Government Employees Hospital Association, Inc. Benefit Plan 1999

A Managed Fee-for-Service Plan with Preferred Provider Organizations and a Point of Service product

Sponsored 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 1999.

Enrollment code for this Plan:

311 Self Only
312 Self and Family

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.geha.com

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 71-6

Government Employees Hospital Association, Inc. Benefit Plan

The Government Employees Hospital Association, Inc., Independence , Missouri, has entered into Contract No. CS1063 with the Office of Personnel Management (OPM) to provide a health benefits plan authorized by the Federal Employees Health Benefits (FEHB) law. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is the official statement of benefits on which you can rely. It describes the benefits, exclusions, limitations, and maximums of the GEHA Benefit Plan for 1999 until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 800/821-6136 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

When you need help with Plan benefits or getting your ID card, call the Plan at 800/821-6136. The Fraud Hotline cannot help you with these.

Using This Brochure

The **Table of Contents and Index** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits,** on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid one way if it is billed by an inpatient facility and paid another way when it is billed by a doctor, physical therapist or outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital, you need to read **Precertification;** hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare.** And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

Table of Contents

Table of Contents *continued*

Help Contain Costs

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and the flexible benefits option. Some include managed care options, such as PPOs, to help contain costs.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with Intracorp before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on page 33 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Carrier has the authority to determine the most effective way to provide services. The Carrier may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Carrier may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Carrier's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

PPO

This Plan offers most of its members the opportunity to reduce out-of-pocket expenses by choosing providers who participate in the Plan's preferred provider organization (PPO) or PPO designations. Consider the PPO cost savings when you review Plan benefits and check with the Carrier to see whether PPO providers are available in your area.

Facilities and Other Providers

Covered facilities

Freestanding ambulatory facility

A facility which meets the following criteria: 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.

In no event shall the term hospital 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 operated as a school or residential treatment facility.

Covered Providers

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, qualified clinical social worker, qualified clinical psychologist, podiatrist, speech, physical and occupational therapist, nurse practitioner/clinical specialist and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1999, the States designated as medically underserved are: Alabama, Idaho, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota, and Wyoming.

PPO arrangements

Benefits under this Plan are available from facilities, such as hospitals, and from providers, such as pharmacies, doctors and other health care personnel, who provide covered services. This Plan covers two types of facilities and providers: (1) those who participate in a preferred provider organization (PPO) and (2) those who do not. Who these health care providers are, and how benefits are paid for their services, are explained below. In general, it works like this:

PPO facilities and providers have agreed to provide most services to Plan members at a lower cost than you'd usually pay a non-PPO provider. Although PPOs are not available in all locations or for all services, when you use these providers you help contain health care costs and reduce what you pay out of pocket. The selection of PPO providers is solely the Carrier's responsibility; continued participation of any specific provider cannot be guaranteed. While PPO providers agree with the Carrier to provide covered services, final decisions about health care are the sole responsibility of the doctor and patient and are independent of the terms of the insurance contract.

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. The availability of every specialty in all areas cannot be guaranteed. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

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

Non-PPO facilities and providers do not have special agreements with the Carrier. The Plan makes its regular payments toward their bills, and you're responsible for any balance.

This Plan's PPO

The Plan has entered into arrangements with Alliance PPO, Inc., Benefit Source, Inc., Community Care Network, Inc., Private Healthcare Systems, SouthCare, PPO USA, 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.

When a PPO hospital is utilized for Inpatient Medical or Surgical services, the Plan prorates the discount between room and board charges and the other hospital charges. The discounted room and board charges will then be paid at **100%** and the discounted other hospital charges will be paid at **90%.** Although mental conditions and substance abuse confinement will continue to be paid at 50%, members may receive a benefit from lower negotiated fees for covered services received from a PPO provider. Precertification of all hospital admissions is still required as outlined on pages 12 and 33 of this brochure.

When a PPO participating doctor is used, the Plan will increase its payment to **90%** for those services normally paid at **80%.** If a non-PPO provider is utilized, the Plan will pay benefits as shown in this brochure.

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. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

POS

This Plan offers a Point of Service (POS) program called *GEHA Select* in the Omaha, Nebraska, service area. The POS program provides a higher level of benefits when services are provided by a participating primary care physician or an approved referral to a participating specialist physician, or non-PPO benefits for services received without a referral. An addendum and a POS selection form that outline benefit levels and special requirements of the POS program are available by calling GEHA at 800/821-6136.

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of expenses an individual must incur for covered services and supplies each calendar year before the Plan pays certain benefits. There is no deductible for inpatient hospital benefits (except under Mental Conditions and Substance Abuse Benefit), prescription drugs or for outpatient charges incurred for accidental injuries within 72 hours of an accident.

You can count toward the deductibles any and all covered reasonable and customary expenses except expenses paid by the Plan.

The amount of the calendar year deductible is $250. When combined covered expenses applied to the deductible for all family members reach $500 during a calendar year, the family deductible is satisfied and benefits are payable for all family members.

There is a separate $500 deductible, per person, per calendar year for hospital inpatient and intensive day treatment under the Mental Conditions and Substance Abuse Benefit.

Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Family limit

There is a separate calendar year deductible of $ 250 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the deductible for all family members reach $500 during a calendar year. This benefit applies only to families with more than two members. Each family member can only contribute the individual deductible of $250 toward the family deductible.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge or the usual, reasonable and customary charge, whichever is less. For instance, when a Plan pays **80%** of reasonable and customary charges for a covered service, you are responsible for **20%** of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's usual, reasonable and customary allowance. For example, if the provider ordinarily charges $100 for a service but the Plan's usual, reasonable and customary allowance is $95, the Plan will pay **80%** of the allowance ($76). You must pay the **20%** coinsurance ($19), plus the difference between the actual charge and the usual, reasonable and customary allowance ($5), for a total member responsibility of $24. Remember, if you use preferred providers, your share of covered charges (after meeting any deductible) is limited to the stated coinsurance amount.

When hospital charges are limited by law

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 - see page 9), the Plan will pay **30%** of the total covered amount as room and board charges and **70%** as other charges and will apply your coinsurance accordingly.

Copayments

A copayment is the stated amount the Plan requires you to pay for a covered service, such as $28 per prescription by mail or $10 per office visit charge at a PPO provider.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but routinely waives the **20%** coinsurance, the actual charge is $80. The Plan will pay $64 (**80%** of the actual charge of $80).

Lifetime maximums

- Benefits for inpatient treatment of substance abuse are limited to one treatment program (30 day maximum) per member per lifetime.
- Benefits for durable medical equipment are limited to $10,000 per person.
- Benefits for smoking cessation are limited to $100 per member.
- Benefits for vision therapy are limited to 30 visits per person.

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan. This brochure is the official statement of benefits on which you can rely.**

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 34-36 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to, benefits from any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is 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. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of the covered expenses. When this Plan pays secondary, it will only make up the difference between the primary plan's coverage and this Plan's coverage. Thus, combined payments from both plans may not equal the entire amount billed by the provider.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) Or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. If you or your dependent sustain an illness or injury caused by another person, the Plan will pay benefits for the illness or injury subject to the requirements outlined below:

(1) The Plan being repaid in full from any recovery or right of recovery you or your dependent has against that other party, and the right, if the Plan decides to, to bring suit in your name; (2) your not taking any action which would prejudice the Plan's right to recover the benefits it paid to, or for, you; and (3) your cooperating in doing what is reasonably necessary to assist the Plan in any recovery, including disclosure of all settlement information requested by the Plan.

The member is required to notify the Plan when a recovery is received. The Plan shall have a lien on the proceeds of any and all recoveries resulting from an accident or illness caused by another person or party, whether received in an out-of-court settlement or by court order, regardless of how the parties characterize the amounts involved in the settlement, i.e. "pain and suffering." No GEHA benefits will be paid until any Medpay, PIP, or No-Fault benefits are exhausted. GEHA's lien extends to and includes payments made under Medpay, PIP, No-Fault, 3rd party, and uninsured or underinsured motorists provisions of any auto policy. Payment of benefits prior to the Plan's being advised of the third-party claim does not waive the Plan's right to withhold benefits where an enrollee or covered family member has not cooperated in protecting the Plan's lien. The Plan's lien extends to all bills related to the accident or illness that were incurred through the date of the final settlement. No reduction in the Plan's lien can occur without the Plan's written consent. The lien remains the obligation of the member until the Plan is reimbursed. Failure to notify the Plan promptly of the claim for damages or to cooperate with the Plan's reimbursement efforts may result in an overpayment by the Plan subject to recoupment from the member. Any reimbursements received by the Plan shall not exceed the total amount paid by the Plan.

