-designated organ transplant facility is not used, the benefits will be limited to 15% for PPO hospital expenses, 15% for PPO physician expenses or 35% of our allowance for non-PPO 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. | If prior approval is not obtained or a Plan-designated organ transplant facility is not used, the benefits will be limited to 10% for PPO hospital expenses, 10% for PPO physician expenses or 25% of our allowance for non-PPO 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. |

| **Organ/tissue transplants –** *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| • Chemotherapy and procedures related to bone marrow transplantation must be performed only at a Plan-designated organ transplant facility to receive maximum benefits.<br>• 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: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount. | PPO: 10% of the Plan allowance<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount. |
| *Not covered:*<br>• *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.*<br>• *Donor search expense for bone marrow transplants.* | *All charges* | *All charges* |
| **Anesthesia** | | |
| Professional fees for the administration of anesthesia<br>Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges. | PPO: 15% of the Plan allowance<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of the Plan allowance<br>Non-PPO: 25% 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

**Here are some 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.
- Unlike Sections (a) and (b), in this section the calendar year deductible applies to only a few benefits. In that case, we added "(deductible applies)".
- 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 Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS ; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in a hospital, such as radiologists, emergency room physicians, anesthesiologists and pathologists, may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers.
- 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.

IMPORTANT

| Benefit Description | You pay | |
|---|---|---|
| **NOTE: The calendar year deductible applies ONLY when we say below: "deductible applies".** | | |
| **Inpatient Hospital** | **Standard Option** | **High Option** |
| Room and board, such as<br>• ward, semiprivate, or intensive care accommodations;<br>• general nursing care; and<br>• meals and special diets.<br>NOTE: We will pay charges for use of a private room if we determine it to be medically necessary. Use of a private room for any other reason will be paid at the rate of the hospital's average semiprivate accommodations. The remaining balance is not a covered expense.<br>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: 15% of the Plan allowance (deductible applies)<br>Non-PPO: 35% of the Plan allowance (deductible applies) | PPO: Nothing<br>Non-PPO: Nothing |
| Other hospital services and supplies, such as:<br>• Operating, recovery and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests and X-rays<br>• Blood or blood plasma, if not donated or replaced<br>• Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen<br>• Anesthetics, including nurse anesthetist services<br>• Take-home items<br>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)<br>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: 15% of Plan allowance (deductible applies)<br>Non-PPO: 35% of the Plan allowance (deductible applies) | PPO: 10% of Plan allowance<br>Non-PPO: 25% of the Plan allowance |

| **Inpatient hospital-** *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Maternity Care – Inpatient Hospital<br>Room and board, such as<br>• ward, semiprivate, or intensive care accommodations<br>• general nursing care; and<br>• meals and special diets<br>Note: Here are some things to keep in mind:<br>• You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby.<br>• 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.<br>Other hospital services and supplies, such as:<br>• Delivery room, recovery, and other treatment rooms;<br>• Prescribed drugs and medicines;<br>• Diagnostic laboratory tests and X-rays<br>• Blood or blood plasma, if not donated or replaced<br>• Dressings and sterile tray services<br>• Medical supplies and equipment, including oxygen<br>• Anesthetics, including nurse anesthetist services<br>• Take-home items<br>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)<br>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. | PPO: 15% of the Plan allowance (deductible applies).<br><br>Non-PPO: 35% of the Plan allowance (deductible applies). | PPO: Nothing<br><br>Non-PPO: Nothing for room and board; 25% of the Plan allowance for other hospital services |

| **Inpatient hospital-** *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Maternity Care – Inpatient Hospital - *continued*<br>• We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. | PPO: 15% of the Plan allowance (deductible applies).<br><br>Non-PPO: 35% of the Plan allowance (deductible applies). | PPO: Nothing for room and board; 10% of the plan allowance for other hospital services<br><br>Non-PPO: Nothing for room and board; 25% of the Plan allowance for other hospital services |
| *Not covered:*<br>• *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*<br>• *Custodial care; see definition.*<br>• *Non-covered facilities, such as nursing homes, extended care facilities, schools*<br>• *Personal comfort items, such as telephone, television, barber services, guest meals and beds*<br>• *Private nursing care* | *All charges* | *All charges* |

| Outpatient hospital or ambulatory surgical center | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| • Operating, recovery, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests, X-rays, and pathology services<br>• Administration of blood, blood plasma, and other biologicals<br>• Blood and blood plasma, if not donated or replaced<br>• Pre-surgical testing<br>• Dressings, casts, and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia service<br>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: 15% of Plan allowance (deductible applies)<br>Non-PPO: 35% of the Plan allowance (deductible applies) | PPO: 10% of Plan allowance (deductible applies)<br>Non-PPO: 25% of the Plan allowance (deductible applies) |
| Maternity Care – Outpatient hospital<br>• Delivery room, recovery, and other treatment rooms;<br>• Prescribed drugs and medicines;<br>• Diagnostic laboratory tests and X-rays, and pathology services;<br>• Administration of blood, blood plasma, and other biologicals;<br>• Blood and blood plasma, if not donated or replaced;<br>• Pre-surgical testing;<br>• Dressings and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia services; | PPO: 15% of the Plan allowance (deductible applies).<br>Non-PPO: 35% of the Plan allowance (deductible applies). | PPO: Nothing .<br>Non-PPO: 25% of the Plan allowance (deductible applies). |
| **Extended care benefits/Skilled nursing care facility benefits** | | |
| No benefits. | All charges. | All charges. |

| Hospice care | You Pay | |
|---|---|---|
| | **Standard Option** | **High 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.<br>• We pay $2000 for hospice care on an outpatient basis.<br>• We pay $150 per day for room and board and care while an inpatient in a hospice up to a maximum of $3,000.<br>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:<br>• Provided while the person is covered by this Plan;<br>• Ordered by the supervising doctor;<br>• Charged by the hospice care program; and<br>• Provided within six months from the date the person entered or re-entered (after a period of remission) a hospice care program.<br>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 Plan limits (deductible applies)<br>Non-PPO: Nothing up to Plan limits (deductible applies) | PPO: Nothing up to Plan limits (deductible applies)<br>Non-PPO: Nothing up to Plan limits (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 | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Ambulance service within 72 hours of an accident is covered as follows:<br>• 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).<br>• 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. | PPO: Nothing up to Plan allowance<br>Non-PPO: Nothing up to Plan allowance | PPO: Nothing up to Plan allowance<br>Non-PPO: Nothing up to 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).<br>• 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. | PPO: 15% of Plan allowance (deductible applies).<br>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (deductible applies) | PPO: 10% of Plan allowance (deductible applies).<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (deductible applies). |
| *Not covered: Travel, even when prescribed by a doctor, except as described for organ transplants (as outlined on page 38)* | *All charges* | *All charges* |

