Government Employees Hospital Association, Inc. Benefit Plan

http://www.geha.com

2002

A fee-for-service plan with a preferred provider organization

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

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

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

Membership dues: There are no membership dues for the Year 2002.

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

RI 71-006

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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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on pages 8 and 9. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means Government Employees Hospital Association, Inc.

- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.

- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

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 or write

THE HEALTH CARE FRAUD HOTLINE
(202) 418-3300
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.

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):

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 verify their continued participation. You can also go to our web page which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory.

We have entered into arrangements with Alliance PPO, Inc.; Community Care Network, Inc.; FCHN; HealthCare Preferred; Healthlink; MultiPlan; PPO Oklahoma; PPO USA; Preferred Care Blue; Private Healthcare Systems; Providence Preferred; SouthCare; 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.

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

How we pay providers

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

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

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB 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. In circumstances where there is limited access to PPO providers, GEHA may negotiate discounts with some providers which will reduce your overall out-of-pocket expenses.

If you want more information about us, call (800) 821-6136, or write to GEHA, P. O. Box 4665, Independence, MO 64051. 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 2002

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

Program-wide changes

- Four states are added to the list of "medically underserved", Georgia, Montana, North Dakota, and Texas. Lousiana is no longer underserved. (Section 3)
- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-Postal premium under the High Option will increase by 18.4% for Self Only or 16.7% for Self and Family. Under the Standard Option, your share of the premium will not increase.
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We changed the PPO networks for the states of New York, New Jersey and Kansas, outside the Kansas City metropolitan area.
- We changed the Facts about this fee-for-service plan section to allow PPO benefits for specific non-PPO providers. When you use a PPO hospital, Non PPO radiologist, anesthesiologist and pathologist services will be allowed at the PPO benefit. This non-standard benefit does not include the services of emergency room physicians. In addition, providers outside the United States will be paid at the PPO level of benefits. (Section 1)
- We changed Other Services by adding Positron Emission Tomography (PET studies) to the list of services that require precertification. (Section 3)
- We changed Physical and occupational therapy to show a combined 60 visit limit per calendar year. (Section 5(a))
- Congenital anomaly surgery is now limited to children under the age of 18 unless there is a functional deficit. (Section 5(b))
- Maternity benefits under the Standard Option have increased to 100% for PPO providers, including pre and postnatal care. (Section 5(a) and 5(c))
- We have changed hospital emergency room benefits to be subject to the calendar year deductible and coinsurance. Previously these were payable after a $75 copayment. Outpatient emergency room treatment of accidental injuries within 72 hours of an accident is still covered at 100%. (Section 5(d))
- Out of pocket calendar year maximums have been increased as follows: In Network $4,000 Self Only, $4,500 Family under Standard Option and $3,000 Self Only, $3,500 Family under High Option. Out of Network $5,000 Self Only, $5,500 Family under Standard Option and $4,000 Self Only, $4,500 Family under High Option. (Section 4)
- The name for our prescription drug Mail Order Drug Program has changed to Home Delivery Pharmacy service. This service will continue to be performed by Merck-Medco RX services. (Section 5(f))
- Under High Option, we have changed the prescription drug copayment amounts to a three-tiered copayment structure. This will add a higher, third level copayment for multi-source brand name drugs (those for which a Federally approved generic equivalent is available). When a Federally approved generic equivalent is available, but you or your physician specify that the prescription must be filled as written (i.e. with a brand name drug), you will pay the multi-source brand name copayment. When a Federally approved generic equivalent is not available, you will pay the single-source brand name copayment. (Section 5(f))

If GEHA is your primary insurance, your High Option prescription drug copayments are:

- Network Retail pharmacy (initial fill not to exceed a 30-day supply, and the first refill) you pay $5 for generic drugs, $15 for single-source brand name drugs, and $30 for multi-source brand name drugs. (See Section 5(f) for the amount you pay on 2nd and subsequent refills.)
- Non-Network Retail pharmacy (initial fill not to exceed a 30-day supply, and the first refill) you pay $5 for generic drugs, $15 for single-source brand name drugs, and $30 for multi-source brand name drugs and any difference between our allowance and the cost of the drug. (See Section 5(f) for the amount you pay on 2nd and subsequent refills.)
- Home Delivery Pharmacy service (for up to a 90-day supply) you pay $10 generic/$35 single-source brand name, and $50 multi-source brand name.

If Medicare A & B is your primary insurance, your High Option prescription drug copayments are less. See section 5(f) for the new copayment amounts.

- We changed Dental benefits to show routine and preventative dental care under Standard Option, payable at 50% of the Plan allowance. Previously we paid 50% of billed charges. (Section 5(h))

We clarified the following:

- Under Your Rights we have explained how we may negotiate discounts with non-PPO providers in limited access areas. (Section 1)
- We clarified Diagnostic and treatment services by explaining that facility charges for clinic or office visits are part of the fee charged by the physician. (Section 5(a))
- We clarified that Urgent Care facility fees are not covered. (Section 5(a))
- We clarified Surgical procedures by explaining that assistant surgeons are allowed when medically necessary. (Section 5(b))
- We clarified Organ/tissue transplants to show that cornea and kidney transplants do not require preauthorization. (Section 5(b))
- We clarified Organ/tissue transplants to show that tandem bone marrow transplants, approved as one treatment protocol are limited to $100,000 when not performed at a Plan designated facility. (Section 5(b))
- We clarified our procedures to explain how we handle claims when others are responsible for injuries. (Section 9)

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, nursing school administered clinic and physician assistant.

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved". For 2002, the states are: Alabama, Georgia, Idaho, Kentucky, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, 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 provider you want, but we must approve some care in advance.