If you or your dependent are injured by the actions of another person or organization and a claim for benefits is submitted for the treatment of that injury, you are required to promptly notify GEHA of the date, circumstances, and all pertinent information relating to the loss.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the **equivalent Medicare amount.** After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 800/821-6136 for assistance.

Physician services

Claims for physician services provided for retired FEHB members, age 65 and older who do not have Medicare Part B are also processed in accordance with 5 USC 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your doctor is a member of the Plan's preferred provider organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO doctor who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the doctor's agreement with the Carrier specifies otherwise, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare-approved amount).

If your physician is not a Plan PPO doctor but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's surgery benefit, the Plan will pay 80% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 20% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance, up to the limiting charge (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount, even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 800/821-6136 for assistance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 8); 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
- Furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- 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
- For cosmetic purposes
- For or related to sex transformation, sexual dysfunction or sexual inadequacy
- Not specifically listed as covered
- Investigational and experimental
- Not reasonably necessary for the diagnosis or treatment of an illness or injury, except for routine physical examinations and immunizations
- Not provided in accordance with accepted professional medical standards in the United States

Benefits will not be paid for:

- 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, the Carrier 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 pages 8-10), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 35), or State premium taxes however applied.
- Procedures, services, drugs and 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.
- Charges in excess of reasonable and customary charges as defined on page 42
- Expenses incurred while not covered by this Plan
- Rest cures
- Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital
- Inpatient private duty nursing
- Stand-by physicians and surgeons
- Clinical ecology and environmental medicine
- Chelation therapy except for acute arsenic, gold, or lead poisoning
- Treatment for impotency, even if there is an organic cause for impotency. (Exclusion applies to medical/surgical treatment as well as prescription drugs.)

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission **must** be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 33 for details.

Waiver

This does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary, see pages 34-36.

Room and board

The Plan pays **100%** of covered charges (no deductible) for semiprivate, ward and intensive care accommodations in a hospital, including meals and special diets and general nursing care.

Private room - Charges for use of private room will be paid at **100%** if determined to be medically necessary by the Plan. Use of a private room for any other reason will be paid at the rate of the hospital's average semiprivate accommodations. The remaining balance is not a covered expense.

Other charges

The Plan pays for other hospital charges as shown below.

Non-PPO benefit

The Plan pays **80%** of other hospital charges

PPO benefit

The Plan pays **90%** of other hospital charges

Other hospital charges include but are not limited to:

- operating, recovery, and other treatment rooms
- diagnostic laboratory tests and X-rays
- drugs and medicines
- administration of blood, blood plasma and oxygen
- dressings, plaster casts and sterile trays service

Limited benefits

Hospitalization for dental work

The Plan pays benefits as shown above for covered room and board and covered hospital services for hospitalization in connection with dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient.

Related benefits

Professional charges

Charges for professional services of a doctor or any other practitioner covered by the Plan, even though billed by a hospital as part of hospital services, are covered under Other Medical Benefits (pages 19-22) and Surgical Benefits (pages 13-15).

Take-home items

Medical supplies, appliances, medical equipment and any covered items billed by a hospital but to be used at home are covered only under Other Medical Benefits.

What is not covered

- Charges by institutions which do not meet the definition of covered facility
- Custodial care (as defined on page 40), even when provided by a hospital
- Hospital room and board when, in the Plan's judgment, an admission or portion of an admission is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered
- Personal comfort items, e.g., charges for television, radios, barber services

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Surgical Benefits

What is covered

The Plan pays for the following services:

After the $250 calendar year deductible has been met, the Plan pays as follows for surgery performed on either an inpatient or outpatient basis:

Non-PPO benefit

80% of reasonable and customary charges incurred in or out of the hospital

PPO benefit

90% of reasonable and customary charges incurred in or out of the hospital

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays as follows:

Non-PPO benefit

80% of the full reasonable and customary charge for the primary procedure

80% of half of the reasonable and customary charge for the secondary procedure

80% of 25% of the reasonable and customary charge for subsequent procedures

PPO benefit

90% of the reasonable and customary charge for the primary procedure

90% of half of the reasonable and customary charge for the secondary procedure

90% of 25% of the reasonable and customary charge for the subsequent procedure

Incidental procedures

Incidental and subset procedures are considered as part of the primary surgery.

Surgical services

This Plan will pay reasonable and customary charges in or out of a hospital, to the extent shown above, for:

- charges of a surgeon, including oral surgery
- 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
- surgical-induced sterilization, even if elective
- surgical correction of congenital anomalies (see Definitions)
- initial breast reconstruction following mastectomy.

Assistant surgeon

When deemed medically necessary, benefits will be covered up to **20%** of the Plan's maximum reasonable and customary allowance for the surgical procedure.

Second opinion (voluntary)

The Plan pays as shown above for charges for a second surgical opinion prior to elective surgery recommended by a surgeon qualified to perform the surgery, if:

- the recommended procedure is covered; and
- the doctor rendering the opinion is not associated or in practice with the doctor who recommended and will perform the surgery.

Charges for a third opinion are payable if the second opinion does not confirm the initial recommendation.

Anesthesia

After the $250 calendar year deductible has been met, the Plan pays as follows for professional fees for the administration of anesthesia:

Non-PPO benefit

80% of reasonable and customary charges

PPO benefit

90% of reasonable and customary charges

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Organ/tissue transplants and donor expenses

The following human organ/tissue transplant procedures are covered, subject to the conditions and limitations below:

What is covered

- Cornea, heart, heart/lung, kidney and liver transplants
- Pancreas transplants, limited to patients whose condition is not treatable by insulin therapy;
- Single or double lung transplants, limited to patients for the following end-stage pulmonary diseases: (1) Primary fibrosis, (2) Primary pulmonary hypertension, or (3) Emphysema; double lung transplants, limited to patients with cystic fibrosis.

Bone marrow transplants and stem cell support as follows:

- Allogeneic bone marrow transplants, limited to patients with (1) Acute leukemia, (2) Advanced Hodgkin's lymphoma, (3) Advanced non-Hodgkin's lymphoma, (4) Advanced neuroblastoma (limited to children over age one), (5) Aplastic anemia, (6) Chronic myelogenous leukemia, (7) Infantile malignant osteopetrosis, (8) Severe combined immunodeficiency, (9) Thalassemia major, or (10) Wiskott-Aldrich syndrome.
- Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support, limited to patients with (1) Acute lymphocytic, or non-lymphocytic leukemia, (2) Advanced Hodgkin's lymphoma, (3) Advanced non-Hodgkin's lymphoma, (4) Advanced neuroblastoma (limited to children over age one), (5) Breast cancer, or (6) Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors, 7) Multiple myeloma or 8) Epithelial ovarian cancer.

All reasonable and customary 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 limitations stated below. This benefit applies only if the recipient is covered by the Plan, and if the donor's expenses are not otherwise covered.

Transportation benefit

The Plan will also provide up to $10,000 per covered transplant for transportation to the 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.

Limitations

The following limitations apply to all covered transplants except for cornea and kidney:

- The process for preauthorizing organ transplants is more extensive than the normal precertification process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact the Plan's Medical Director, so that the Plan can arrange to review the clinical results of the evaluation and determine if the proposed procedure meets the Plan's definition of "medically necessary" and is on the list of covered transplants. Coverage for the transplant must be authorized in advance, in writing, by the Plan's Medical Director.
- The transplant must be performed at a Plan-designated organ transplant facility to receive maximum benefits.
- If prior approval is not obtained or a Plan-designated organ transplant facility is not used, the benefits will be limited to 90% for PPO hospital expenses, 90% for PPO physician expenses, or 80% of reasonable and customary charges for non-PPO hospital and surgery expenses up to a maximum of $100,000 per transplant. If the Plan cannot refer a member in need of a transplant to a designated facility, the $100,000 maximum will not apply.
- If benefits are limited to $100,000 per transplant, included in the maximum are all charges for hospital, medical and surgical care incurred while the patient is hospitalized for a covered transplant surgery and subsequent complications related to the transplant. Outpatient expenses for chemotherapy and any process of obtaining stem cells or bone marrow associated with autologous bone marrow transplant (autologous stem cell support) are included in benefits limit of $100,000 per transplant. Expenses for aftercare such as outpatient prescription drugs are not a part of the $100,000 limit.
- 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.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

What is 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 search expense for bone marrow transplants.