## Section 5 (d). Emergency services/accidents

IMPORTANT

**Here are some important things to keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductibles are:

  **High Option:** $300 per person ($600 per family)

  **Standard Option:** $450 per person ($900 per family)

  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.

- 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, keep in mind that the professionals who provide services to you in a hospital, such as radiologists, emergency room physicians, anesthesiologists and pathologists, may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers.
- 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.

IMPORTANT

### 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.

| Benefit Description | You pay | |
|---|---|---|
| **NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.** | | |
| **Accidental injury** | **Standard Option** | **High Option** |
| If you receive care for your accidental injury within 72 hours, we cover:<br>• Treatment outside a hospital or in the outpatient/emergency room department of a hospital<br>• Related outpatient physician care | PPO: Nothing (No deductible)<br>Non-PPO: Only the difference between our allowance and the billed amount (No deductible) | PPO: Nothing (No deductible)<br>Non-PPO: Only the difference between our allowance and the billed amount (No deductible) |

| **Accidental injury** - *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Note: Emergency room charges associated directly with an inpatient admission are considered "Other charges" under Inpatient Hospital Benefits (see page 42) 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. | | |
| If you receive care for your accidental injury after 72 hours, we cover:<br>• Non-surgical physician services and supplies<br>• Surgical care<br>Note: We pay Hospital benefits if you are admitted. | PPO: 15% of Plan allowance<br>Non-PPO: 35% of Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of Plan allowance<br>Non-PPO: 25% of Plan allowance and any difference between our allowance and the billed amount |
| **Emergency room – non-accidental injury** | | |
| Outpatient services and supplies billed by a hospital for emergency room treatment<br>Note: We pay Hospital benefits if you are admitted<br>The $75 copayment per occurrence does not apply to the calendar year deductible nor count toward the maximum out-of-pocket limit.<br>Emergency room physician charges are paid the same as other diagnostic and treatment services, see page 20. | PPO: $75 copayment per occurrence<br>Non-PPO: $75 copayment per occurrence | PPO: $75 copayment per occurrence<br>Non-PPO: $75 copayment per occurrence |

| Ambulance – accidental injury | You Pay | |
|---|---|---|
| | **Standard Option** | **High Option** |
| Ambulance service within 72 hours of an accident is covered as follows:<br>• 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).<br>• 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. | PPO: Nothing up to Plan allowance<br>Non-PPO: Nothing up to Plan allowance | PPO: Nothing up to Plan allowance<br>Non-PPO: Nothing up to Plan allowance |
| **Ambulance – non-accidental injury** | **You Pay** | |
| | **Standard Option** | **High Option** |
| • Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary).<br>• 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. | PPO: 15% of Plan allowance<br>Non-PPO: 35% of Plan allowance and any difference between our allowance and the billed amount | PPO: 10% of Plan allowance<br>Non-PPO: 25% of Plan allowance and any difference between our allowance and the billed amount |
| *Not covered: Travel, even when prescribed by a doctor, except as described for organ transplants (as outlined on page 38)* | *All charges* | *All charges* |

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

IMPORTANT

**Parity**

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

You may now choose to get care Out-of-Network (same as before) or **In-Network** (new in 2001). When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**Here are some important things to keep in mind about these benefits:**

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 55.

| Benefit Description | You pay<br>After the calendar year deductible… | |
|---|---|---|
| **NOTE: The calendar year deductible applies to almost all benefits in this Section.** | | |
| **In-Network benefits** | **Standard Option** | **High Option** |
| All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.<br>Note: In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. | Your cost sharing responsibilities are no greater than for other illness or conditions. | Your cost sharing responsibilities are no greater than for other illness or conditions. |

| **In-Network benefits** - *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers<br>• Medication management | $25 copayment per office visit (No deductible) | $15 copayment per office visit (No deductible) |
| • Inpatient professional fees | 15% of Plan allowance for Inpatient professional fees | 10% of the Plan allowance for Inpatient professional fees |
| • Diagnostic tests<br>• Laboratory tests to monitor the effect of drugs prescribed for your condition | 15% of Plan allowance | 10% of Plan allowance |
| **Inpatient hospital** | | |
| Room and board, such as<br>• ward, semiprivate, or intensive care accommodations;<br>• general nursing care; and<br>• meals and special diets.<br>NOTE: We will pay charges for use of a private room if we determine it to be medically necessary. Use of a private room for any other reason will be paid at the rate of the hospital's average semiprivate accommodations. The remaining balance is not a covered expense.<br>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. | 15% of Plan allowance | Nothing (No deductible) |
| Other hospital services and supplies<br>• Services provided by a hospital or other facility<br>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, and facility-based intensive outpatient treatment | 15% of Plan allowance | 10% of Plan allowance<br>(No deductible for inpatient services) |

| **In-Network benefits** - *Continued* | **You Pay** | |
|---|---|---|
| | **Standard Option** | **High Option** |
| **Outpatient hospital** | | |
| Services provided by a hospital | 15% of Plan allowance | 10% of Plan allowance |
| **Emergency room – non-accidental injury** | | |
| Outpatient services and supplies billed by a hospital for emergency room treatment<br><br>Note: We pay Hospital benefits if you are admitted.<br>The $75 copayment per occurrence does not apply to the calendar year deductible nor count toward the maximum out-of-pocket limit.<br>Emergency room physician charges are paid the same as other diagnostic and treatment services, see page 20. | $75 copayment per occurrence | $75 copayment per occurrence |
| *Not covered: Services we have not approved.*<br>*Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.* | *All charges* | *All charges* |