Transitional Care:

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

- lose access to your PPO specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or

- lose access to your PPO specialist because we terminate our contract with your specialist for other than cause,

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

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

Hospital care:

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

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

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

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

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. (See page 55 for mental health/substance abuse precertification.)
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, proposed treatment, or surgery;
  - Name and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

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

If your hospital stay needs to be extended:

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

What happens when you do not follow the precertification rules

- 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 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 (See page 55)
Positron Emission Tomography (Pet Study)

Section 4. Your costs for covered services

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

•Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive 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 under High Option and $450 per person under 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 reach $600 under High Option and $900 under Standard Option.
- We also have a separate deductible for:
  - Mental health and substance abuse treatment of $300, per person, under High Option and $450, per person, under 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 reach $600 under High Option and $900 under Standard Option.
  - Mental health and substance abuse treatment of $500, per person, per calendar year, for out-of-network hospital inpatient and hospital outpatient/intensive day treatment

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

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

•Coinsurance

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

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

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

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

•Differences between our allowance and the bill

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

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

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

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

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

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 <u>catastrophic protection</u> 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

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

- $4,500 for Self and Family (High Option) or $5,500 (Standard Option) and $4,000 for Self Only (High Option) or $5,000 (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 56 and 59 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);
- Expenses in excess of our allowable amount or maximum benefit limitations;
- Expenses for well child care and immunizations;
- Expenses for dental and chiropractic care;
- Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements (see pages 12-14);
- Expenses for prescription drugs purchased through retail or Home Delivery Pharmacy service.

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 (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the Medicare equivalent amount.

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

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

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

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is **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 permitted to collect only up to the Medicare approved amount.

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

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

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

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

- If your physician accepts Medicare assignment, then we waive some of your deductibles, copayment and coinsurance for covered charges.

- If your physician does not accept Medicare assignment, then you pay the difference between 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 the physician to reduce the charges. If the physician does not, report the physician to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

When you have a Medicare Private Contract with a physician

A physician may ask you to sign a private contract agreeing that you can be billed directly for services Medicare ordinarily covers. 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 pages 8 and 9 for how our benefits changed this year and pages 96 and 97 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.

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 deductible is $300 per person ($600 per family) under the High Option and $450 per person ($900 per family) under the Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 non-PPO benefits are the standard benefits of this Plan. PPO benefits apply when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay the services of radiologists, anesthesiologists and pathologists who are not preferred providers at the preferred provider rate. This non-standard benefit does not include the services of emergency room physicians.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…	
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**Standard Option**	**High Option**
Professional services of physicians • In physician's office • Routine physical examinations • Office medical consultations • Second surgical opinions Note: The facility charge for clinic or office visits is considered a part of the fee charged by the physician.	PPO: $10 copayment for office visits to primary care physicians; $25 copayment for office visits to specialists (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount.	PPO: $15 copayment (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued next page

Diagnostic and treatment services *(continued)*	**You pay**	
	Standard Option	**High Option**
Professional services of physicians • Emergency room physician care (non accidental injury) • During a hospital stay • At home	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Urgent care facilities except for services of covered physicians, xray and laboratory services.*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests		
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.

Preventive care, adult	You Pay	
	Standard Option	**High Option**
Routine screenings, limited to: • Total Blood Cholesterol screenings • Chlamydial infection • Colorectal cancer screening, including – Annual coverage of one fecal occult blood test for members age 40 and older – Sigmoidoscopy • Prostate cancer screening – Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older • Routine pap test Annual coverage of one pap smear for women age 18 and older • Routine mammogram – Mammograms for diagnostic and/or routine screening • Routine immunizations: – Tetanus-diphtheria (Td) booster – Influenza/Pneumococcal vaccines	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance 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: • Childhood immunizations recommended by the American Academy of Pediatrics • For well-child care charges for routine examinations, immunizations and care • Initial examination of a newborn child covered under a family enrollment	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)
• Vision examinations, limited to: – Examinations for amblyopia and strabismus	PPO: $10 copayment for office visits to primary care physicians; $25 copayment for office visits to specialists (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount.	PPO: $15 copayment (No deductible) 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: • Prenatal care • Delivery • Postnatal care • Physician care such as non-routine sonograms. Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery, see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your doctor, or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. • We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	PPO: Nothing (No deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount.	PPO: Nothing (No deductible) 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	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Routine sonograms to determine fetal age, size or sex.* • *Home uterine monitoring devices, unless preauthorized by our Medical Director.* • *Charges related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest.* • *Charges for services and supplies incurred after termination of coverage.*	*All charges*	*All charges*

Family planning	You Pay	
	Standard Option	**High Option**
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance 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		
Diagnosis and treatment of infertility, except as shown in *Not covered.* Note: Benefits are limited to a maximum of $3,000 per calendar year per person.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Fertility drugs* • *Assisted reproductive technology (ART) procedures, such as:* – *artificial insemination* – *in vitro fertilization* – *embryo transfer and GIFT* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*	*All charges*

Allergy care	You Pay	
	Standard Option	**High Option**
Testing and treatment, including materials (such as allergy serum) Allergy testing is limited to $500 per person per calendar year. Allergy injections	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Clinical ecology and environmental medicine* • *Provocative food testing and sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies		
• Antibiotic therapy • Chemotherapy and radiation therapy Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 39. • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy • Growth hormone therapy (GHT) Note: – GHT is covered under the prescription drug benefit. We only cover GHT when we preauthorize the treatment. Call (800) 821-6136 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. • Respiratory and inhalation therapies Note – Some medications required for treatment therapies may be available through the Home Delivery Pharmacy service or a PAID Participating Pharmacy. Medications obtained from these sources are covered under the Prescription Drug Benefits on pages 61-66.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Chelation therapy except for acute arsenic, gold or lead poisoning*	*All charges*	*All charges*

Physical and occupational therapies	You Pay	
	Standard Option	**High Option**
• 60 visits per calendar year for the combined services of the following: – qualified physical therapists and – qualified occupational therapists. 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.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and when a physician: 1) orders the care; 2) identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3) indicates the length of time the services are needed. Note: When you receive medically necessary physical or occupational therapy on an outpatient basis from a qualified professional therapist at a skilled nursing facility, your therapy is covered up to plan limits.		
Not covered: • *Exercise programs* • *Long-term rehabilitative therapy*	*All charges*	*All charges*

Speech therapy	You Pay	
	Standard Option	**High Option**
30 visits per calendar year for the services of a qualified speech therapist. Note: We only cover speech therapy when a physician: 1) orders the care; 2) identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3) indicates the length of time the services are needed. Note: When you receive medically necessary speech therapy on an outpatient basis from a qualified speech therapist at a skilled nursing facility, your therapy is covered up to plan limits	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Computer devices to assist with communications* • *Computer programs of any type, including but not limited to those to assist with speech therapy*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)		
Diagnostic hearing tests performed by an MD or DO	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing testing conducted by audiologists* • *Hearing aids, testing and examinations for them*	*All charges*	*All charges*