Oral and maxillofacial surgery

Oral surgery benefits are limited to the following procedures:

- Extraction of impacted (unerupted or partially erupted) teeth;
- Alveoloplasty, partial or radical removal of the lower jaw with bone graft;
- Correction of cleft palate, fractures of the jaw and/or facial bones;
- Excision of bony cysts of the jaw unrelated to tooth structure;
- 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;
- Incision and drainage of infected tissue unrelated to tooth structure;
- Repair of accidental injury to sound natural teeth (including, but not limited to, expenses for X-rays, drugs, crowns, bridgework, inlays, and dentures) performed within 12 months of the accident. 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 23).

Mastectomy surgery

- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

What is not covered

- Cosmetic surgery (see Definitions), except for prompt repair of injury caused by an accident, congenital anomalies and breast reconstruction following a mastectomy
- Charges for removal of corns, calluses or trimming of toenails
- Reversal of sterilization
- Orthodontic treatment
- Radial keratotomy or other keratoplasties
- Intra-oral soft tissue grafts
- Any oral or maxillofacial surgery not specifically listed as covered
- Orthognathic surgery, even if necessary because of TMJ dysfunction or disorder

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary.

Inpatient hospital

Hospital bassinet or nursery charges for days on which mother and child are both confined are considered other hospital expenses of the mother and not expenses of the child. However, when a newborn requires definitive treatment or evaluation for medical or surgical reasons, during or after the mother's confinement, the newborn is considered a patient in his or her own right. Under these circumstances, expenses of the newborn (including incubation charges by reason of prematurity) are eligible for benefits only if the child is covered by a family enrollment.

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See page 33 for details.

Intracorp offers a high risk pregnancy program at no cost to you. To take full advantage of this service and obtain valuable information concerning prenatal care, you should call Intracorp at 800/747-GEHA as soon as your pregnancy is confirmed.

Room and board

100% for covered room and board charges

Other charges

The Plan pays for other hospital charges (as explained on page 12)

Non-PPO benefit

The Plan pays **80%** of other hospital charges (as explained on page 12)

PPO benefit

The Plan pays **100%** of other hospital charges (as explained on page 12)

Obstetrical care

The Plan pays for the following maternity care (including care, delivery or miscarriage) by a doctor (M.D. or D.O.) or licensed nurse midwife. The $250 calendar year deductible applies to non-PPO providers. Prenatal and postnatal care is considered to be included in the delivery fee for non-PPO providers. There is no deductible for PPO providers.

Non-PPO benefit

The Plan pays **80%** of reasonable and customary charges incurred in or out of the hospital.

PPO benefit

The Plan pays **100%** of the reasonable and customary charges incurred in or out of hospital.

Related benefits

Contraceptive devices and drugs

Devices and drugs obtainable only by written prescription (see pages 24-26)

Diagnosis and treatment of infertility

Charges related to diagnosis and treatment of infertility will be covered up to a maximum of $3,000 per calendar year per person. Drugs to treat infertility are not covered.

Voluntary sterilization

Surgically-induced sterilization, even if elective (see page 13)

Well child care

Routine doctor visits and immunizations are paid under Additional Benefits (see page 23).

Wellness program

See page 23 for additional services available for you.

For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

What is not covered

- 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 result of rape or incest
- Routine sonograms to determine fetal age and/or size
- Charges for services and supplies incurred after termination of coverage
- Reversal of sterilization
- Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, as well as services and supplies related to ART procedures, are not covered.
- Home uterine monitoring devices, unless preauthorized by the Plan Medical Director

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Mental conditions

Inpatient care

Inpatient hospital expenses are limited to **50%** of reasonable and customary charges subject to the $500 hospital inpatient and intensive day treatment mental conditions/substance abuse deductible, per member, per calendar year, for treatment of mental conditions. All reasonable and customary charges count toward the deductible and benefits are limited to 100 days per calendar year.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 33 for details.

Inpatient visits

The Plan pays **50%** of reasonable and customary charges for inpatient visits by covered providers and for psychotherapy sessions, after the Plan's overall $250 calendar year deductible has been met. All reasonable and customary charges count toward the calendar year deductible. Benefits are limited to 100 inpatient visits per calendar year**.**

Substance abuse

Inpatient care

Inpatient care for the treatment of alcoholism and drug abuse is available for one treatment program (30 day maximum) per lifetime. Inpatient care for treatment of alcoholism and drug abuse is subject to ongoing review for need for acute inpatient care.

The Plan pays **50%** of reasonable and customary charges for inpatient hospital charges and inpatient visits by covered providers and psychotherapy sessions. Benefits are subject to the $500 hospital inpatient and intensive day treatment mental conditions/substance abuse deductible.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan 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 page 33 for details.

Lifetime maximum

Benefits are limited to one treatment program (30 day maximum) per lifetime for alcoholism and drug abuse.

Mental conditions and substance abuse

Outpatient care

The following describes the outpatient mental conditions and substance abuse benefits:

Outpatient visits

Home and office visits by covered providers are covered, including visits for psychotherapy sessions and group sessions, up to a maximum of 30 sessions per calendar year for the treatment of mental conditions and substance abuse. The Plan pays **50%** of reasonable and customary charges for up to 30 sessions per calendar year, after the Plan's overall $250 calendar year deductible has been met. All reasonable and customary charges count toward the calendar year deductible.

Intensive day treatment

The Plan provides intensive hospital day treatment, limited to **50%** of reasonable and customary charges, after the $500 hospital inpatient and intensive day treatment mental conditions/substance abuse deductible, per member, per calendar year. All reasonable and customary charges count toward the deductible. Benefits are limited to 60 days of treatment per calendar year. If you are uncertain if treatment will be considered intensive day treatment, you may contact the Plan's Customer Service Department.

Calendar year maximum

Benefits for the treatment of mental conditions on an inpatient basis are limited to 100 days per calendar year. Benefits for Intensive Day Treatment are limited to 60 days per calendar year.

Catastrophic protection

When the deductibles and coinsurance for all covered family members (or an individual under Self Only) exceeds $8,000 for the treatment of mental conditions (inpatient or outpatient), and outpatient substance abuse in any one calendar year, the Plan will pay in full all remaining reasonable and customary charges incurred during the remainder of that same year up to the calendar year maximum.

What is not covered

- Marital, family and other counseling services including therapy for sexual problems
- Services rendered or billed by a school or halfway house or a member of its staff

Other Medical Benefits

What is covered

After the $250 calendar year deductible has been met, the Plan pays expenses for the services listed below and on pages 20-22 as follows except where noted:

Non-PPO benefit

The Plan pays **80%** of reasonable and customary charges

PPO benefit

The Plan pays **90%** of reasonable and customary charges, except:

You pay a $10 copayment for the doctor's professional fee for each office visit and services rendered by the doctor in conjunction with the office visit such as diagnostic X-ray or laboratory tests. These expenses are not subject to the $250 calendar year deductible nor counted toward the maximum out of pocket limits.

Services rendered on a different date than the office visit or by any other provider will be subject to the deductible and coinsurance. The $10 copayment and 100% benefit will not be paid for any office visit when rendered with services for other plan benefits. These include, but are not limited to: surgery; physical, speech and occupational therapies; radiation therapy; chemotherapy; dialysis; or durable medical equipment.

The following services and supplies are covered if prescribed by a doctor and rendered by a covered provider:

- Allergy treatment
- Anesthetics and their administration
- Artificial eyes and limbs and orthopedic devices
- Chemotherapy
- First breast prosthesis and bra following a mastectomy. Replacement prosthesis and bra will be covered every two years.
- First pair of contact lenses or ocular implant lenses if required to correct an impairment existing after intraocular surgery or 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.
- Oxygen
- Professional services of doctors, including home, office and hospital visits
- Renal dialysis
- Splints, casts, and similar devices used for reduction of fractures and dislocations
- Transfusions, and blood and blood plasma not donated or replaced
- Ultraviolet and radiant heat treatments and diathermy
- X-ray, radium and radioactive isotope therapy and antibiotic therapy
- X-rays, laboratory tests, electrocardiograms, basal metabolism readings, and other diagnostic tests
- Initial evaluation and laboratory data by physician for weight loss and medically indicated surgery for morbid obesity. Surgery must be approved prior to the surgery by the Plan. All other types of treatment for weight loss are not covered.