**Preauthorization**

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of the following network authorization processes:

- You must call United Behavioral Health at (877) 564-7505 to receive authorization for inpatient and outpatient care from a Network provider. They will authorize any covered treatment and tell you what Network providers are available for your treatment.
- If you do not receive preauthorization for care from a Network provider, Out-of-Network benefits will be paid for covered services.

| **In-Network benefits** - *Continued* | |
|---|---|
| **Network deductibles and Out-of-pocket maximums** | There is a separate calendar year deductible and separate out-of-pocket maximum for mental health/ substance abuse treatment.<br><br>The separate deductible is $300 per person, $600 per family (High Option); or $450 per person, $900 per family (Standard Option). This separate deductible covers both in-network and out-of-network services combined and applies to almost all of the benefits in this section.<br><br>The separate out-of-pocket maximum is $2,500 Self Only, $3,000 Self and Family (High Option); or $3,000 Self Only, $3,500 Self and Family (Standard Option). After you meet this out-of-pocket maximum, we pay 100% of our allowable amount for the remainder of the calendar year. The separate mental health/substance abuse deductible does not apply to this out-of-pocket maximum.<br><br>Out-of-pocket expenses for this mental health/substance abuse benefit are:<br>• The 10% you pay for other hospital, inpatient professional fees, emergency room physician services and diagnostic services under the High Option.<br>• The 15% you pay for other hospital, inpatient professional fees, emergency room physician services and diagnostic services under the Standard Option.<br><br>Note: In addition, expenses which apply to the in-network mental health/substance abuse out-of-pocket maximums are also applied to the out-of-network mental health/substance abuse out-of-pocket maximum. |
| **Network deductibles and Out-of-pocket Maximums** | The following cannot be included in the accumulation of mental health/substance abuse out-of-pocket expenses:<br>• Expenses in excess of the Plan allowance or maximum benefit limitations.<br>• The $15 copayment (High Option) and $25 copayment (Standard Option) for office professional services and medication management.<br>• $300 (High Option) and $450 (Standard Option) calendar year mental health/substance abuse deductible.<br>• $75 copayment for outpatient emergency room services<br>• Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements (see pages 10 and 11)<br>• Expenses for prescription drugs purchased through retail or Mail Order Program. |
| **Network limitation** | If you do not obtain and follow an approved treatment plan, we will provide only Out-of-Network benefits. |
| **How to submit network claims** | You or your provider should submit claims to:<br><br>United Behavioral Health<br>P.O. Box 8570<br>Emeryville, CA 94662-8570<br><br>If you need help in filing your claim, get in touch with us at (816) 257-5500, toll-free (800) 821-6136, TDD (800) 821-4833 or contact United Behavioral Health at (877) 564-7505. |

## Out-of-Network Benefit

**Here are some important things to 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.
- See pages 51-54 for In-Network 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.

| Description | You Pay | |
|---|---|---|
| **Out-of-Network mental health and substance abuse benefits** | **Standard Option** | **High Option** |
| **Inpatient Hospital/Facility for treatment of mental health,** 100 day limit per calendar year, precertification required.<br>**Inpatient Hospital/Facility treatment of alcoholism and drug abuse**, 30 day maximum per lifetime, precertification required.<br>**Outpatient Hospital/Intensive Day Treatment Program for mental health /substance abuse**, 60 day limit per calendar year | 50% of Plan allowance and any difference between our allowance and the billed amount; $500 inpatient hospital and outpatient hospital /intensive day treatment deductible applies per person, per year | 50% of Plan allowance and any difference between our allowance and the billed amount; $500 inpatient hospital and outpatient hospital /intensive day treatment deductible applies per person, per year |
| **Inpatient Visits for Psychotherapy**, 100 inpatient visits limit per calendar year<br>**Outpatient Visits for Psychotherapy and group sessions**, limited to 30 sessions per calendar year for treatment of mental health and substance abuse | 50% of Plan allowance and any difference between our allowance and the billed amount, $450 mental health calendar year deductible applies<br>Both Network and Out-of-Network expenses will apply to the mental health deductible. | 50% of Plan allowance and any difference between our allowance and the billed amount, $300 mental health calendar year deductible applies<br>Both Network and Out-of-Network expenses will apply to the mental health deductible. |

| Out-of-Network Benefit – *Continued* | | |
|---|---|---|
| *Not covered out-of-network:*<br>• *Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems.*<br>• *Treatment for learning disabilities and mental retardation*<br>*Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs* | *All charges* | *All charges* |

| | |
|---|---|
| **Lifetime Maximum** | Out-of-Network inpatient care for the treatment of alcoholism and drug abuse is limited to a 30 day maximum per lifetime. |
| **Precertification** | The medical necessity of your admission to a hospital or other covered facility for a mental health or substance abuse must be precertified to receive Out-of-Network benefits. Emergency admissions must be reported within two business days following admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500.<br>Call United Behavioral Health at (877) 564-7505 to precertify. |
| **Out-of-Network Deductible calendar year maximums & out-of-pocket maximums** | The calendar year mental health/substance abuse deductible is:<br>**High Option:** $300 per person ($600 per family)<br>**Standard Option:** $450 per person ($900 per family)<br>The calendar year deductible applies to almost all mental health/substance abuse benefits in this Section.<br>There is a separate $500 hospital inpatient and outpatient hospital/intensive day treatment mental health/substance abuse deductible, per person, per calendar year. Inpatient hospital care for mental health is limited to 100 days per calendar year. Intensive Day Treatment is limited to 60 visits per calendar year.<br>Inpatient care for the treatment of alcoholism and drug abuse is available 30 day maximum per lifetime.<br>Inpatient visits for psychotherapy sessions are limited to 100 visits per calendar year.<br>Home and office visits for psychotherapy and group sessions for mental health/substance abuse are limited to 30 sessions per calendar year.<br>When the deductibles and coinsurance for all covered family members (or an individual under Self Only) exceeds $8,000 for the treatment of mental health (inpatient or outpatient) and outpatient substance abuse in any one calendar year, we will pay in full all remaining allowable charges incurred during the remainder of that same year. |

Out-of-pocket expenses for this mental health/substance abuse benefit are:

- The $500 deductible for Inpatient and Outpatient Hospital/Intensive Day Treatment of mental health/substance abuse
- The 50% you pay for inpatient and outpatient hospital and intensive day treatment expenses;
- The 50% you pay for inpatient visits;
- The 50% you pay for outpatient care.