Vision services (testing, treatment, and supplies)	You Pay	
	Standard Option	**High Option**
• First pair of contact lenses or ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury. • 30 outpatient vision therapy visits by an opthalmologist or optometrist per person per lifetime	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Computer programs of any type, including but not limited to those to assist with vision therapy.* • *Eyeglasses* • *Radial keratotomy and other refractive surgeries*	*All charges*	*All charges*
Foot care		
Routine foot care only when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	PPO: $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. 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 Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *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	You Pay	
	Standard Option	**High Option**
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, 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 Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups*	*All charges*	*All charges*
Durable medical equipment (DME)		
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 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. Serve a specific therapeutic purpose in the treatment of an illness or injury. 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: • Hospital beds; • Wheelchairs; • Crutches; and • Walkers.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

DME - continued next page

Durable medical equipment (DME) -*(continued)*	**You Pay**	
	Standard Option	**High Option**
Note: Call us at (800) 821-6136 as soon as your physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call. Note: Benefits for durable medical equipment are limited to $10,000 per person, lifetime maximum.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Computer devices to assist with communications* • *Computer programs of any type, including but not limited to those to assist with vision therapy or speech therapy* • *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 84)* • *Lifts, such as seat, chair or van lifts* • *Wigs*	*All charges*	*All charges*
Home health services		
25 in-home visits per calendar year, not to exceed one visit up to two hours per day when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed. Note: Covered services are based on our review for medical necessity.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

Home Health services - continue on next page

Home health services -*(continued)*	**You Pay**	
	Standard Option	**High Option**
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Custodial care;* • *Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;.* • *Inpatient private duty nursing;*	*All charges*	*All charges*
Chiropractic		
Chiropractic services limited to: • 30 visits per calendar year for manipulation of the spine • X-rays, used to detect and determine nerve interferences due to spinal subluxations or misalignments Note: No other benefits for the services of a chiropractor are covered under any other provision of this Plan. In medically underserved areas, services of a chiropractor that are listed above are subject to the stated limitations. In medically underserved areas, services of a chiropractor that are within the scope of his/her license and are not listed above are eligible for regular Plan benefits.	PPO and Non-PPO: All charges in excess of $9 per visit All charges in excess of $25 for X-rays of the spine Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.	PPO and Non-PPO: All charges in excess of $9 per visit All charges in excess of $25 for X-rays of the spine Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.
Not covered: • *Any treatment not specifically listed as covered.* • *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.*	*All charges*	*All charges*

Alternative treatments	You Pay	
	Standard Option	**High Option**
Acupuncture 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 Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *All other alternative treatments, including clinical ecology and environmental medicine.* • *Any treatment not specifically listed as covered* • *Naturopathic services* *(Note: benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 10.)*	*All charges*	*All charges*
Educational classes and programs		
Coverage is limited to: • Smoking Cessation – Up to $100 to aid in smoking cessation-per person per lifetime, including related expenses such as drugs.	PPO: all charges in excess of $100 Non-PPO: all charges in excess of $100	PPO: all charges in excess of $100 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 deductible is $300 per person ($600 per family) under the High Option and $450 per person ($900 per family) under the Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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.**
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay the services of radiologists, anesthesiologists and pathologists who are not preferred providers at the preferred provider rate. This non-standard benefit does not include the services of emergency room physicians.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…	
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**Standard Option**	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Electroconvulsive therapy • Removal of tumors and cysts • Correction of congenital anomalies - limited to children under the age of 18 unless there is a functional deficit. (See Reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. Criteria regarding complications of obesity and body mass index must be met. Treatment must be precertified. • Insertion of internal prostethic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons are covered up to 20% of our allowance for the surgeon's charge for procedures when it is medically necessary to have an assistant surgeon. 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 Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Surgical procedures *(continued)*	**You Pay**	
	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: • For the primary procedure based on: – Full Plan allowance • For the secondary procedure(s) based on: – One-half of the Plan allowance • For the subsequent procedure(s) based on: – 25% of the Plan allowance Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician or surgeon* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*

Reconstructive surgery	You Pay	
	Standard Option	**High Option**
Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm - limited to children under the age of 18 unless there is a functional deficit. Examples of congenital anomalies are: cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage) Note: We pay for internal breast prostheses as hospital benefits if billed by a hospital. If included with the surgeon's bill, surgery benefits will apply. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated promptly or as soon as the member's medical condition permits.* • *Surgeries related to sex transformation or sexual dysfunction* • *Surgeries to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit.*	*All charges*	*All charges*

Oral and maxillofacial surgery	You Pay	
	Standard Option	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate • Excision of cysts and incision of abscesses unrelated to tooth structure; • Extraction of impacted (unerupted or partially erupted) teeth; • Alveoloplasty, partial or radical removal of the lower jaw with bone graft; • Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues; • Open reduction of dislocations and excision, manipulation, aspiration or injection of temporo-mandibular joints; • Removal of foreign body, skin, subcutaneous areolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones and incision/excision of salivary glands and ducts; • Repair of traumatic wounds; • Incision of the sinus and repair of oral fistulas; • Surgical treatment of trigeminal neuralgia; • Repair of accidental injury to sound natural teeth such as: expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. Masticating (biting or chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at **100%** for charges incurred within 72 hours of an accident (see page 50). • Other oral surgery procedures that do not involve the teeth or their supporting structures.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Orthodontic treatment* • *Any oral or maxillofacial surgery not specifically listed as covered* • *Orthognathic surgery, even if necessary because of TMJ dysfunction or disorder.*	*All charges*	*All charges*

Organ/tissue transplants	You Pay	
	Standard Option	**High Option**
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single or double lung transplants, limited to patients for the following end-stage pulmonary diseases: (1) Pulmonary fibrosis, (2) Primary pulmonary hypertension, (3) Emphysema, or (4) cystic fibrosis • Pancreas (limited to patients whose condition is not treatable by insulin therapy) • Allogeneic bone marrow transplants – only for patients with acute leukemia, advanced Hodgkin's lymphoma, Advanced non-Hodgkin's lymphoma, Advanced neuroblastoma (limited to children over age one), Aplastic anemia, Chronic myelogenous leukemia, Infantile malignant osteopetrosis, Severe combined immunodeficiency, Thalassemia major, or Wiskott-Aldrich syndrome • Intestinal transplants (small intestine), small intestine with the liver, small intestine with multiple organs such as the liver, stomach, and pancreas • 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. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Organ/tissue transplants*(continued)*	**You Pay**	
	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. Transportation Benefit • We will also provide up to $10,000 per covered transplant for transportation (mileage or airfare) to a plan designated facility and reasonable temporary living expenses (i.e. lodging and meals) for the recipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 100 miles from the designated transplant facility. Transportation benefits are 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 Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Limited Benefits • 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. (Cornea and kidney transplants do not require preauthorization by GEHA's Medical Director.)		