Outpatient hospital services

Coverage is provided for the services and supplies described in "Other Medical Benefits" when such services and supplies are rendered in and billed by the outpatient department of a hospital.

Emergency room services

Non-PPO benefit

You pay $75 copayment per occurrence for services and supplies billed by the hospital for emergency room treatment of an illness. These expenses are not applied to the $250 calendar year deductible nor counted toward the maximum out-of-pocket limits.

PPO benefit

You pay $75 copayment per occurrence for services and supplies billed by the hospital for emergency room treatment of an illness. These expenses are not applied to the $250 calendar year deductible nor counted toward the maximum out-of-pocket limits.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Other Medical Benefits *continued*

Other outpatient hospital services

Coverage is provided for the services and supplies described in "Other Medical Benefits" when such services and supplies are rendered in and billed by the outpatient department of a hospital.

Non-PPO benefit — The Plan pays **80%** of covered charges.

PPO benefit — The Plan pays **90%** of covered charges.

Services must be rendered in and billed by a covered hospital. Only services and supplies billed by a hospital qualify for the **90%** (PPO) benefit.

Routine services

In addition to coverage on page 19 of diagnostic X-rays, laboratory and pathological services and machine diagnostic tests, the following routine (screening) services are covered as preventive care:

Breast cancer screening — Mammograms are covered for diagnostic and/or routine screening services.

Cervical cancer screening — Annual coverage of one pap smear for women age 18 and older

Colorectal cancer screening — Annual coverage of one fecal occult blood test for members age 40 and older

Prostate cancer screening — Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older

Routine physical — Routine physical examinations, diagnostic laboratory tests, including pap smears and X-rays

Limited benefits

Acupuncture

The plan will provide benefits for medically necessary acupuncture treatments if performed by a Medical Doctor (MD) or Doctor of Osteopathy (DO). Benefits are limited to 20 procedures per calendar year.

Allergy testing

The Plan will provide benefits for medically necessary allergy testing. Benefits are limited to $500 per calendar year.

Chiropractor

The following services of a chiropractor will be covered, subject to the calendar year deductible, to the following extent:

(a) adjustments by hands-only of the spinal column, up to a maximum of 30 adjustments per calendar year, and up to a maximum payable by the Plan of $9 per adjustment; and

(b) use of X-rays to detect and determine the presence or absence of nerve interferences due to spinal subluxations or misalignments up to a maximum payable by the Plan of $25 per calendar year.

Charges exceeding these amounts are not applied toward the calendar year deductible.

No other benefits for these 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.

Durable medical equipment

The Plan will provide benefits for the purchase or rental, at the option of the Plan, of durable medical equipment, including respirators, oxygen equipment, wheelchairs, hospital beds, crutches, and other items determined by the Plan to be durable medical equipment. To obtain maximum benefits, contact our Customer Service Department or Managed Care Department before the rental or purchase of any durable medical equipment.

Benefits are limited to a lifetime maximum of $10,000 per person.

Hospice care

What is covered — **100%** of the covered charges, subject to the $250 calendar year deductible, for a hospice care program for each period of care, up to:

- $2,000 for hospice care on an outpatient basis
- $150 per day for room and board and care while an inpatient in a hospice up to a maximum of $3,000

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

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 service or inpatient hospice stay that is a 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

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.

What is 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

Occupational and speech therapy

Outpatient visits for any services provided by an occupational or speech therapist, when prescribed by a doctor and rendered by a qualified professional therapist, are available up to a combined total of 30 visits per person per calendar year. Speech therapy must be to restore functional speech when there has been a loss of attained functional speech due to illness or injury, such as stroke or brain trauma, and when therapy is rendered in accordance with a doctor's specific instructions as to duration and type.

Outpatient dental

The Plan pays benefits under Other Medical Benefits for covered outpatient hospital services in connection with dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient.

Physical therapy

Outpatient visits for physical therapy, when prescribed by a doctor and rendered by a qualified professional therapist, are available up to a total of 50 visits per calendar year.

Skilled nursing care

The Plan will provide benefits for in-home services of a registered nurse (R.N.) and licensed practical nurse (L.P.N.) but not to exceed two hours per day of skilled nursing care for up to a total of 25 visits per calendar year. Covered services are based on review by the Plan for medical necessity.

Smoking cessation benefit

After satisfaction of the calendar year deductible, the Plan will pay up to $100 for enrollment in one smoking cessation program per member per lifetime. Drugs to aid in smoking cessation are covered under this benefit subject to the calendar year deductible and subject to the $100 lifetime maximum. You must purchase these drugs and file the receipt from the pharmacy including the name of drug, patient's name, date, and amount of purchase with the GEHA claim office.

Vision therapy

Outpatient visits for vision therapy provided by an ophthalmologist or optometrist are available up to a total of 30 visits per person, per lifetime.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

What is not covered

- Routine eye examinations, eyeglasses, contact lenses, or hearing aids, except as described above
- 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 40)
- Orthopedic shoes, arch supports, or other supportive devices for the feet
- Travel, even when prescribed by a doctor, except as described for organ transplants (as outlined on page 14)
- Treatment, other than by surgery, of Temporomandibular Joint (TMJ) dysfunction and disorders.
- Custodial care (as defined on page 40)

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Additional Benefits

The following services are covered and are **not** subject to the calendar year deductible:

Accidental injury

100% of covered charges, subject to reasonable and customary allowance (no calendar year deductible) incurred within 72 hours of an accident for treatment outside a hospital or in the outpatient department of a hospital. Emergency room charges associated directly with an inpatient admission are considered "Other charges" under Inpatient Hospital Benefits (see page 12) 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.

Well child care

For covered dependents under age 22, the Plan pays **100%** of the reasonable and customary charges for the following covered services:

- Doctor office visits including the costs associated with routine physical examinations, laboratory tests, and routine childhood immunizations recommended by the American Academy of Pediatrics
- The first routine newborn examination including routine screening (inpatient or outpatient)

24-Hour Nurse Phone Service

For any of your health concerns, 24 hours a day, 7 days a week, 365 days a year, you may call 800/747-GEHA at any time and talk with a registered nurse who will discuss treatment options and answer your health questions.

In addition, 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 you or your covered dependent's pregnancy. Complimentary educational materials include the book "From Here to Maternity." The program also provides you with additional complimentary items such as an infant car seat.

The 24-hour phone service also makes available a registered nurse who will take precertification information outside of regular business hours. Call 800/747-GEHA.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Prescription Drug Benefits

What is covered

This program enables you to purchase medication which requires a prescription by Federal law and is prescribed by your doctor from a local pharmacy or receive up to a 90-day supply of maintenance medication through the Mail Order Drug Program. Prescription drugs are not subject to the calendar year deductible and any coinsurance or copayments paid by you do not count toward the catastrophic protection benefit.

- Drugs that by Federal law of the United States require a doctor's prescription
- Insulin
- Needles and syringes for the administration of covered medications
- Ostomy supplies

What is not covered

- Drugs to aid in smoking cessation except those limited to the $100 lifetime maximum as part of the smoking cessation benefit (see page 21). You may not obtain smoking cessation drugs with your PAID Prescription card or through the Mail Order Drug Program. You must purchase these drugs and file the claim with the GEHA claim office.
- Drugs available without a prescription
- Vitamins and nutritional supplements
- Medical supplies such as dressings and antiseptics
- Drugs which are investigational
- Drugs prescribed for weight loss
- Drugs to treat infertility
- Drugs to treat impotency

From a pharmacy

You will be provided with a combination GEHA PAID Prescription identification card. In most cases, you simply present the card together with the prescription to the pharmacist. For the initial amount prescribed by doctor not to exceed a 30-day supply and the first refill, you pay **$15** for name brand drugs and **$5** for generic drugs, except for drugs that cost (plus any dispensing fee) less than the copayment (in which case the drug will be made available at cost plus any dispensing fee). The second refill and all subsequent refills will require that you pay the greater of **$15** or **50%** coinsurance for name brand drugs or the greater of **$5** or **50%** coinsurance for generic drugs. 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. For long-term prescription needs, you should use the Mail Order Drug Program to receive higher benefits. You may fill your prescription at any pharmacy participating in the PAID TelePAID system. You may obtain the names of participating pharmacies by calling 800/551-7675.