In addition, expenses which apply to the in-network mental health/substance abuse out-of-pocket maximums are also applied to the out-of-network mental health/substance abuse out-of-pocket maximum.

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

- Expenses in excess of the Plan allowance or maximum benefit limitations.
- Expenses for outpatient psychotherapy sessions in excess of 30 sessions per year.
- Expenses for inpatient care in excess of 100 days per year.
- $300 calendar year deductible for High Option.
- $450 calendar year deductible for Standard Option.
- Expenses for intensive day treatment in excess of 60 days per year.
- Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements (see pages 10 and 11).
- Expenses for prescription drugs purchased through retail or Mail Order Program.
- Expenses in excess of the 50% of our allowable amount for inpatient substance abuse charges.

## How to submit out-of-network claims

You or your provider should submit claims to:

United Behavioral Health
P.O. Box 8570
Emeryville, CA 94662-8570
(877) 564-7505

If you need help in filing your claim, get in touch with us at (816) 257-5500, toll-free (800) 821-6136 or TDD (800) 821-4833.

## Section 5 (f). Prescription drug benefits

**IMPORTANT**

**Here are some important things to keep in mind about these benefits:**

- We cover prescribed drugs and medications, as described in the chart beginning on page 61.
- 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 A*bout coordinating benefits with other coverage*, including with Medicare.
- Under the High Option plan, if Medicare is your primary insurance and you have both Medicare Part A & B coverage, you pay less for your prescriptions (see page 62).

**IMPORTANT**

- **Who can write your prescription.** A licensed physician must write the prescription or a licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a PAID network pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy. For medications you may take on a regular, long-term basis, we pay a higher level of benefits through the Mail Order Drug Program.

  - **Preferred Prescriptions voluntary formulary** Your prescription drug program includes a voluntary "formulary" feature. The Preferred Prescriptions 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 nonformulary medications, can help contain the increasing cost of prescription drug coverage without sacrificing quality.

    In many therapeutic categories, there are several drugs of similar effectiveness. Many doctors are often unaware of the significant variations in price among these similar drugs and, as a result, their prescribing decisions often do not consider cost. However, when the cost difference is brought to their attention, doctors will frequently prescribe the less costly medications.

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

- **These are the dispensing limitations:**

  - **Using the PAID Retail Network** To receive maximum savings you must present your card at the time of each purchase, and your enrollment information must be current and correct. In most cases, you simply present the card together with the prescription to the pharmacist. Each purchase is limited to a 30-day supply. Refills cannot be obtained until **75%** of the drug has been used. 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. You may fill your prescription at any pharmacy participating in the PAID TelePAID system. For the names of participating pharmacies, call (800) 551-7675.

  - **Using the Mail Order Drug Program** Through this program, you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, ostomy supplies, diabetic supplies and insulin, syringes and needles for covered injectable medications, and oral contraceptives. Some medications may not be available in a 90-day supply from Merck-Medco RX 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 the mail order drug program you should obtain a prescription from your physician for a 90-day supply. Some medications may require approval by Medco or GEHA. Not all drugs are available through The Mail Order Drug Program. Each enrollee will receive an installment kit that includes a brochure describing The Mail Order Drug Program, including a Patient Profile Questionnaire, order form 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 Patient Profile Questionnaire kit the first time you order through this program. Complete the information on the back of the pre-addressed, postage paid envelope, enclose your prescription and the correct copayment.

    Mail to:
    Merck-Medco RX Services
    P.O. Box 98830
    Las Vegas, NV 89195-0249

    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 about your prescription, you may call the Mail Order Drug Program toll-free at (800) 551-7675 from 5 a.m. to 9 p.m. Monday through Friday, and 5 a.m. through 3 p.m. on Saturday, PST. Emergency consultation is available seven days a week, 24 hours per day. Forms necessary for refills and future prescription orders will be provided each time you receive a supply of medication from the program.

    **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 special order envelope.

    **To order online:** Go to www.geha.com/benefit/prescrip.html then click on the link to Merck-Medco, or go to www.merck-medco.com

## Prescription drug benefits – *Continued*

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

  At participating pharmacies, do not present your GEHA drug card. Purchase your drug and submit the bill to your primary insurance. When they have made payment, file the claim and the Explanation of Benefits (EOB) with GEHA (see page 71). If you use GEHA's prescription drug card when another insurance is primary, you will be responsible for reimbursing us any amount in excess of our secondary benefit.

  Drugs purchased at non-participating pharmacies should be submitted to our claims office (see page 71) along with the primary insurance EOB. We will accept either the drug receipts or a PAID Prescriptions, Inc. drug claim form. **Do not submit these claims to Paid Prescriptions, Inc when we are your secondary insurance.**

  If another insurance is primary, you should use their drug benefit. If you elect to use the Mail Order Drug Program, Merck-Medco RX Services will bill you directly. Pay Merck-Medco RX the amount billed and submit the bill to your primary insurance. When your primary insurance makes payment, file the claim and their EOB to us (see page 71).

