Government Employees Hospital Association, Inc. Benefit Plan 2000

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 the Year 2000.

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

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Introduction

Government Employees Hospital Association, Inc.
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This brochure describes the benefits you can receive from the GEHA Benefit Plan under its contract, CS1063, with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually, they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000, and are shown on pages 6 and 7. You do not have a right to benefits that were available before January 1, 2000, unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Government Employees Hospital Association, Inc. as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

How to use this brochure

This brochure has ten sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Fee-for-Service Plan (FFS). This Plan is a FFS Plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.

4. What if we deny your claim or request for preauthorization. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. How to file a claim. Look here to find specific information on how to file claims with us.

7. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

8. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

9. Fee-for-Service Facts. This section contains information about precertification, protection against catastrophic expenses, and a definition section.

10. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Fee-for-Service Plans

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

The FFS plan reimburses you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan. The type and extent of covered services varies by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

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

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, PPO Oklahoma, PPO USA, SouthCare and United Payors & United Providers, Inc. (UP&UP), which are Preferred Providers or networks of hospitals and/or doctors in all states. The doctors and hospitals participating in these networks have agreed to provide services to Plan members. You always have the right to choose a PPO provider or a non-PPO provider for medical treatment.

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 13 and 39 of this brochure.

When a PPO participating doctor is used, the Plan will increase its payment to **90%** for those services normally paid at **75%.** If a non-PPO provider is utilized, the Plan will pay benefits as shown in this brochure.

Section 1. Fee-for-Service Plans *continued*

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

Section 2. How we change for 2000

Program-wide changes

- This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.
- If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your provider is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90 day period expires.
- You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.
- If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- Your share of the premium will increase by 26.1% for Self Only or 26.6% for Self and Family.
- The copayment for doctor's office visits has increased to $15. Previously the copayment was $10.
- Services rendered by the doctor in conjunction with an office visit such as diagnostic X-rays and laboratory tests will be subject to the calendar year deductible and paid at 90% if the provider is in the PPO network. Previously these charges were paid at 100% after the office visit copayment.
- The coinsurance for non-PPO providers will be 75%. Previously the coinsurance for non-PPO providers was 80%.
- The calendar year deductible will be $300. Previously the calendar year deductible was $250.
- The family limit on deductibles will be $600. Previously the family limit on deductibles was $500.
- The copayments at Mail Order for non-Medicare members, including members with Part A or Part B only, will be $10 for generic drugs and $30 for brand name drugs. Previously the copayments at Mail Order were $7 for generic drugs and $28 for brand name drugs.
- Members with Medicare Part A & B primary will now have a copayment for drugs at Mail Order and Retail. At Mail Order the copayment for members with Medicare A & B is $5 for generic drugs and $15 for brand name drugs. At retail the copayment is $3 for generic drugs and $10 for brand

Section 2. How we change for 2000 *continued*

name drugs for the initial prescription and first refill. For subsequent refills at retail the copayment is the greater of $3 or 50% for generic drugs and the greater of $10 or 50% of brand name drugs. Previously members with Medicare A & B did not have a copayment at Mail Order or for the initial prescription and first refill at retail.

Section 3. How to get benefits

How do I keep my health care expenses down?

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 39 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.

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.

How much do I pay for services?

You must share the cost of some services. These cost sharing measures include deductibles, coinsurance and copayments. These and other measures are described in more detail below.

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.

Section 3. How to get benefits *continued*

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 $300. When combined covered expenses applied to the deductible for all family members reach $600 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 $300 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 $600 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 $300 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 **75%** of reasonable and customary charges for a covered service, you are responsible for **25%** 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 **75%** of the allowance ($71.25). You must pay the **25%** coinsurance ($23.75), plus the difference between the actual charge and the usual, reasonable and customary allowance ($5), for a total member responsibility of $28.75. 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 38), 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 $30 per prescription by mail or $15 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

Section 3. How to get benefits *continued*

ordinarily charges $100 for a service but routinely waives the **25%** coinsurance, the actual charge is $75. The Plan will pay $56.25 (**75%** of the actual charge of $75).

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.

Do I have to submit claims?

You usually do not have to submit claims to us if you use preferred providers. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Please see section 6, How to file a claim, for specific information you need to know before you file a claim with us.