Organ/tissue transplants - continued on next page

Organ/tissue transplants*(continued)*	**You Pay**	
	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)	PPO: $15 copayment (no deductible)
• The transplant must be performed at a Plan-designated organ transplant facility to receive maximum benefits.	Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount.	Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
• If benefits are limited to $100,000 per transplant, included in the maximum are all charges for hospital, medical and surgical care incurred while the patient is hospitalized for a covered transplant surgery and subsequent complications related to the transplant. Outpatient expenses for chemotherapy and any process of obtaining stem cells or bone marrow associated with bone marrow transplant (stem cell support) are included in benefits limit of $100,000 per transplant. Tandem bone marrow transplants approved as one treatment protocol are limited to $100,000 when not performed at a Plan designated facility. Expenses for aftercare such as outpatient prescription drugs are not a part of the $100,000 limit.	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 on next page

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. • 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 Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Services or supplies for or related to surgical transplant procedures (including administration of high-dose chemotherapy) for artificial or human organ/tissue transplants not listed as specifically covered.* • *Donor screening tests and donor search expenses, except those performed for the actual donor.* • *Donor search expense for bone marrow transplants.*	*All charges*	*All charges*
Anesthesia		
Professional fees for the administration of anesthesia in – • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance 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 5(a) and 5(b), in this Section 5(c) the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". The calendar year deductible is $300 per person ($600 per family) under the High Option and $450 per person ($900 per family) under the Standard Option.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay the services of radiologists, anesthesiologists and pathologists who are not preferred providers at the preferred provider rate. This non-standard benefit does not include the services of emergency room physicians.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification

IMPORTANT

Benefit Description	You pay	
NOTE: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".		
Inpatient Hospital	**Standard Option**	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. NOTE: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate. NOTE: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance (calendar year deductible applies)	PPO: Nothing Non-PPO: Nothing
Other hospital services and supplies, such as: • Operating, recovery and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) NOTE: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance (calendar year deductible applies)	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance

Inpatient hospital - continued on next page

Inpatient hospital *(continued)*	**You Pay**	
	Standard Option	**High Option**
Maternity Care – Inpatient Hospital Room and board, such as • ward, semiprivate, or intensive care accommodations • general nursing care; and • meals and special diets Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify. Other hospital services and supplies, such as: • Delivery room, recovery, and other treatment rooms; • Prescribed drugs and medicines; • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay.	PPO: Nothing Non-PPO: 35% of the Plan allowance (calendar year deductible applies).	PPO: Nothing Non-PPO: Nothing for room and board; 25% of the Plan allowance for other hospital services

Inpatient hospital - continued on next page

Inpatient hospital *(continued)*	**You Pay**	
	Standard Option	**High Option**
Maternity Care – Inpatient Hospital - *continued* • We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment.	PPO: 15% of the Plan allowance (calendar year deductible applies). Non-PPO: 35% of the Plan allowance (calendar year deductible applies).	PPO: Nothing for room and board; 10% of the plan allowance for other hospital services Non-PPO: Nothing for room and board; 25% of the Plan allowance for other hospital services
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see definition.* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*

Outpatient hospital or ambulatory surgical center	You Pay	
	Standard Option	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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 the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance (calendar year deductible applies)	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 25% of the Plan allowance (calendar year deductible applies)
Not covered: • *Urgent care facilities except for services of covered physicians, xray and laboratory services.*	*All charges*	*All charges*
Maternity Care – Outpatient hospital • Delivery room, recovery, and other treatment rooms; • Prescribed drugs and medicines; • Diagnostic laboratory tests and X-rays, and pathology services; • Administration of blood, blood plasma, and other biologicals; • Blood and blood plasma, if not donated or replaced; • Pre-surgical testing; • Dressings and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia services;	PPO: Nothing. Non-PPO: 35% of the Plan allowance (calendar year deductible applies).	PPO: Nothing . Non-PPO: 25% of the Plan allowance (calendar year 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. • We pay $2000 for hospice care on an outpatient basis. • We pay $150 per day for room and board and care while an inpatient in a hospice up to a maximum of $3,000. These benefits will be paid if the hospice care program begins after a person's primary doctor certifies terminal illness and life expectancy of six months or less and any services or inpatient hospice stay that is part of the program is: • Provided while the person is covered by this Plan; • Ordered by the supervising doctor; • Charged by the hospice care program; and • Provided within six months from the date the person entered or re-entered (after a period of remission) a hospice care program. Remission is the halt or actual reduction in the progression of illness resulting in discharge from a hospice care program with no further expenses incurred. A readmission within three months of a prior discharge is considered as the same period of care. A new period begins after three months from a prior discharge with maximum benefits available.	PPO: Nothing up to the Plan limits (calendar year deductible applies) Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)	PPO: Nothing up to the Plan limits (calendar year deductible applies) Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)
Not covered: • *Charges incurred during a period of remission, charges incurred for treatment of a sickness or injury of a family member that are covered under another Plan provision, charges incurred for services rendered by a close relative, bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services*	*All charges*	*All charges*

Ambulance – accidental injury	You Pay	
	Standard Option	**High Option**
Ambulance service within 72 hours of an accident is covered as follows: • Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary). • Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation.	PPO: Nothing up to the Plan allowance Non-PPO: Nothing up to the Plan allowance	PPO: Nothing up to the Plan allowance Non-PPO: Nothing up to the Plan allowance
Ambulance – non-accidental injury		
• Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary). • Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation.	PPO: 15% of the Plan allowance (calendar year deductible applies). Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan allowance (calendar year deductible applies). Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies).
Not covered: • *Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means.*	*All charges*	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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 deductible is $300 per person ($600 per family) under the High Option and $450 per person ($900 per family) under the Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 non-PPO benefits are the standard benefits of this Plan. PPO benefits apply when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay the services of radiologists, anesthesiologists and pathologists who are not preferred providers at the preferred provider rate. This non-standard benefit does not include the services of emergency room physicians.