Each participating pharmacy has a TelePAID system which calculates the coinsurance. The Pharmacist receives an electronic message displaying the correct amount to charge you. You will be required to sign a signature log to prove you have received the prescription drug. You do not file a PAID prescription card claim with GEHA.

Some medications may require prior approval by Medco or GEHA.

Waiver

When Medicare Parts A and B are the primary payers, you do not have a prescription copay on any prescription received through the Mail Order Drug Program. If you use your identification card to buy your drugs through a participating pharmacy, there is no copayment for the initial amount prescribed by a doctor not to exceed a 30-day supply and the first refill. Subsequent refills are subject to a copayment of the greater of **$5** or **50%** of cost for generic drugs and **$15** or **50%** of cost for name brand drugs.

To claim benefits

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. Box 712
Parsippany, NJ 07054-0712

Your claim will be calculated on the **50%** coinsurance or **$15** or **$5** copayments described above. Reimbursement will be based on GEHA's cost had you used a participating pharmacy.

You must submit original drug receipts.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Prescription Drug Benefits *continued*

By mail

Through the Mail Order Drug Program, you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, ostomy supplies, diabetic supplies and insulin, syringes and needles for covered injectable medication, and oral contraceptives. You may receive refills of the original prescription for up to one year. You must pay a copayment of **$28** for name brand drugs and **$7** for generic drugs. Controlled substances may not be available in a 90-day supply from Merck-Medco RX even though the prescription is for 90 days. A **$28** or **$7** copayment is charged for each supply of medication received from Merck-Medco RX Services. Even though insulin, syringes, diabetic supplies and ostomy supplies do not require a physician's prescription, to obtain through mail order drug program you should obtain a prescription from your physician for a 90-day supply. Some medications may require prior approval by Medco or GEHA.

Each enrollee will receive an installment kit that includes a brochure describing the Mail Order Drug Program, including a Patient Profile Questionnaire, and a pre-addressed, postage paid order envelope.

Waiver

When Medicare Parts A and B are the primary payers, you do not have a prescription copay on any prescription received through the Mail Order Drug Program. In order to be eligible to receive prescriptions by mail with no copayments, you must have supplied proof of your enrollment in Parts A and B directly to Merck-Medco RX Services. (A photocopy of your Medicare card may be used to verify your enrollment in Medicare.)

Preferred Prescriptions voluntary formulary

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

A formulary is a list of commonly prescribed medications from which your physician may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other nonformulary medications, can help contain the increasing cost of prescription drug coverage without sacrificing quality.

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

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

To claim benefits

Complete the Patient Profile Questionnaire kit the first time you order under this program. Complete the information on the back of the pre-addressed, postage paid envelope, enclose your prescription(s) and your **$28** or **$7** copayment per prescription, and mail to:

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

Members should receive their medication within 14 days from the date they mail their prescription, along with reorder instructions and a postage paid reorder envelope.

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

Coordinating with other drug coverage

If you also have drug coverage through another carrier and GEHA is secondary, follow these procedures instead of those outlined above in order to receive maximum reimbursement:

At participating pharmacies, do not present your drug card. Purchase your drug and submit the bill to your primary carrier. When they have made payment, file the claim and Explanation of Benefits (EOB) with GEHA's claims office (see page 28). If you use GEHA's prescription drug card when another carrier is primary, you may be responsible for reimbursing GEHA any amount in excess of GEHA's secondary benefit.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Drug purchases at non-participating pharmacies should be submitted to GEHA's claims office (see page 28) along with the primary carrier's EOB. GEHA will accept either the drug receipts or a PAID Prescriptions, Inc. drug claim form. **Do not submit these claims to Paid Prescriptions, Inc. when GEHA is secondary.**

If another carrier is primary, you should use that carrier's drug benefit. If you elect to use the Mail Order Drug Program, Merck-Medco RX Services will bill you directly. Pay Merck-Medco RX the amount billed and submit the bill to your primary carrier. When they make payment, file the claim and the primary carrier's EOB to GEHA's claims office (see page 28).

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Dental Benefits

What is covered

The following is a complete list of preventive and restorative services covered by the Plan, subject to benefit limits.

Preventive care

Diagnostic and preventive services up to $22 a visit, 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.

Restorative care

ADA Code	Description	Plan Pays
	AMALGAM RESTORATIONS (including polishing)	
2110	Amalgam-one surface	$21
2120	Amalgam-two surfaces	$28
2130	Amalgam-three surfaces	$28
2131	Amalgam-four surfaces	$28
2140	Amalgam-one surface	$21
2150	Amalgam-two surfaces	$28
2160	Amalgam-three surfaces	$28
2161	Amalgam-four surfaces	$28
	SILICATE RESTORATION	
2210	Silicate cement per restoration	$21
	SILICATE OR PLASTIC OR COMPOSITE RESTORATIONS	
2330	Acrylic or plastic or composite resin-one surface	$21
2331	Acrylic or plastic or composite resin-two surfaces	$28
2332	Acrylic or plastic or composite resin-three surfaces	$28
2335	Acrylic or plastic or composite resin-involving incisal angle or four or more surfaces	$28
2337	Composite resin-one surface	$21
2338	Composite resin-two surfaces	$28
2339	Composite resin-three surfaces	$28
	GOLD FOIL RESTORATIONS	
2410	Gold Foil- one surface	$21
2420	Gold Foil- two surfaces	$28
2430	Gold Foil- three surfaces	$28
2435	Gold Foil- three surfaces including inlay	$28
	GOLD INLAY RESTORATIONS	
2510	Gold Inlay- one surface	$21
2520	Gold Inlay- two surfaces	$28
2530	Gold Inlay- three surfaces	$28
	PORCELAIN RESTORATIONS	
2610	Porcelain Inlay- one surface	$21
2620	Porcelain Inlay- two surfaces	$28
2630	Porcelain Inlay- three surfaces	$28

Extractions

	SIMPLE EXTRACTIONS (includes local anesthesia and post-operative care)	
7110	Single tooth	$21
7120	Each additional tooth	$21
7210	Surgical Extractions (each)	$21

There is no limit to the number of covered fillings or extractions in a calendar year.

Related benefits

Oral and maxillofacial surgery

For covered oral surgery, see page 15.

What is not covered

- Orthodontia, periodontal and any other services not listed as covered

How to Claim Benefits

Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 800/821-6136 to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you have a question concerning Plan benefits, contact the Carrier at 800/821-6136 or you may write to the Carrier at P.O. Box 4665, Independence, MO 64051-4665. You may also contact the Carrier by fax at 816/257-3233, at its website at http://www.geha.com or by e-mail at cs.geha@geha.com.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with providers.

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA 1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted 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 enrollee
- Name and address of person or firm providing the service or supply
- Dates that services or supplies were furnished
- Type of each service or supply and the charge
- Diagnosis

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer must be sent with your claim.
- A copy of the Medicare Summary Notice (MSN) if Medicare is primary must be sent with your claim.
- Bills for private duty nurses 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 doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and medicine that are not ordered through the mail order drug program must include a receipt that includes prescription number, name of drug, prescribing doctor's name, date and charge.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. If possible, include a receipt showing the exchange rate on the date the claimed services were performed.
- To control administrative costs, the Plan will not issue benefit checks that do not exceed $1.

Canceled checks, cash register receipts or balance due statements are not acceptable.

After completing a claim form E-1 and attaching proper documentation, send claims to:

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

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

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. The Carrier will not provide duplicate or year end statements.

Submit claims promptly

Claims should be filed within 90 days from the date the expense for which claim is being made was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. The Plan will not accept a claim submitted later than December 31st of the calendar year following the one in which the expense for which the claim is being made was incurred, except where the enrollee was legally incapable. Once benefits have been paid, there is a three year limitation on the reissuance of uncashed checks.