Who provides my health care?

In a Fee-for-Service Plan, you may choose any covered facility or provider.

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

Section 3. How to get benefits *continued*

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 operating 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 2000, the States designated as medically underserved are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, South Carolina, South Dakota, Utah and Wyoming.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 800/821-6136. If you are new to the FEHB Program, we will reimburse your covered expenses. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

What if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. If it is, you may be able to continue seeing your provider for up to 90 days after you receive notice that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

If you continue seeing your specialist or OB/GYN under these conditions, your cost will be no more than you would normally pay for the services covered.

How do you decide if a service is 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

Section 3. How to get benefits *continued*

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.

Section 4. What if we deny your claim or request for preauthorization

What should I do before filing a disputed claim?

Before you ask us to reconsider your claim, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did the provider use the correct procedure code for the services performed (surgery, laboratory test, X-ray, office visit, etc.)? Have your provider indicate any complications of any surgical procedures performed. Your provider should also include copies of an operative or procedure report, or other documentation that supports your claim.

If we deny your request for preauthorization or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Approve your request for preauthorization; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for preauthorization.

What if I have a serious or life threatening condition and you haven't responded to my request for preauthorization?

Call us at 800/821-6136 and we will expedite our review.

Section 4. What if we deny your claim or request for preauthorization *continued*

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your request, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division II at 202/606-3818 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;

2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;

3. Copies of all letters you sent us about the claim;

4. Copies of all letters we sent you about the claim; and

5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;

2. The estate of a person once enrolled in the Plan; and

3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

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

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

Section 4. What if we deny your claim or request for preauthorization *continued*

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

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 39 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 page 34.

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.

PPO benefit

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

Non-PPO benefit

The Plan pays **75%** 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.

Section 5. Benefits *continued*

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 20-24) and Surgical Benefits (pages 14-17).

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 41), 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.

Surgical Benefits

What is covered

The Plan pays for the following services:

After the $300 calendar year deductible has been met, the Plan pays as follows for surgery performed on either an inpatient or outpatient basis:

PPO benefit

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

Non-PPO benefit

75% 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:

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 procedures

Non-PPO benefit

75% of the full reasonable and customary charge for the primary procedure

75% of half of the reasonable and customary charge for the secondary procedure

75% of 25% of the reasonable and customary charge for subsequent procedures

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

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

Section 5. Benefits *continued*

- 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
- surgically-induced sterilization, even if elective
- surgical correction of congenital anomalies (see Definitions)
- breast reconstruction surgery following a mastectomy, including surgery to produce a symmetrical appearance of the other breast. Benefits will be provided for all stages of breast reconstruction following a mastectomy, including treatment of any physical complications, including lymphedemas, and for breast prostheses, including surgical bras and replacements.

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 $300 calendar year deductible has been met, the Plan pays as follows for professional fees for the administration of anesthesia:

PPO benefit

90% of reasonable and customary charges

Non-PPO benefit

75% of reasonable and customary charges

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;

Section 5. Benefits *continued*

- 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 75% 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.

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.

Section 5. Benefits *continued*

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 24).

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.

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.

Section 5. Benefits *continued*

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 39 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 13)

PPO benefit

The Plan pays **100%** of other hospital charges (as explained on page 13)

Non-PPO benefit

The Plan pays **75%** of other hospital charges (as explained on page 13)

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 $300 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..

PPO benefit

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

Non-PPO benefit

The Plan pays **75%** of reasonable and customary charges incurred in or out of the hospital

Related benefits

Contraceptive devices and drugs

Devices and drugs obtainable only by written prescription (see pages 25 and 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 15)

Well child care

Routine doctor visits and immunizations are paid under Additional Benefits (see page 25).

Wellness program

See page 25 for additional services available for you.

For whom

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

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

Section 5. Benefits *continued*

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.

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 39 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 $300 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 39 for details.

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

Section 5. Benefits *continued*

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 $300 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 $300 calendar year deductible has been met, the Plan pays expenses for the services listed below and on page 21-24 as follows except where noted:

PPO benefit

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

You pay a $15 copayment for the doctor's professional fee for each office visit. These expenses are not subject to the $300 calendar year deductible nor counted toward the maximum out of pocket limits.