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: • Treatment outside a hospital or in the outpatient/emergency room department of a hospital • Related outpatient physician care Note: Emergency room charges associated directly with an inpatient admission are considered "Other charges" under Inpatient Hospital Benefits (see page 44) and are not part of this benefit, even though an accidental injury may be involved. Expenses incurred after 72 hours, even if related to the accident, are subject to regular benefits and are not paid at 100%. This provision also applies to dental care required as a result of accidental injury to sound natural teeth. Masticating (chewing) incidents are not considered to be accidental injuries.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount (No deductible)

Accidental injury - continued on next page

Accidental injury *(continued)*	**You Pay**	
	Standard Option	**High Option**
If you receive care for your accidental injury after 72 hours, we cover: • Non-surgical physician services and supplies • Surgical care Note: We pay Hospital benefits if you are admitted.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Medical emergency		
Outpatient medical or surgical services and supplies billed by a hospital for emergency room treatment. Note: We pay Hospital benefits if you are admitted.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Ambulance – accidental injury		
Ambulance service within 72 hours of an accident is covered as follows: • Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary). • Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation.	PPO: Nothing up to the Plan allowance Non-PPO: Nothing up to the Plan allowance	PPO: Nothing up to the Plan allowance Non-PPO: Nothing up to the Plan allowance

Ambulance - continued on next page

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). • 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 the Plan allowance (calendar year deductible applies). Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan allowance (calendar year deductible applies). Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies).
Not covered: • *Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means.*	*All charges*	*All charges*

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

IMPORTANT

You may choose to get care Out-of-Network or In-Network. 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 separate calendar year mental health/substance abuse 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 57.

IMPORTANT

Benefit Description	You pay After the mental health/substance abuse calendar year deductible…	
NOTE: The mental health/substance abuse calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
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. 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 on next page

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 • Medication management	$25 copayment per office visit (No deductible)	$15 copayment per office visit (No deductible)
• Inpatient professional fees • Diagnostic tests • Laboratory tests to monitor the effect of drugs prescribed for your condition	15% of the Plan allowance	10% of the Plan allowance
Inpatient hospital		
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate NOTE: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	15% of the Plan allowance	Nothing (No deductible)
Other hospital services and supplies • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, and facility-based intensive outpatient treatment	15% of the Plan allowance	10% of the Plan allowance (No deductible for inpatient services)

In-Network benefits - continued on next page

In-Network benefits *(continued)*	**You Pay**	
	Standard Option	**High Option**
Outpatient hospital		
Services provided by a hospital	15% of the Plan allowance	10% of the Plan allowance
Emergency room – non-accidental injury		
Outpatient services and supplies billed by a hospital for emergency room treatment Note: We pay Hospital benefits if you are admitted.	15% of the Plan allowance	10% of the Plan allowance
Not covered: Services we have not approved. *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 obtain a treatment plan and follow 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 on next page

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. 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. The separate out-of-pocket maximum is $3,000 Self Only, $3,500 Self and Family (High Option); or $4,000 Self Only, $4,500 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. Out-of-pocket expenses for this mental health/substance abuse benefit are: • The 10% you pay for other hospital services and supplies, inpatient professional fees, emergency room physician services and diagnostic services under the High Option. • The 15% you pay for hospital services, inpatient professional fees, emergency room physician services and diagnostic services under the Standard Option. 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: • Expenses in excess of the Plan allowance or maximum benefit limitations. • The $15 copayment (High Option) and $25 copayment (Standard Option) for office professional services and medication management. • $300 (High Option) and $450 (Standard Option) calendar year mental health/substance abuse deductible. • Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements (see pages 12, 13 and 14). • Expenses for prescription drugs purchased through retail or Home Delivery Pharmacy service.
Network limitation	If you do not obtain 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: United Behavioral Health P.O. Box 8570 Emeryville, CA 94662-8570 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 53-56 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.

Benefit 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 • **Inpatient Hospital/Facility treatment of alcoholism and drug abuse** – 30 day maximum per lifetime – Precertification required • **Outpatient Hospital/Intensive Day Treatment Program for mental health /substance abuse** – 60 day limit per calendar year	50% of the Plan allowance and any difference between our allowance and the billed amount; $500 inpatient hospital and outpatient hospital /intensive day treatment deductible applies per person, per year	50% of the Plan allowance and any difference between our allowance and the billed amount; $500 inpatient hospital and outpatient hospital /intensive day treatment deductible applies per person, per year

Out-of-Network Benefit - continued on next page

Out-of-Network Benefit *(continued)*	**You Pay**	
	Standard Option	**High Option**
• **Inpatient Visits for Psychotherapy** – 100 inpatient visits limit per calendar year • **Outpatient Visits for Psychotherapy and group sessions** – 30 session limit per calendar year for treatment of mental health and substance abuse	50% of the Plan allowance and any difference between our allowance and the billed amount, $450 mental health calendar year deductible applies Both Network and Out-of-Network expenses will apply to the mental health deductible.	50% of the Plan allowance and any difference between our allowance and the billed amount, $300 mental health calendar year deductible applies Both Network and Out-of-Network expenses will apply to the mental health deductible.
Not covered out-of-network: • *Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems.* • *Treatment for learning disabilities and mental retardation* • *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. See Section 3 for details. Call United Behavioral Health at (877) 564-7505 to precertify.

Out-of-Network benefits - continued on next page

Out-of-Network Benefit *(continued)*

Out-of-Network Deductible calendar year maximums & out-of-pocket maximums

The calendar year mental health/substance abuse deductible is $300 per person ($600 per family) under the High Option and $450 per person ($900 per family) under the Standard Option.

The calendar year deductible applies to all mental health/substance abuse benefits in this Section except inpatient and outpatient hospital facility charges.

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.

Inpatient care for the treatment of alcoholism and drug abuse is available up to a 30 day maximum per lifetime.

Inpatient visits for psychotherapy sessions are limited to 100 visits per calendar year.

Home and office visits for psychotherapy and group sessions for mental health/substance abuse are limited to 30 sessions per calendar year.

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.

Out-of-Network benefits - continued on next page

Out-of-Network Benefit *(continued)*

- 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 12, 13 and 14).
- Expenses for prescription drugs purchased through retail or Home Delivery Pharmacy service.
- 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 64.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible for prescription drugs.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Under the High Option plan, if Medicare is your primary insurance and you have both Medicare Part A & B coverage, you pay less for your prescriptions (see page 65).