Direct payment to hospital or provider of care

If you wish to authorize direct payment to a hospital, in addition to filing the Employee Statement of Claim (E-1), show your identification card upon admission. The hospital will furnish their own form or will send an itemized statement to GEHA. Payments may be made directly to providers of service even when assignment has not been submitted, unless evidence is submitted that member has paid provider.

Submit hospital and doctor bills itemized to show:

- name of the person for whom service was rendered;
- name of the attending doctor and/or admitting hospital and address; and
- date charge was incurred, statement of the diagnosis, treatment rendered and amount of the charge for each service.

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used only: 1) by the Carrier and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education. As part of its administration of the prescription drug benefits, the Plan may disclose information about the member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

Disputed claims review

Reconsideration

If a claim for payment is denied by the Carrier, you must ask the Carrier, in writing, and, within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.)? Indicate any complications of any surgical procedure(s) performed. Include copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment should have been paid.

Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information, it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Carrier's letter affirming its initial denial.

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Carrier requesting reconsideration;
- A copy of the Carrier's reconsideration decision (if the Carrier failed to respond, provide instead (a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement - If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

Protection Against Catastrophic Costs

Catastrophic protection

For those services with coinsurance, the Plan pays **100%** of reasonable and customary charges for the remainder of the calendar year after out-of-pocket expenses for coinsurance exceed**:**

- $3,000 for Self and Family and $2,500 for Self Only if you use PPO providers
- $4,000 for Self and Family and $3,500 for Self Only if you use non-PPO providers. Any of the above expenses for PPO providers also count toward this limit. Therefore your eligible out of pocket expenses will not exceed this amount whether or not you use PPO providers

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

- The **10%** you pay for PPO charges under Inpatient Hospital (other charges), outpatient hospital charges and Other Medical and Surgical Benefits
- The **20%** you pay for Non-PPO charges under Inpatient Hospital (Other charges), Other Medical, Surgical and Maternity Benefits

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

- The $250 calendar year deductible;
- The $10 copayment for doctor's office visits, X-ray and laboratory tests;
- The $75 copayment for hospital emergency room expenses;
- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Expenses for well child care and immunization;
- Expenses for mental conditions, substance abuse, dental and chiropractic care;
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see page 5 and 33).
- Expenses for prescription drugs purchased through retail or Mail Order Drug Program.

Mental conditions and outpatient substance abuse

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

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

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

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

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Expenses for outpatient psychotherapy sessions in excess of 30 sessions per year;
- Expenses for inpatient care in excess of 100 days per year.
- Expenses for inpatient provider visits in excess of 100 visits per year.
- Expenses for Intensive Day Treatment in excess of 60 days per year.
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see page 5 and 33).
- Expenses for prescription drugs purchased through retail or Mail Order Drug Program.
- Expenses in excess of the **50%** of reasonable and customary charges for inpatient substance abuse charges.

Carryover

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

Information You Have A Right To Know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 800/821-6136 or you may write the Carrier at P.O. Box 4665, Independence, MO 64051-4665. You may also contact the Carrier by fax at 816/257-3233, at its website at http://www.geha.com or by e-mail at cs.geha@geha.com.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Precertification

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. **It is your responsibility to ensure that precertification is obtained.** If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500.

To precertify a scheduled admission:

- You, your representative, your doctor or your hospital must call Intracorp prior to admission. The toll-free number is 800/747-GEHA (800/747-4342) and is available 24 hours per day.
- 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 of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

Intracorp will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Carrier's precertification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 34-36). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States and Puerto Rico.

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 800/747-GEHA within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by $500.

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within two business days following the day of the mother's discharge. Intracorp offers a high risk pregnancy program at no cost to you. To take full advantage of this service and obtain valuable information concerning prenatal care, you should call Intracorp at 800/747-GEHA as soon as your pregnancy is confirmed.

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless the Carrier is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary, the inpatient hospital benefits will not be paid. However, medical supplies and services otherwise payable on an outpatient basis will be paid.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by $500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect primary/secondary status of this Plan and Medicare (see pages 8-10).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both a FEHB plan and Medicare.

This Plan is primary if:

1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;

2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;

3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or

4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Medicare is primary if:

1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;

2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;

3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);

4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;

5) You are enrolled in Part B only, regardless of your employment status;

6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Part A and B); or

7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;

8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or

9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is primary

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived as follows:

Inpatient Hospital Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance applicable to surgical and medical care.

Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A, the Plan waives the inpatient deductible and coinsurance for hospital charges. If you are enrolled in Medicare Part B, the Plan waives the deductible and coinsurance for doctors' inpatient services and outpatient care.

Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan waives the calendar year deductible and coinsurance.

Additional Benefits: If you are enrolled in both Medicare Parts A and B, the Plan waives the coinsurance for outpatient treatment.

Prescription Drugs: If you have Medicare Parts A and B, the Plan will waive the copayment on the Mail Order Drug Program. If you use your identification card to buy your prescription drugs through a participating pharmacy, there is no copayment for the initial amount prescribed by doctor not to exceed a 30-day supply and the first refill. Subsequent refills are subject to a copayment of the greater of **$5 or 50%** of cost for generic drugs and **$15 or 50%** of the cost for name brand drugs.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its 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 enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment; that is, they have agreed not to bill you for more than the **Medicare-approved amount** for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the limiting charge, is 115 percent of the Medicare-approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid **only** if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. The Medicare Summary Notice (MSN) will have more information about this limit.

If your doctor does not participate with Medicare, asks you to pay more than the limiting charge **and** he or she is under contract with this Plan, call the Plan. If your doctor is **not** a Plan doctor, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare Summary Notice (MSN) . In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is primary if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. The Carrier has contracted with most Medicare Part B claims processors (also known as the carriers) to receive electronic copies of your claims after Medicare has rendered payment of their benefits, thus eliminating the need for you to submit your Part B claims to this Carrier. If you completed and returned a "GEHA Express" participation form or received notice that you were pre-enrolled in the "GEHA Express" program and did not decline to participate, you are included in this program. You may call the Plan's "GEHA Express" toll-free number, 800/282-4342, to obtain additional information about this program.

If your Medicare Part B carrier has not made arrangements with this Plan to receive electronic claims, you should initially submit your claims to Medicare and, after Medicare has paid its benefits, this Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, you must submit the Medicare Summary Notice (MSN) form from Medicare and duplicates of all bills along with a completed claim form. This Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare Summary Notice (MSN) .

Enrollment Information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to claim benefits" on pages 28-30.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system (see "Effective date" on page 40). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see "If you are hospitalized" below.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you a FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.

- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB Plan.
- Report additions and deletions (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

  You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 35 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

  Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will pay for only 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date, and coverage may not exceed the 18 or 36-month period noted above.

Notification and election requirements:

- **Separating employees -** Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.
- **Children -** You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.
- **Former spouses -** You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events, the date of the qualifying event; or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available - or chosen - when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Definitions

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 Carrier to issue payment of benefits directly to the provider. The Carrier 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.

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 Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

Cosmetic procedure

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.

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; exercising; 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.

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

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.

Hospice care program

A coordinated program of home and inpatient palliative and supporting care for the terminally ill patient and the patient's family that is provided by a medically supervised team under the direction of a Plan approved independent Hospice Administration.

Hospice care agency - an agency or organization which meets all of the following:

(1) provides hospice care 24 hours a day;

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

(3) is staffed by at least one doctor (M.D., D.O.), one R.N., one licensed or certified social worker, and has a full-time administrator;

(4) provides for skilled nursing services, medical social services, psychological counseling, dietary counseling; and

(5) provides an ongoing quality assurance program.

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.

Medically necessary

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Carrier 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 conditions/ 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 Carrier; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Prompt repair

The Carrier considers prompt repair of an accidental injury to be services rendered within the consecutive 90-day period following the date of an accidental injury or as soon as the member's medical condition permits.