Services rendered by the doctor or any other provider in conjunction with the office visit such as diagnostic X-ray or laboratory tests will be subject to the annual deductible of $300 and are paid at 90%.

Non-PPO benefit

The Plan pays **75%** of reasonable and customary charges

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

- Allergy treatment
- Anesthetics and their administration

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

Section 5. Benefits *continued*

- Artificial eyes and limbs and orthopedic devices other than orthotics
- Chemotherapy
- Breast prostheses and bras following a mastectomy.
- 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

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

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 $300 calendar year deductible nor counted toward the maximum out-of-pocket limits.

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 $300 calendar year deductible nor counted toward the maximum out-of-pocket limits.

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.

Section 5. Benefits *continued*

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.
Non-PPO benefit	The Plan pays **75%** of covered charges
Routine and preventive services	In addition to coverage on page 21 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
	Coverage of one sigmoidoscopy every five years beginning at age 50
Prostate cancer screening	Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older
Routine physical	Routine physical examinations and diagnostic laboratory tests, including pap smears, cholesterol screenings, and X-rays.
Immunizations	Influenza and pneumonia
	Tetanus and diptheria

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.

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

Section 5. Benefits *continued*

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 Medical Management 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 $300 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.

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.

Section 5. Benefits *continued*

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 physical therapist, are available up to a total of 50 visits per calendar year.

Prior to beginning physical therapy treatments, you should contact our Medical Management Department to preauthorize benefits. Continuing physical therapy claims will be subject to concurrent review for medical necessity. Physical therapy claims will be denied if the plan determines the therapy is not medically necessary. Please preauthorize.

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 one visit up to two hours per day of skilled nursing care for up to a total of 25 visits per calendar year. Covered services are based on 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.

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 42)
- 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 16)
- Treatment, other than by surgery, of Temporomandibular Joint (TMJ) dysfunction and disorders.
- Custodial care (as defined on page 41)
- Wigs
- Lifts, such as seat, chair or van lifts

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 13) 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.

Section 5. Benefits *continued*

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

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 24). 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

Section 5. Benefits *continued*

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 a doctor not to exceed a 30-day supply and the first refill, you pay **$5** for generic drugs and **$15** for brand name 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 **$5** or **50%** coinsurance for generic drugs or the greater of **$15** or **50%** coinsurance for brand name 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. As part of the administration of the prescription drug program, GEHA reserves the right to maximize the participant's quality of care as it relates to the utilization of pharmacies. 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.

Medicare copayments

If you have Medicare A & B primary, you pay a smaller copay for your prescriptions:

At a PAID Pharmacy you pay:
New Prescription and first refill: **$3** generic, **$10** brand name
Second and subsequent refills: **$3** or **50%** whichever is greater for generic, **$10** or **50%** whichever is greater for brand name.

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.

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 **$10** for generic drugs and **$30** for brand name 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 **$30** or **$10** 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. Not all drugs are available through Mail Order. 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.

Section 5. Benefits *continued*

Medicare copayments

If you have Medicare A & B primary, you pay a smaller copay for your prescriptions:

At Mail Order:
$5 for 90 day supply of generic, **$15** for 90 day supply of brand name.

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 $30 or $10 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.

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 31). If you use GEHA's prescription drug card when another carrier is primary, you will be responsible for reimbursing GEHA any amount in excess of GEHA's secondary benefit.

Section 5. Benefits *continued*

Drug purchases at non-participating pharmacies should be submitted to GEHA's claims office (see page 31) 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 31).

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

Section 5. Benefits *continued*

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 17.

What is not covered

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

Non-FEHB Benefits Available to Plan Members

Non-Covered Prescription Drugs 800/417-1893

Certain prescription drugs not covered by GEHA's Prescription Drug Program are available to members at a discount. If your physician writes a prescription for a non-covered drug to treat impotency or hair loss, you can purchase it through mail order, paying 100% of the discounted amount. To order, complete the mail order envelope and enclose your prescription along with a check or credit card number. If paying by a check, please call first to obtain the cost of the medication. Full payment must be included with your order. Mail to:

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

CONNECTION Dental 800/296-0776

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

CONNECTION Dental *Plus* 800/793-9335

Available for an additional premium, CONNECTION Dental *Plus* is a 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, 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. Certain waiting periods and limitations apply.