  In some cases, Medicare covers prescription drugs and supplies. If Medicare is your primary insurance and you use prescription drugs or supplies covered by Medicare, we will attempt to recover the cost of the drug or supply from Medicare. You must cooperate with us in obtaining this reimbursement. If we are unsuccessful in recovering our payment from Medicare, we reserve the right to require you to purchase the medication and then file a claim with Medicare. After Medicare makes payment, you may file a claim with us for the out-of-pocket cost, in excess of your GEHA copayment.

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

*Prescription drug benefits begin on next page.*

| Benefit Description | You Pay | |
|---|---|---|
| **Covered medications and supplies** | **Standard Option** | **High Option** |
| Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a reply envelope.<br><br>You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:<br><br>• Drugs and medicines that by Federal law of the United States require a doctor's prescription<br>• Insulin<br>• Needles and syringes for the administration of covered medications<br>• Contraceptive drugs and devices<br>• Ostomy supplies | GEHA Primary:<br><br>**Network Retail Pharmacy** (initial amount prescribed, for up to a 30-day supply):<br><br>$5 generic/50% brand name for up to 30-day supply<br><br>**Non-Network Retail** you pay:<br><br>$5 generic/50% brand name and any difference between our allowance and the cost of the drug (You must submit your claim to PAID Prescriptions, L.L.C.)<br><br>**Mail Order** for up to a 90-day supply, you pay:<br><br>$15 generic/50% brand name | GEHA Primary:<br><br>**Network Retail Pharmacy** (initial amount prescribed, not to exceed a 30-day supply, and the first refill):<br><br>$5 generic/$15 brand name<br><br>Second refill and all subsequent refills, you pay the greater of:<br><br>$5 or 50% generic/$15 or 50% brand name<br><br>**Non-Network Retail** you pay the greater of:<br><br>$5 or 50% generic/$15 or 50% brand name and any difference between our allowance and the cost of the drug (You must submit your claim to PAID Prescriptions, L.L.C.)<br><br>**Mail Order** for up to a 90-day supply, you pay:<br><br>$10 generic/$30 brand name |

| Benefit Description | You Pay | |
|---|---|---|
| **Covered medications and supplies** | **Standard Option** | **High Option** |
| Here are some things to keep in mind about our prescription drug program:<br>• Note: If there is no generic equivalent available, you pay the brand name copay.<br>• Note: If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to:<br>PAID Prescriptions, L.L.C.<br>P.O. Box 712<br>Parsippany, NJ 07054-0712<br>Your claim will be calculated on the 50% 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. | Medicare A & B Primary:<br>**Network Retail Pharmacy** (initial amount prescribed, for up to a 30-day supply):<br>$5 generic/50% brand name<br>**Non-Network Retail** you pay:<br>$5 generic/50% brand name and any difference between our allowance and the cost of the drug (You must submit your claim to PAID Prescriptions, L.L.C.)<br>**Mail Order** for up to a 90-day supply, you pay:<br>$15 generic/50% brand name | Medicare A & B Primary:<br>**Network Retail Pharmacy** (initial amount prescribed, not to exceed a 30-day supply, and the first refill):<br>$3 generic/$10 brand name<br>Second refill and all subsequent refills, you pay the greater of:<br>$3 or 50% generic/$10 or 50% brand name<br>**Non-Network Retail** you pay the greater of:<br>$3 or 50% generic/$10 or 50% brand name and any difference between our allowance and the cost of the drug (You must submit your claim to PAID Prescriptions, L.L.C.)<br>**Mail Order** for up to a 90-day supply, you pay:<br>$5 generic/$15 brand name |

| Benefit Description | You Pay | |
|---|---|---|
| **Covered medications and supplies** | **Standard Option** | **High Option** |
| *Not covered:*<br>• *Drugs and supplies for cosmetic purposes*<br>• *Vitamins, nutrients and food supplements even if a physician prescribes or administers them including enteral formula available without a prescription*<br>• *Nonprescription medicines*<br>• *Drugs to aid in smoking cessation except those limited to the $100 lifetime maximum as part of the smoking cessation benefit (see page 31). You may not obtain smoking cessation drugs with your PAID Prescription card or through the Mail Order Drug Program. You must purchase these drugs and file the claim with us..*<br>• *Medical supplies such as dressings and antiseptics*<br>• *Drugs which are investigational*<br>• *Drugs prescribed for weight loss*<br>• *Drugs to treat infertility*<br>• *Drugs to treat impotency* | *All charges* | *All charges* |

## Section 5 (g). Special features

| Special features | Description |
|---|---|
| **Flexible benefits option** | Under the flexible benefits option, we determine the most effective way to provide services.<br>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.<br>• Alternative benefits are subject to our ongoing review.<br>• By approving an alternative benefit, we cannot guarantee you will get it in the future.<br>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.<br>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. |
| **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) 747-GEHA 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”. |

## Section 5 (h). Dental benefits

IMPORTANT

**Here are some important things to keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There are no changes in dental benefits for 2001. Our benefit description has been reworded.

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.

IMPORTANT

### 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 for repair of accidental injury to sound natural teeth (including, but not limited to, expenses for X-rays, drugs, crowns, bridgework, inlays, and dentures). Masticating (biting or chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at 100% for charges incurred within 72 hours of an accident. Services incurred after 72 hours are paid at regular Plan benefits.