Reasonable and customary

The Carrier allows benefits, unless otherwise indicated, to the extent that they are reasonable and customary. The reasonable and customary charge for any service or supply is the usual charge for the service or supply in the absence of insurance. The usual charge may not be more than the general level of reasonable and customary charges for illness or injury of comparable severity and nature made by other providers within the geographic area in which the service or supply is provided. This is generally determined by the use of prevailing health care charges guides such as that prepared by the Health Insurance Association of American (HIAA) and is updated at least annually. HIAA guides are applied at the 80^{th} percentile to surgery, doctor's services, therapy (physical, speech and occupational), X-ray and lab expenses. The Carrier may apply charge guides for other services, such as anesthesiology or outpatient facility charges, as such data become available. When there are exceptions to this general method of determining the reasonable and customary charge, such as when HIAA data is unavailable or services occur infrequently, the Carrier may determine the reasonable and customary charge based on other credible data sources available, such as charge guides prepared by Medical Data Research (MDR), applied at a comparable percentile level, and statistically derived charges developed by the Carrier or by MediRisk, Inc. The Carrier may also conduct independent geographic surveys to determine the usual cost of a service or supply in the area. If the Carrier negotiates a reduced fee amount on an individual claim for services or supplies which is lower than the reasonable and customary amount, covered benefits will be limited to the negotiated amount. Your coinsurance will be based on the reduced fee amount. When a PPO provider is used, or when the Plan negotiates with a non-PPO provider a reduced fee amount on an individual claim, the fee that has been negotiated is considered the reasonable and customary charge.

Sound natural tooth

Tooth with normal, healthy periodontium and adequate sound healthy dentin and enamel to withstand normal masticatory forces.

Index

Non-FEHB Benefits Available to Plan Members

Your GEHA membership is enhanced through five GEHA CONNECTION programs.

FREE PROGRAMS – No additional premium is required.

GEHA members have FREE access to national networks for dental, vision and hearing care. Participating providers offer reduced fees, discounts and other services for GEHA members. No special enrollment or fees are required. There are no claims to file. Simply call the toll-free numbers below to find participating providers in your area. Show your CONNECTION ID card before you receive services.

CONNECTION Dental 800/296-0776

Participating dentists agree to limit their charges to a reduced 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. CONNECTION Dental currently has more than 19,000 participating dentists. If your dentist is not yet part of the network, ask your dentist to call GEHA for a CONNECTION Dental information packet.

CONNECTION Vision 800/800-EYES

Through CONNECTION Vision, GEHA members get discounts off the retail price of lenses, frames and specialty items such as tints, lightweight plastics and scratch-resistant coatings; a 30-day satisfaction refund guarantee; and a 30-day lowest price guarantee on a complete set of eyewear. For discounts on mail-order contact lenses and non-prescription sunglasses, call 800/878-3901. This program is available through Coast to Coast Vision, a national company with more than 9,000 locations nationwide.

CONNECTION Hearing 800/456-6801

Through CONNECTION Hearing, GEHA members get a free hearing evaluation, a 20 percent discount off the retail price of hearing aids, a 30-day satisfaction refund guarantee, free unlimited follow-up visits, and free annual checkups of hearing aids. Members, their covered dependents and member/spouse's parents and grandparents are eligible. The member must be present with his/her CONNECTION ID card for family members to receive CONNECTION Hearing benefits.This program is available through Miracle Ear, a national hearing aid company with more than 1,500 locations to serve you.

SUPPLEMENTAL Programs – Available for an additional premium

CONNECTION Dental *Plus* 800/793-9335

CONNECTION Dental *Plus* is a comprehensive dental benefit plan that supplements regular GEHA dental coverage. Benefits are payable for more than 140 dental procedures including crowns, root canals, gum surgery, bridgework, dentures, and orthodontia and routine care such as cleanings, exams and fillings. Enrollment for members is open year-round. This optional supplemental dental insurance is provided directly by GEHA.

CONNECTION Long-Term Care 888/469-GEHA

CONNECTION Long-Term Care offers GEHA members a 10 percent premium discount on long-term care insurance, with additional discounts 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.

Benefits described on this page are neither offered nor guaranteed under contract with the FEHB Program, but are made available to GEHA members and their covered dependents enrolled in GEHA in 1999. The cost of CONNECTION programs is not included in the health plan premium you pay. Charges for these services do not count toward your GEHA deductible or out-of-pocket maximum. The GEHA PPO copayment does not apply. CONNECTION benefits are not subject to the FEHB disputed claims procedure. GEHA does not guarantee that providers are available in all areas or that prices at a participating provider are lower than prices that may be available from a non-participating provider.

Benefits on this page are not part of the FEHB contract.

How GEHA Changes January 1999

Do not rely on this page. It is not an official statement of benefits.

Benefit changes

Program-wide Changes

- Several changes have been made in compliance with the President's mandate to implement the recommendations of the Patient Bill of Rights.
- The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. **Office visits for the medical aspects of treatment do not count toward the 30 outpatient Mental Conditions visit limit.**
- If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.
- The definition of experimental or investigational now applies to biological products.
- The States designated as medically underserved have changed for 1999. Idaho and North Dakota have been added, and West Virginia is no longer underserved. See page 6 for details.

Changes to this Plan

- For 1999, all member out-of-pocket expenses subject to the catastrophic limit, PPO and non-PPO alike, will accumulate until the $2,500/$3,000 limit is reached. Thereafter, PPO expenses will be paid in full by GEHA, but non-PPO out-of-pocket expenses will continue to be the member's responsibility until the $3,500/$4,000 limit is reached. Previously GEHA had a single catastrophic limit of $2,500 self only/$3,000 family for both PPO and non-PPO expenses.
- Hospital outpatient emergency room charges are now subject to a $75 copayment. Previously hospital outpatient emergency room charges were subject to the deductible and paid at 95% for PPO hospitals and 80% for non-PPO hospitals. The $75 copayment cannot be counted toward the out-of-pocket expenses maximum.
- The copayment for drugs obtained through the Mail Order Program has increased to $28 for name brand drugs . Previously the copayment was $25 for name brand drugs.
- The calendar year deductible has changed to $250. Previously the calendar year deductible was $175.
- The family limit on deductibles has changed to $500 during a calendar year. Previously the family limit on deductibles was $350.
- The PPO benefit for other hospital charges (inpatient and outpatient) has changed to 90%. Previously other hospital charges at PPO hospitals were paid at 95%. Hospital Room and Board expenses continue to be paid at 100%.
- Acupuncture benefits are limited to 20 treatments in a calendar year. Previously there was no limit on the number of visits.
- If you do not use a PPO Provider, GEHA pays benefits based on the reasonable and customary (R&C) cost of a service or supply in an area. This is determined using the Health Insurance Association (HIAA) prevailing health care charges guides. For 1999, HIAA guides will be applied at the 80th percentile. Previously, HIAA guides were applied at the 90th percentile. This means that your out of pocket costs will increase if 1) you receive services from a non-PPO Provider AND 2) your provider's charges are in the top 20 percent of provider charges in your area.
- Benefits for autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for breast cancer, multiple myeloma or epithelial ovarian cancer are limited to a maximum of $100,000 per transplant if not performed at a plan designated transplant facility. Previously no benefits were payable if not performed at a plan designated transplant facility.

- Benefits for the diagnosis and treatment of infertility will be subject to a $3,000 calendar year maximum per person. Previously infertility benefits were subject to a $5,000 lifetime maximum per person. Drugs to treat infertility are not covered and were not previously covered.
- The brochure has been clarified to show that treatment of impotency is not covered, regardless of the cause. Previously benefits were paid in some cases for treatment of organic impotency.
- Some Ambulatory Surgery Centers that were not previously covered will be covered. See criteria for "Freestanding ambulatory facility" on page 5. Reasonable and customary data will be applied to facility charges and surgery performed in Ambulatory Surgery Centers.
- The PPO network has changed in some states. United Payors and United Providers, Inc. has been replaced by PPO USA in some areas. National Preferred Provider Network, Inc. has been replaced by Community Care Network, Inc. Private Healthcare Systems, SouthCare, and Up & Up. Members will receive a PPO directory for their area and are advised to call providers to confirm participation before receiving care.

Summary of Benefits for GEHA Benefit Plan - 1999

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $250 calendar year deductible.