IMPORTANT

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

- **Who can write your prescription.** A licensed physician or a licensed dentist must write the prescription. For Home Delivery Pharmacy service prescriptions, the physician must be licensed in the United States. In addition, your mailing address must be within the United States or include an APO address.
- **Where you can obtain them.** You may fill the prescription at a PAID network pharmacy, a non-network pharmacy, or by home delivery. 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 Merck-Medco Home Delivery Pharmacy service.
  - **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 non-formulary medications, can help contain the increasing cost of prescription drug coverage without sacrificing quality.

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

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

Prescription drug benefits - continued on next page

Prescription drug benefits *(continued)*

- **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 Merck-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 Home Delivery Pharmacy service** Through this service, you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, ostomy supplies, diabetic supplies and insulin, syringes and needles for covered injectable medications, and oral contraceptives. Some medications may not be available in a 90-day supply from 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 Home Delivery Pharmacy service, you should obtain a prescription from your physician for a 90-day supply. Some medications may require approval by Merck-Medco or GEHA. Not all drugs are available through the Home Delivery Pharmacy service. In order to use the Home Delivery Pharmacy service, your prescriptions must be written by a physician licensed in the United States. In addition, your mailing address must be within the United States or include an APO address. Each enrollee will receive an installment kit that includes a brochure describing the Home Delivery Pharmacy service, an order form, a questionnaire, and a return envelope.

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

    Mail to: 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 Home Delivery Pharmacy service toll-free at (800) 551-7675 available 24 hours a day, 7 days a week. Emergency consultation with a registered pharmacist is available seven days a week, 24 hours per day. Forms necessary for refills will be provided each time you receive a supply of medication from the service.

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

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

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

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

Prescription drug benefit - continued on next page

Prescription drug benefits *(continued)*

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

  At participating pharmacies, do not present your GEHA drug card. Purchase your drug 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 74). 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 74) along with the primary insurance EOB. We will accept either the drug receipts or a PAID Prescriptions, Inc. drug claim form. **Submit these claims to GEHA, P.O. 4665, Independence, MO 64051-4665, when we are your secondary insurance.**

  If another insurance is primary, you should use their drug benefit. If you elect to use the Home Delivery Pharmacy service, 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 74).

  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.

- **Three-tier drug benefit** Under the **High Option**, we divide prescription drugs into three categories or tiers: generic, single-source brand name, and multi-source brand name. When an approved generic equivalent is available, that is the drug you will receive, unless you or your physician specify that the prescription must be filled as written. When an approved generic equivalent is not available, you will pay the brand name single-source copayment. If an approved generic equivalent is available, but you or your physician specify that the prescription must be filled as written, you will pay the brand name multi-source copayment.

  - **Generic drugs:** are chemically and therapeutically equivalent to the corresponding brand drug, but are available at a lower price. Equivalent generic products for brand name medications become available after a patent and other exclusivity rights for the brand expire. The Food and Drug Administration must approve all generic versions of a drug and assure that they meet strict standards for quality, strength and purity. The FDA requires that generic equivalent medications contain the same active ingredients and be equivalent in strength and dosage to brand name drugs. The main difference between a generic and its brand name drug is the cost of the product.

  - **Single-source** brand name drugs are available from only one manufacturer and are patent-protected. No generic equivalent is available.
  - **Multi-source** brand name drugs are available from more than one manufacturer and have a least one generic equivalent alternative available.

- **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 benefit - continued 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, an order form, a questionnaire, and a reply envelope. • You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: – Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not Covered*. – Insulin – Needles and syringes for the administration of covered medications – Contraceptive drugs – Ostomy supplies Note: A generic equivalent will be dispensed if it is available unless you or your physician specifies that the prescription be dispensed as written, when a Federally approved generic drug is available.	GEHA Primary: **Network Retail Pharmacy** (initial amount prescribed, for up to a 30-day supply): $5 generic/50% brand name for up to 30-day supply **Non-Network Retail** you pay: $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.) **Home Delivery Pharmacy Service** for up to a 90-day supply, you pay: $15 generic/50% brand name	GEHA Primary: **Network Retail Pharmacy** (initial fill not to exceed a 30-day supply, and the first refill): $5 generic/$15 single-source brand name/$30 multi-source brand name All subsequent refills, you pay the greater of 50% or the copayments described above **Non-Network Retail** (initial fill not to exceed a 30-day supply, and the first refill): $5 generic/$15 single-source brand name/$30 multi-source brand name and any difference between our allowance and the cost of the drug All subsequent refills, you pay the greater of 50% or the copayments described above and any difference between our allowance and the cost of the drug (You must submit your claim to PAID Prescriptions, L.L.C.) **Home Delivery Pharmacy Service** for up to a 90-day supply, you pay: $10 generic/$35 single-source brand name/$50 multi-source brand name

Prescription drug benefits - continued on next page

Prescription drug benefits	You Pay	
Covered medications and supplies	**Standard Option**	**High Option**
Here are some things to keep in mind about our prescription drug program: • Note: If there is no generic equivalent available, you pay the brand name copayment. • 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: PAID Prescriptions, L.L.C. P.O. 2187 Lee's Summit, MO 64063-2187 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. Note: A generic equivalent will be dispensed if it is available unless you or your physician specifies that the prescription be dispensed as written, when a Federally approved generic drug is available.	Medicare A & B Primary: **Network Retail Pharmacy** (initial amount prescribed, for up to a 30-day supply): $5 generic/50% brand name **Non-Network Retail** you pay: $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.) **Home Delivery Pharmacy Service** for up to a 90-day supply, you pay: $15 generic/50% brand name	Medicare A & B Primary: **Network Retail Pharmacy** (initial fill not to exceed a 30-day supply, and the first refill): $3 generic/$10 single-source brand name/$25 multi-source brand name All subsequent refills, you pay the greater of 50% or the copayments described above **Non-Network Retail** you pay: (initial fill not to exceed a 30-day supply, and the first refill): $3 generic/$10 single-source brand name/$25 multi-source brand name and any difference between our allowance and the cost of the drug All subsequent refills, you pay the greater of 50% or the copayments described above and any difference between our allowance and the cost of the drug (You must submit your claim to PAID Prescriptions, L.L.C.) **Home Delivery Pharmacy Service** for up to a 90-day supply, you pay: $5 generic/$17 single-source brand name/$30 multi-source brand name

Prescription drug benefit - continued on next page

Prescription drug benefits *(continued)*	**You Pay**	
Covered medications and supplies	**Standard Option**	**High Option**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them including enteral formula available without a prescription* • *Nonprescription medicines* • *Drugs to aid in smoking cessation except those limited to the $100 lifetime maximum as part of the smoking cessation benefit (see page 33). You may not obtain smoking cessation drugs with your PAID Prescription card or through the Home Delivery Pharmacy service. You must purchase these drugs and file the claim with us.* • *Medical supplies such as dressings and antiseptics* • *Drugs which are investigational* • *Drugs prescribed for weight loss* • *Drugs to treat infertility* • *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. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
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 is no calendar year deductible for dental benefits.