### Dental benefits

| Service | Standard Option Scheduled Allowance | | High Option Scheduled Allowance | |
|---|---|---|---|---|
| | We pay | You pay | We pay | You Pay |
| Diagnostic and preventive services, limited to two visits per year including examination, prophylaxis (cleaning), X-rays of all types and fluoride treatment. Benefits are payable per visit not per service | 50% of billed charges for diagnostic and preventive services (maximum two visits per year) | 50% of billed charges for diagnostic and preventive services | $22 per visit (maximum two visits per year) | All charges in excess of the scheduled amounts listed to the left |

| **Dental benefits** - *Continued* | | | | |
|---|---|---|---|---|
| **Service** | **Standard Option Scheduled Allowance** | | **High Option Scheduled Allowance** | |
| | **We pay** | **You pay** | **We pay** | **You pay** |
| **Amalgam restorations**<br>**Resin- Based Composite Restorations**<br>**Gold Foil Restorations**<br>**Inlay/Onlay Restorations** | $21 One Surface<br>$28 Two or More Surfaces | All charges in excess of the scheduled amounts listed to the left | $21 One Surface<br>$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 amounts listed to the left | $21 Simple Extraction | All charges in excess of the scheduled amounts listed to the left |

# Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

**Non-Covered Prescription Drugs** **(800) 417-1893**

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

Merck-Medco Rx Services
P.O. Box 98830
Las Vegas, NV 89195-0249

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**

GEHA health plan members have access to special features offered on the Merck-Medco web site, www.merck-medco.com. On this web site, you can refill mail order prescriptions and manage your mail order account. A new feature is online shopping for thousands of non-prescription drugstore products available from CVS, America's leading retail pharmacy chain. Items available include nonprescription medications, vitamins, herbal remedies and personal care products.

**CONNECTION Dental** **(800) 296-0776**

Free to all GEHA health plan members, CONNECTION Dental offers cost savings at 20,000 providers nationwide. Participating dentists agree to limit their charges to a fee schedule for GEHA members. When you choose a participating dentist, you pay only up to the maximum charge on the CONNECTION Dental fee schedule. If your dentist has not yet joined, ask your dentist to call GEHA for a CONNECTION Dental information packet. Call for a list of providers in your area.

**CONNECTION Dental *Plus*** **(800) 793-9335**

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

**CONNECTION Hearing** **(800) 456-6801**

Free to all GEHA health plan members, CONNECTION Hearing offers cost savings at 1,500 Miracle Ear locations nationwide. The program provides a free hearing evaluation, up to a 20 percent discount off the retail price of hearing aids, a 30-day satisfaction refund guarantee, free unlimited follow-up visits, and free annual checkups of hearing aids. Program benefits are available to GEHA health plan members and their families, including parents and grandparents. Call to locate providers in your area.

**CONNECTION Long-Term Care** **(888) 469-GEHA**

Available for an additional premium, CONNECTION Long-Term Care offers GEHA health plan members and their families (including spouses, parents, grandparents, in-laws and grandparents-in-law) a 10 percent premium discount on long-term care insurance, with an additional discount when a spouse also enrolls. The program is available through CNA. Long-term care policies from CNA provide coverage for home health care, adult day care, assisted living, nursing home and hospice care.

**CONNECTION Vision** **(800) 800- EYES**

Free to all GEHA health plan members, CONNECTION Vision offers cost savings at more than 11,000 eye care locations nationwide. GEHA health plan members get discounts off the retail price of lenses, frames and specialty items such as tints, lightweight plastics and scratch-resistant coatings. Discounts are available for surgical procedures (including LASIK, RK, PRK and ALK) not covered under the GEHA health plan. For discounts on mail-order contact lenses and non-prescription sunglasses, call (800) 878-3901. This program is offered through Coast to Coast Vision. Call to locate providers in your area. When you purchase the dental plan, but not GEHA health insurance, you also have free access to the CONNECTION Vision program.

*Benefits described on this page are neither offered nor guaranteed under contract with the FEHB Program. The cost of CONNECTION programs is not included in the health plan premium you pay. Charges for these services do not count toward your GEHA deductible or out-of-pocket maximum. The GEHA PPO copayment does not apply. CONNECTION benefits are not subject to the FEHB disputed claims procedure. 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.*

Benefits on pages 67 and 68 are not part of the FEHB contract.

## Section 6. General exclusions -- things we don't cover

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

We do not cover the following:

- Services, drugs, or supplies you receive while you were not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; sexual dysfunction or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage;
- Services or supplies furnished without charge (except as described on page 78); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits;
- Services or supplies for cosmetic purposes;
- Services or supplies not specifically listed as covered;
- Services or supplies not reasonably necessary for the diagnosis or treatment of an illness or injury, except for routine physical examinations and immunizations;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 16), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 17), or State premium taxes however applied;
- Charges in excess of the "Plan allowance" as defined on page 83;
- Rest cures;
- 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.);
- Computer devices to assist with communications; or
- Computer programs of any type, including but not limited to those to assist with vision therapy or speech therapy.

## Section 7. Filing a claim for covered services

### How to claim benefits

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

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at (800) 821-6136.

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

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

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

In addition:

- You must send a copy of the explanation of benefits (EOB) from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse and should include nursing notes.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not ordered through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.

## Records

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

## Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

## Overseas claims

Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. If possible, include a receipt showing the exchange rate on the date the claimed services were performed.

## When we need more information

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

## Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval:

| Step | Description |
|---|---|
| **1** | Ask us in writing to reconsider our initial decision. You must:<br>(a) Write to us within 6 months from the date of our decision; and<br>(b) Send your request to us at: GEHA, P.O. Box 4665, Independence, MO 64051-4665*;* and<br>(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br>(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| **2** | We have 30 days from the date we receive your request to:<br>(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or<br>(b) Write to you and maintain our denial -- go to step 4; or<br>(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |
| **3** | 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.<br>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.<br>We will write to you with our decision. |
| **4** | If you do not agree with our decision, you may ask OPM to review it.<br>You must write to OPM within:<br>• 90 days after the date of our letter upholding our initial decision; or<br>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or<br>• 120 days after we asked for additional information.<br>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436. |

Send OPM the following information:

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

Note: If you want OPM to review different claims, 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 provide a copy of your specific written consent with the review request.

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

**5** 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.

**6** 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. 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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (800) 821-6136 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division II 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 are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

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

#### · What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, You may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare + Choice plan you have.

#### • The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

**Claims process –** You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do

something about filing your claims, call us at (800) 821-6136 or visit our web site at www.geha.com.