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	**Non-PPO benefit: 100%** room and board, **80%** of other hospital charges **PPO benefit: 100%** room and board; **90** % of other hospital charges	12
	Surgical	**Non-PPO benefit: 80%*** of covered surgical charges, including oral surgery **PPO benefit: 90%*** of covered surgical charges	13-15
	Medical	**Non-PPO benefit: 80%*** of covered professional services **PPO benefit: 90%*** of covered professional services	19-22
	Maternity	**Non-PPO benefit:** Same benefits as for illness or injury **PPO benefit: 100%** of covered services	16-17
	Mental Conditions	**50%** of covered hospital charges after a separate **$500** deductible has been met. For professional services, the Plan pays **50%*** of the reasonable and customary charge of covered providers for hospital visits including psychotherapy sessions**.** Inpatient days and provider inpatient visits are limited to 100 per calendar year	18
	Substance Abuse	One inpatient substance abuse treatment program (30 day maximum) per member per lifetime. The Plan pays **50%** of the reasonable and customary charges subject to the **$500** hospital inpatient and intensive day treatment deductible	18
Outpatient care	**Hospital**	**Non-PPO benefit: 80%*** of covered hospital charges **PPO benefit: 90 %*** of covered hospital charges	19-20
	Surgical	**Non-PPO benefit: 80%*** of covered surgical charges, including oral surgery **PPO benefit: 90%*** of covered surgical charges	13-15
	Medical	**Non-PPO benefit: 80%*** of other covered professional services **PPO benefit:** $10 copay per covered office visits including X-ray and lab, and **90%*** of other covered professional services	19-22
	Maternity	**Non-PPO benefit:** Same benefits as for illness or injury **PPO benefit: 100%** of covered services	16-17
	Skilled Nursing Care	**Non-PPO benefit: 80%*** limited to two hours per day for 25 visits in a calendar year **PPO benefit: 90%*** limited to two hours per day for 25 visits in a calendar year	21
	Mental Conditions/ Substance Abuse	For professional services, the Plan pays covered providers for home and office visits for psychotherapy sessions, including group sessions, up to a maximum of **30** sessions per calendar year, and up to a maximum payable of 50%* of the reasonable and customary charge per session. The Plan pays **50%** for Intensive Day Treatment up to 60 visits per year subject to the inpatient and intensive day treatment **$500** deductible	18
Emergency care	**Accidental Injury Illness**	**100%** of covered charges (no deductible) incurred within 72 hours of an accident **$75** copayment for outpatient hospital emergency room charges	23 19
Prescription drugs	**From a pharmacy**	Member pays **$15** for name brand or **$5** for generic drugs for 30-day supply for initial prescription and one refill. Subsequent refills are paid at **50%**	24
	By mail	Member pays **$28** for name brand, **$7** for generic drugs for 90-day supply of maintenance medications and oral contraceptives	25
Dental care		Routine preventive dental care and accidental injury to sound natural teeth	27
Additional benefits		Accidental injury, Well Child Care, 24-Hour nurse phone service	23
Protection against catastrophic costs		**100%** after applicable coinsurance reaches **$3,000** (Self and Family) or **$2,500** (Self Only) for PPO providers; **$4,000** Self and Family or **$3,500** Self Only for non-PPO providers	31
		100% for Mental Conditions and Outpatient Substance Abuse Benefits after applicable coinsurances and deductible reach **$8,000** for all covered family members combined. No benefits are payable for inpatient days and visits in excess of 100 or Intensive Day Treatment in excess of 60 days per calendar year	31

1999 Rate Information for Government Employees Hospital Association, Inc. 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 most career U.S. Postal Service employees, but do not apply to non-career employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		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
Self Only	311	$72.06	$36.25	$156.13	$78.54	$84.98	$23.33
Self and Family	312	$160.39	$73.21	$347.51	$158.62	$183.29	$50.31

Addendum to 1999 Brochure

For members residing in the Omaha, Nebraska, area, a pilot program of enhanced PPO benefits is available through the **GEHA's PPO USA Network.**

To be eligible for GEHA Select benefits, you must enroll in the GEHA Select plan by completing an application form and submitting it to GEHA prior to December 31, 1998. You must also comply with all requirements of the GEHA Select program including residing and receiving program benefits from PPO providers in the Omaha service area.

GEHA Select benefits are as follows:

Hospital inpatient

At PPO hospitals, there is no deductible if the admission is precertified. Covered expenses are paid at **100%** of the negotiated amount, after a **$75** copayment per confinement.

Precertification by Intracorp is required at least 24 hours prior to admission. Emergency admissions must be certified the day of admission. To precertify a hospital admission call 800/747-GEHA (4342).

Hospital outpatient and ambulatory surgical centers

At PPO hospitals and PPO Ambulatory Surgical Centers, there is no deductible. Covered expenses are paid at **100%** of the negotiated amount, after a **$25** per visit copayment. Prior approval of the outpatient hospital service and ambulatory surgical centers services by Intracorp is required.

Hospital emergency room, non-accident

At PPO hospitals, there is no deductible. Covered expenses are paid at **100%** of the negotiated amount, after a **$50** copayment.

Hospital emergency room within 72 hours of accidental injury

100% of covered expenses.

Physicians outpatient treatment

For PPO primary care physicians and preapproved referrals by Intracorp to PPO specialists, there is no deductible. Covered expenses are paid at **100%** of the negotiated amount, after a **$5** copayment for each visit. A separate **$5** copayment applies to each PPO provider who renders service.

Physician inpatient treatment (surgical and medical)

For PPO primary care physicians and preapproved PPO specialists, there is no deductible. Covered services are paid at **100%** of the negotiated amount if the hospital stay was approved in advance by Intracorp for GEHA Select reimbursement.

All GEHA Select copayments except the **$5** physician copayment apply to the out-of-pocket limit described in the GEHA brochure.

Maternity

At PPO hospitals and for PPO physicians, there is no deductible or copayment. Benefits are paid at **100%** of the negotiated amount.

Precertification by Intracorp is required. Newborn confinements that extend beyond the mother's discharge must also be precertified. Intracorp offers a high risk pregnancy program at no cost to you. To take full advantage of this service and obtain valuable information concerning prenatal care, you should call Intracorp at 800/747-GEHA (4342) as soon as your pregnancy is confirmed.

Program requirement

When you enroll in GEHA Select, you may receive GEHA Select benefits for visits to PPO primary care physicians, PPO specialists or PPO hospitals.

To qualify for GEHA Select benefits, no prior referral or approval is necessary for visits to GEHA Select PPO primary care physicians. GEHA Select PPO primary care physicians are network physicians in family practice, general practice, internal medicine, obstetrics/gynecology and pediatrics. Prior approval from Intracorp is required for visits to any other provider.

To receive GEHA Select benefits for services rendered by a physician specialist, you must receive authorization from Intracorp prior to the visit to the specialist. The specialist must participate in the PPO Network.

If you have a chronic, complex or serious medical condition that causes you to see a PPO specialist frequently, Intracorp will work with your doctor to develop a treatment plan for you that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

To obtain GEHA Select benefits for outpatient hospital services, you must receive care at a PPO hospital and receive prior approval of the hospital outpatient service by Intracorp.

To obtain approval for referrals to specialty physicians and outpatient hospital services, call 800/747-GEHA (4342).

PPO hospitals, PPO primary care physicians, and PPO specialists are shown in your PPO directory, or you may call 800/747-GEHA (4342) to obtain names of PPO hospitals, PPO primary care physicians, and PPO specialists in your area.

Program limitations

All regular Plan limitations on benefits described in the GEHA brochure apply to GEHA Select benefits. These include lifetime limits on durable medical equipment, vision therapy and calendar year limit on infertility expenses. Physical, Speech, and Occupational therapy services are not eligible for GEHA Select benefits. Calendar year limits on the number of occupational, speech and physical therapy visits listed in the brochure apply.

Requirements for approval of transplant procedures and use of designated transplant facility as outlined in the GEHA brochure apply.

When regular plan benefits apply

GEHA Select benefits do not apply to prescription drug benefits, mental conditions and substance abuse benefits, dental benefits, and chiropractic benefits.

For services in the Omaha, Nebraska area, if you do not use a PPO hospital, PPO primary care physician, or PPO specialist, and/or do not obtain approval by Intracorp as required, regular non-PPO plan benefits apply as described in the GEHA brochure.

Services outside the Omaha, Nebraska area are not eligible for GEHA Select benefits. PPO benefits (90%) apply outside the Omaha area if a PPO provider is used.

How GEHA Select changes 1999

- If GEHA Select program requirements for authorization from Intracorp are not met, benefits will be paid at the non-PPO benefit (80%) as described in the GEHA brochure.

  Previously, if Program requirements for authorization from Intracorp were not met PPO benefits as described in the GEHA brochure (95% or 90%) would be paid if the provider participates in the PPO.