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. The repair of accidental injury to sound natural teeth includes but is not limited to, expenses for xrays, 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% up to the plan allowance for diagnostic and preventive services (maximum two visits per year)	50% up to the plan allowance and all charges in excess of the plan allowance for diagnostic and preventive services	$22 per visit (maximum two visits per year)	All charges in excess of the scheduled amount listed to the left

Dental benefits - continued on next page

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

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

The benefits on pages 70 and 71 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 the Home Delivery Pharmacy service, paying 100% of the discounted amount. To order, complete the form called Ordering Medications from the Home Delivery Pharmacy Service. 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 Hearing **(877) 674-3594** **www.miracle-ear.com**

Free to all GEHA health plan members, **CONNECTION** Hearing offers cost savings at 1,155 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 for 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.

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

Free to all GEHA health plan members, CONNECTION Dental offers cost savings at 22,000 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.

<table>
<tr><th rowspan="2">Covered Services</th><th rowspan="2">Calendar Year Deductible Per Person</th><th rowspan="2">Provider Participation</th><th colspan="3">Benefit Percentages</th></tr>
<tr><th>1st Year</th><th>2nd Year</th><th>3rd Year</th></tr>
<tr><td rowspan="2">Class A
Specified Diagnostic and Preventative</td><td rowspan="2">$0</td><td>In-Network</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Out-of-Network</td><td>60%</td><td>80%</td><td>80%</td></tr>
<tr><td rowspan="2">Class B
Other Diagnostic, Preventative, Restorative & Specified Oral Surgery</td><td rowspan="2">$50</td><td>In-Network</td><td>70%</td><td>75%</td><td>80%</td></tr>
<tr><td>Out-of-Network</td><td>50%</td><td>55%</td><td>60%</td></tr>
<tr><td rowspan="2">Class C
Endodontics, Periodontics, Prosthodontics & Crowns, Inlays, Onlays</td><td rowspan="2">$100</td><td>In-Network</td><td rowspan="2">0%
12 Month Waiting Period</td><td>40%</td><td>50%</td></tr>
<tr><td>Out-of-Network</td><td>30%</td><td>40%</td></tr>
<tr><td rowspan="2">Class D
Orthodontics-Comprehensive Case (ages 6-18)</td><td rowspan="2">$0</td><td>In-Network</td><td rowspan="2">0%
24 Month Waiting Period</td><td rowspan="2">0%
24 Month Waiting Period</td><td>50%</td></tr>
<tr><td>Out-of-Network</td><td>25%</td></tr>
</table>

Benefits described on page 70 and 71 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.

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 17) 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;
- Surgery to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit;
- Services or supplies not specifically listed as covered;
- Services or supplies not reasonably necessary for the diagnosis or treatment of an illness or injury, except for routine physical examinations and immunizations;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 18), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 19), or State premium taxes however applied;
- Charges in excess of the "Plan allowance" as defined on page 86;
- Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital;
- Inpatient private duty nursing;
- Stand-by physicians and surgeons;
- Clinical ecology and environmental medicine;

- Chelation therapy except for acute arsenic, gold, or lead poisoning;
- Treatment for impotency, even if there is an organic cause for impotency. (Exclusion applies to medical/surgical treatment as well as prescription drugs.);
- Treatment other than surgery of temporomandibular joint dysfunction and disorders (TMJ);
- Computer devices to assist with communications; 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.

Mail to: GEHA
P.O. Box 4665
Independence, MO 64051-4665

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

When you must file a claim -- such as for 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 purchased through the Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.

- To control administrative costs, we will not issue benefit checks that do not exceed $1.

Records

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

Deadline for filing your claim

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

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send itemized bills that include an English translation. 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: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: GEHA, P.O. Box 4665, Independence, MO 64051-4665*;* and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (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. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street, NW, Washington, D.C. 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; 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 include 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 or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

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

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 (Part A or Part B)**

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

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your 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 the Original Medicare Plan – When Original 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 Home Delivery Pharmacy service and at retail pharmacies as shown on page 65.
- **Chiropractic Benefits:** There is no change in benefit limits or maximums for chiropractic care when Medicare is primary. See page 32 for benefits.
- **Physical, Speech and Occupational Therapy Benefits:** There is no change in benefit limits or maximums for 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		✓
c) Are a former spouse of an annuitant	✓	
d) Are a former spouse of 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 another type of Medicare+Choice plan -- 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 provide all the benefits that Original Medicare covers. 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. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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, eliminating 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 with your physician**

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

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

If you or a dependent suffer injuries in an accident or become ill because of another person's act or omission, and you later receive compensation from that person and/or your own or other insurance, you are required to refund GEHA. We will make conditional payments, subject to our contractual benefits. Included in GEHA's lien are any services and supplies to diagnose or treat the injuries or illness. You are required to reimburse GEHA for the benefit payments even if the total compensation received is not sufficient to compensate you or your dependent for the damages sustained. In other words, unless we agree otherwise in writing, you are bound to reimburse the Plan in full even if you are not "made whole" for all of the damages by the compensation. GEHA's lien is not subject to reduction for attorney's fees or costs under the "common fund" doctrine without GEHA's written consent.