**We waive some costs when you have Medicare –** When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- **Inpatient Hospital Benefits:** If you are enrolled in Medicare Part A, we waive the deductible and coinsurance
- **Medical and Surgery Benefits and Mental Health/Substance Abuse care:** If you are enrolled in Medicare Part B, we waive the deductible and coinsurance.
- **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 for drugs through the Mail Order Drug Program and at retail pharmacies as shown on page 62.
- **Chiropractic Benefits:** There is no change in benefit limits or maximums for chiropractic care when Medicare is primary. See page 31 for benefits.
- **Physical, Speech and Occupational Therapy Benefits:** There is no change in benefit limits or maximums for rehabilitative therapy when Medicare is primary.

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

| **Primary Payer Chart** | | |
|---|---|---|
| **A. When either you -- or your covered spouse -- are age 65 or over and …** | **Then the primary payer is…** | |
| | **Original Medicare** | **This Plan** |
| 1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability), | | ✓ |
| 2) Are an annuitant, | ✓ | |
| 3) Are a reemployed annuitant with the Federal government when… | | |
| a) The position is excluded from FEHB, or…… | ✓ | |
| b) The position is not excluded from FEHB…… | | ✓ |
| Ask your employing office which of these applies to you. | | |
| 4) 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), | ✓ | |
| 5) Are enrolled in Part B only, regardless of your employment status, | ✓ (for Part B services) | ✓ (for other services) |
| 6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty, | ✓ (except for claims related to Workers' Compensation.) | |
| **B. When you -- or a covered family member – have Medicare based on end stage renal disease (ESRD) and…** | | |
| 1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD, | | ✓ |
| 2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD, | ✓ | |
| 3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision, | ✓ | |
| **C. When you or a covered family member have FEHB and…** | | |
| 1) Are eligible for Medicare based on disability, and | | |
| a) Are an annuitant, or…….. | ✓ | |
| b) Are an active employee…… | | ✓ |

· **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

**This Plan and another Plan's Medicare managed care plan:** You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles.

**Suspended FEHB coverage and a Medicare managed care plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminatiung your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

•**Private Contract**

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

· **Enrollment in Medicare Part B**

Note: We cannot require you to enroll in Medicare. If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program.

## TRICARE

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

## Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits.

## Medicaid

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

## 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

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. If you or your dependent are injured by the actions of another person or organization and a claim for benefits is submitted for the treatment of that injury, you are required to promptly notify the subrogation unit of GEHA of the date, circumstances, and all pertinent information relating to the loss. The phone number is (800) 821-4742.

If you need more information, contact us for our subrogation procedures. If you or your dependent sustain an illness or injury caused by another person, GEHA will pay for the illness or injury subject to the requirements outlined below:

(1) GEHA being reimbursed in full from any recovery or right of recovery you or your dependent has against that other party, and the right, if we decide to bring suit in your name; (2) your not taking any action which would prejudice GEHA's right to recover the benefits it paid to, or for, you; and (3) your cooperating in doing what is reasonably necessary to assist GEHA in any recovery, including disclosure of all settlement information requested by us. No GEHA benefits will be paid until any Medpay, PIP, or No-Fault benefits are exhausted.

You must cooperate fully with our efforts to obtain information from your auto insurance carrier, attorney, medical provider or other parties by signing a release authorizing us to obtain this information.

You must tell us when a recovery is received. GEHA shall have a lien on the proceeds of any and all recoveries resulting from an accident or illness caused by another person or party, whether received in an out-of-court settlement or by court order, and regardless of how characterized by the parties, i.e. as "pain and suffering." GEHA's lien shall be satisfied in full out of the proceeds of such recovery(ies) prior to the satisfaction of the claims(s) of any other individual, including, but not limited to, you, covered family member(s), and/or your attorney regardless of the "made whole" or "common fund" doctrines. GEHA's lien extends to and includes payments made by any source, including but not limited to, Medpay, PIP, No-Fault, 3rd party, and uninsured or underinsured motorists provisions of any auto policy. No reduction in the GEHA's lien can occur without our written consent. The lien remains the obligation of the member until we are reimbursed. Failure to notify us promptly of the claim for damages or to cooperate with our reimbursement efforts may result in an overpayment by GEHA that can be collected from you. Any reimbursements received by GEHA shall not exceed the total amount paid by GEHA. Payment of benefits prior to telling us of the third-party claim doesn't waive our right to withhold benefits where an enrollee or covered family member has not cooperated in protecting GEHA's lien.

## 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.

**Copayment**

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

**Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13-14.

**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.

**Covered services**

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

**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. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

**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:

(1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercise; dressing;
(2) homemaking, such as preparing meals or special diets;
(3) moving the patient;
(4) acting as companion or sitter;
(5) supervising medication that can usually be self administered; or

(6) 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.

**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 13.

**Durable medical equipment**

Equipment and supplies that:

(1) are prescribed by your attending doctor;
(2) are medically necessary;
(3) are primarily and customarily used only for a medical purpose;
(4) are generally useful only to a person with an illness or injury;
(5) are designed for prolonged use; and
(6) serves a specific therapeutic purpose in the treatment of an illness or injury.

**Effective date**

The date the benefits described in this brochure are effective:

(1) January 1 for continuing enrollments and for all annuitant enrollments;
(2) the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during the open season for the first time; or
(3) 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.

**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.

**Expense**

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

**Group health coverage**

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

**Infertility**

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

**Intensive day treatment**

Outpatient treatment of mental condition or substance abuse rendered at and billed by a facility that meets the definition of a hospital. Treatment program must be established which consists of individual or group psychotherapy and/or psychological testing.

**Medical necessity**

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

(1) are appropriate to diagnose or treat the patient's condition, illness or injury;
(2) are consistent with standards of good medical practice in the United States;
(3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider,
(4) are not a part of or associated with the scholastic education or vocational training of the patient; and
(5) 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.

**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 allowance as follows:

We consult standard industry guides, such as national databases of prevailing health care charges from Ingenix. We use the 70$^{th}$ percentile. This means that out of every 100 reports, 30 charges billed may be more, but 70 charges will be the allowed amount or less. Charges determined in this way include, but are not limited to, surgery, doctor's services, physical therapy, speech therapy, occupational therapy, lab testing and X-ray expenses. Some Plan allowances are stated in this brochure. These include limited benefits such as chiropractic care and routine dental care.