GEHA enforces our right of reimbursement by asserting a lien against any and all compensation that you or your dependent receive, whether by court order or out-of-court settlement, and regardless of how that compensation is characterized, such as "pain and suffering". GEHA's lien includes payments from any source, including Medpay, Personal Injury Protection, no-fault coverage, third-party, and uninsured and underinsured motorists coverage. You must cooperate with GEHA by promptly notifying our subrogation unit when you or a dependent file a claim against some other person(s) for compensation. You must supply GEHA with all relevant information relating to the claim, and sign any releases GEHA requires to obtain information about that claim from other sources. You must promptly disclose to GEHA all information relating to any settlement or recovery received. In addition, you must: accept GEHA's lien for the full amount of the benefits paid; assign any proceeds from third-parties, your own, or other insurance to GEHA when asked to do so; and sign a Reimbursement Agreement if asked by GEHA to do so. However, a Reimbursement Agreement is not necessary to enforce the lien. The lien extends to all related expenses incurred prior to the settlement or judgment date, whether or not those expenses were submitted in a timely manner to GEHA. Related expenses incurred after all settlements are not included in the lien. In short, GEHA is entitled to be reimbursed for all benefits paid for medical care resulting from the injury or illness through the date of settlement of your claim, unless we agree in writing to accept less than 100% of the lien. The lien remains the member's obligation until it is satisfied in full. Failure to reimburse GEHA or cooperate with our reimbursement efforts may result in an overpayment that can be collected from you or any dependent.

Please contact GEHA's Subrogation unit at (800) 821-4742, Ext. 5503, or Ext. 5735, to report your claim or discuss this process.

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.

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 15-16.

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Plan may determine to be congenital anomalies. Surgical correction of congenital anomalies is limited to children under the age of 18 unless there is a functional deficit. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 15.

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.

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 15.

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) serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The date the benefits described in this brochure are effective:

(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.

Expense

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

Experimental or investigational services

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

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

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

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

Group health coverage

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

Infertility

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

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 Plan allowance as follows:

We consult standard industry guides, such as national databases of prevailing health care charges from Ingenix. We use the 70th percentile. This means that out of every 100 reports, 30 charges billed may be more, but 70 charges will be the allowed amount or less. Charges determined in this way include, but are not limited to, surgery, doctor's services, physical therapy, speech therapy, occupational therapy, lab testing and X-ray expenses; and under the Standard Option diagnostic and preventive dental services. 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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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.

• Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

•Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

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Long Term Care Insurance Is Coming Later in 2002!

Many FEHB enrollees think that their health plan and/or Medicare covers long-term care. Unfortunately, they are *WRONG*!

How are YOU planning to pay for the future custodial or chronic care you may need? Consider buying long term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for care in a nursing home, in an assisted living facility, in your home, adult day care, hospice care, and more. *Long term care insurance can supplement care provided by family members, reducing the burden you place on them*.

I'm healthy. I won't need long term care. Or, will I?

- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but you should have a plan just in case. *LTC insurance may be vital to your financial and retirement planning.*

Is long term care expensive?

- Yes. A year in a nursing home can exceed $50,000 and only three 8-hour shifts a week can exceed $20,000 a year, that's before inflation!
- LTC can easily exhaust your savings but LTC insurance can protect it.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at "*Not covered*" in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

- Employees will get more information from their agencies during the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

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, 2002. 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 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. 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 open season. Your coverage will begin January 1, 2002. 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 2002 Guide to Federal Employees Health

Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

Temporary Continuation of Coverage (TCC)

See Section 11, FEHB Facts; it explains Temporary Continuation of Coverage

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 may not show all pages where the terms appear.

Summary of benefits for GEHA – Standard Option 2002

- **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: • Diagnostic and treatment services provided in the office ……..	PPO: $10 copay primary care physician; $25 copay specialist for covered office visits and 15%* of other covered professional services including X-ray and lab Non-PPO: 35%* of covered professional services	21-42
Services provided by a hospital: • Inpatient …….. • Outpatient …….	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	43-49
Emergency benefits: • Accidental injury • Medical emergency other professional services ……	Nothing up to plan allowance of covered charges incurred within 72 hours of an accident Regular benefits*	50-52
Mental health and substance abuse treatment ……..	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	53-60
Prescription drugs ……	Network pharmacy: Member pays $5 for generic drugs/50% brand name for up to 30 day supply. Non-network pharmacy: Member pays $5 for generic drugs/50% brand name and any difference between our allowance and the cost of the drug. By mail: Member pays $15 for generic drugs/50% brand name for 90-day supply	61-66
Dental Care ……..	50% up to plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions	68-69
Special features: Flexible benefits option, services for deaf and hearing impaired, high-risk pregnancies		67
Protection against catastrophic costs (your out-of-pocket maximum) ……	Nothing after $4000/Self Only or $4,500/Family enrollment per year for PPO providers; Nothing after $5,000/Self Only or $5,500/Family enrollment per year for Non-PPO providers. Some costs do not count toward this protection	16-17

Summary of benefits for GEHA – High Option 2002

- **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: • 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 Non-PPO: 25%* of covered professional services	21-42
Services provided by a hospital: • Inpatient ……. • Outpatient* ……	PPO: Nothing for room and board, 10% of other hospital charges Non-PPO: Nothing for room and board, 25% of other hospital charges	43-49
Emergency benefits: • Accidental injury …… • Medical emergency other professional services …….	Nothing up to plan allowance of covered charges incurred within 72 hours of an accident Regular benefits*	50-52
Mental health and substance abuse treatment ……..	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	53-60
Prescription drugs ……	Network pharmacy: Member pays $5 for generic drugs/$15 single-source brand name/$30 multi-source brand name for up to 30 day supply for the initial fill and first refill. Subsequent fills are the greater of 50% or the copays listed above. Non-network pharmacy: Member pays $5 for generic drugs/$15 single-source brand name/$30 multi-source brand name for up to a 30 day supply for the initial fill and first refill and any difference between our allowance and the cost of the drug. Subsequent fills are the greater of 50% or the copays listed above and any difference between our allowance and the cost of the drugs. By mail: Member pays $10 for generic drugs/ $35 single-source brand name/$50 multi-source brand name for 90-day supply.	61-66
Dental Care ……..	Charges in excess of the scheduled amounts for diagnostic and preventive services, restorations, and extractions	68-69
Special features: Flexible benefits option, services for deaf and hearing impaired, high-risk pregnancies		67
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; Nothing after $4,000/Self Only or $4,500/Family enrollment per year for Non PPO providers. Some costs do not count toward this protection	16-17

2002 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, 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 who are not career postal employees. 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	$97.86	$59.70	$212.03	$129.35	$115.52	$42.04
High Option Self and Family	312	$223.41	$119.50	$484.06	$258.91	$263.75	$79.16
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