Some Plan allowances may be submitted to medical consultants who recommend allowances based on special industry guidelines. We may also conduct independent surveys to determine the usual cost of a service or supply in a geographic area.

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.

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

**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 or Obstetrics/Gynecology (OB/Gyn). Doctors listed in provider directories or advertisements under any other medical specialty or sub-specialty area (such as Internal Medicine doctors also listed under Cardiology or Geriatrics, or Pediatric sub-specialties such as Pediatric Allergy) are considered specialists, not primary care physicians, Chiropractors, eye doctors, dentists, and mental health/substance abuse providers 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.

**Us/We**

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

**You**

You refers to the enrollee and each covered family member.

## Section 11. FEHB facts

### No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. Also, your employing or retirement office can answer your questions and give you *a Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

### Types of coverage available for you and your family

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

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

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

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

## When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitant premiums begin on January 1.

## Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

## When you retire

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

## When you lose benefits

### · When FEHB coverage ends

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

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

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

### · Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

### · 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.

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

Get the RI 79-27, which describes TCC, and the RI 70-5, *the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

**· 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

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.

## Inspector General Advisory

**Stop health care fraud!** Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

**Penalties for Fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

# Department of Defense/FEHB Demonstration Project

## What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

## Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

## The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

## When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2000 open season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open seasons. Your coverage will begin January 1 of the year following the open season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

## TCC eligibility

See Section 11, FEHB Facts; it explains Temporary Continuation of Coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

## Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

# Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.


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# Summary of benefits for GEHA – Standard Option 2001

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $450 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

| Benefits | You Pay | Pages |
|---|---|---|
| Medical services provided by physicians:<br>• 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<br>Non-PPO: 35%* of covered professional services | 19-40 |
| Services provided by a hospital:<br>• Inpatient ……..<br>• Outpatient ……. | PPO: 15%* of covered hospital charges<br>Non PPO: 35%* of covered hospital charges | 41-47 |
| Emergency benefits:<br>• Accidental injury …….<br>• Medical emergency outpatient hospital ……<br>• Medical emergency other professional services …… | Nothing up to plan allowance of covered charges incurred within 72 hours of an accident<br>$75 copayment per occurrence<br>Regular benefits* | 48-50 |
| Mental health and substance abuse treatment …….. | In-Network: Regular cost sharing<br>Out-of-Network: Benefits are limited | 51-57 |
| Prescription drugs …… | From a pharmacy: Member pays $5 for generic drugs or 50% brand name for up to 30 day supply;<br>By mail: Member pays $15 for generic drugs or 50% brand name for 90-day supply | 58-63 |
| Dental Care …….. | 50% of billed charges for routine preventative and charges in excess of the scheduled amounts for restorations and extractions | 65-66 |
| Special features: Flexible benefits option, services for deaf and hearing impaired, high-risk pregnancies | | 64 |
| Protection against catastrophic costs (your out-of-pocket maximum) …… | Nothing after $3,000/Self Only or $3,500/Family enrollment per year for PPO providers;<br>Nothing after $4,000/Self Only or $4,500/Family enrollment per year for Non-PPO providers.<br>Some costs do not count toward this protection | 14-15 |

## Summary of benefits for GEHA – High Option 2001

- **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 $300 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.

| Benefits | You Pay | Pages |
|---|---|---|
| Medical services provided by physicians:<br>• Diagnostic and treatment services provided in the office ……. | PPO: $15 copay per covered office visit and 10%* of other covered professional services including x-ray and lab<br>Non-PPO: 25%* of covered professional services | 19-40 |
| Services provided by a hospital:<br>• Inpatient …….<br>• Outpatient* …… | PPO: Nothing for room and board, 10% of other hospital charges<br>Non-PPO: Nothing for room and board, 25% of other hospital charges | 41-47 |
| Emergency benefits:<br>• Accidental injury ……<br>• Medical emergency outpatient hospital ……..<br>• Medical emergency other professional services ……. | Nothing up to plan allowance of covered charges incurred within 72 hours of an accident<br>$75 copayment per occurrence<br>Regular benefits* | 48-50 |
| Mental health and substance abuse treatment …….. | In-Network: Regular cost sharing<br>Out-of-Network: Benefits are limited | 51-57 |
| Prescription drugs …… | From a pharmacy: Member pays $5 for generic drugs or $15 brand name for up to a 30 day supply;<br>By mail: Member pays $10 for generic drugs or $30 brand name for 90-day supply | 58-63 |
| Dental Care …….. | Charges in excess of the scheduled amounts for routine preventative, restorations, and extractions | 65-66 |
| Special features: Flexible benefits option, services for deaf and hearing impaired, high-risk pregnancies | | 64 |
| Protection against catastrophic costs (your out-of-pocket maximum) …… | Nothing after $2,500/Self Only or $3,000/Family enrollment per year for PPO providers;<br>Nothing after $3,500/Self Only or $4,000/Family enrollment per year for Non PPO providers.<br>Some costs do not count toward this protection | 14-15 |

# 2001 Rate Information for
# Government Employees Hospital Association, Inc. (GEHA) Benefit Plan

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

**Postal rates** apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

| | | Non-Postal Premium | | | | Postal Premium | |
|---|---|---|---|---|---|---|---|
| | | Biweekly | | Monthly | | Biweekly | |
| Type of Enrollment | Code | Gov't Share | Your Share | Gov't Share | Your Share | USPS Share | Your Share |
| High Option Self Only | 311 | $86.59 | $50.42 | $187.61 | $109.25 | $102.22 | $34.79 |
| High Option Self and Family | 312 | $195.82 | $102.36 | $424.28 | $221.78 | $231.17 | $67.01 |
| Standard Option Self Only | 314 | $82.50 | $27.50 | $178.75 | $59.58 | $97.63 | $12.37 |
| Standard Option Self and Family | 315 | $187.50 | $62.50 | $406.25 | $135.42 | $221.88 | $28.12 |