CONNECTION Hearing 800/456-6801

Free to all members, CONNECTION Hearing offers cost savings at 1,500 Miracle Ear locations nationwide. The program provides a free hearing evaluation, up to a 20% discount off the retail price of hearing aids, a 30-day satisfaction refund guarantee, free unlimited follow-up visits, and free annual checkups of hearing aids. Program benefits are available to GEHA members and their families, including parents and grandparents. The member must be present with his/her CONNECTION ID card for family members to receive CONNECTION Hearing benefits. Call to locate providers in your area.

CONNECTION Long-Term Care 888/469-GEHA

Available for an additional premium, CONNECTION Long-Term Care offers GEHA members a 10% premium discount on long-term care insurance. Applicants may also qualify for additional discounts due to good health or by applying at the same time as their spouse. The program is available through CNA. Long-term care policies from CNA provide coverage for home health care, adult day care, assisted living, nursing home and hospice care.

CONNECTION Vision 800/800-EYES

Free to all members, CONNECTION Vision offers cost savings at more than 10,000 eye care locations nationwide. GEHA members get discounts off the retail price of lenses, frames and specialty items such as tints, lightweight plastics and scratch-resistant coatings. New this year are discounts on surgical procedures (including LASIK, RK, PRK and ALK) not covered under the GEHA health plan. For discounts on mail-order contact lenses and non-prescription sunglasses, call 800/878-3901. This program is offered through Coast to Coast Vision. Call to locate providers in your area.

CONNECTION Vitamins 800/738-8482

Free to all members, CONNECTION Vitamins offers members a 5% discount on vitamins and other nutritional supplements ordered by mail. You'll also receive $5 off your first order. This program is offered through SDV Vitamins, a mail-order division of Rexall Sundown. When you call to request a catalog or place an order, indicate the GEHA source code: GEHA99.

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 2000. 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 provide are lower than prices that may be available from a non-participating provider.

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

Section 6. How to File a Claim

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 web site 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.

Section 6. How to File a Claim *continued*

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.

Section 7. General exclusions – Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness or condition. The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- Procedures, services, drugs and supplies related to sex transformations, sexual dysfunction or sexual inadequacy;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan;
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage;

Section 7. General exclusions – Things we don't cover *continued*

- Services or supplies furnished without charge (except as described on page 37); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits;
- Services or supplies for cosmetic purposes;
- Services or supplies not specifically listed as covered;
- Services or supplies not reasonably necessary for the diagnosis or treatment of an illness or injury, except for routine physical examinations and immunizations;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, 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 page 38), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 36), or State premium taxes however applied;
- Charges in excess of reasonable and customary charges as defined on page 43;
- Rest cures;
- Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital;
- Inpatient private duty nursing;
- Stand-by physicians and surgeons;
- Clinical ecology and environmental medicine;
- Chelation therapy except for acute arsenic, gold, or lead poisoning;
- Treatment for impotency, even if there is an organic cause for impotency. (Exclusion applies to medical/surgical treatment as well as prescription drugs.);
- Computer devices to assist with communications;
- Computer programs of any type, including but not limited to those to assist with vision therapy or speech therapy.

Section 8. Limitations - Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB

Section 8. Limitations - Rules that affect your benefits *continued*

enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office, or call SSA at 800/638-6833.

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 page 36).

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;

Section 8. Limitations - Rules that affect your benefits *continued*

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, you will pay a $5 copayment for generic drugs and a $15 copayment for brand name drugs through the Mail Order Drug Program. If you use your identification card to buy prescription drugs through a participating pharmacy, you will pay a $3 copayment for generic drugs and a $10 copayment for brand name drugs for the initial amount prescribed by the doctor not to exceed a 30-day supply and the first refill. Subsequent refills are subject to a copayment of the greater of **$3** or **50%** of the cost for generic drugs and **$10** or **50%** of the cost for brand name 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.

Section 8. Limitations - Rules that affect your benefits *continued*

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) .

Other group insurance coverage

When anyone has coverage with us and with another group health plan it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

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.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Section 8. Limitations - Rules that affect your benefits *continued*

When others are responsible for injuries

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 for the illness or injury subject to the requirements outlined below:

(1) The Plan being reimbursed 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 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. No GEHA benefits will be paid until any Medpay, PIP, or No-Fault benefits are exhausted.

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, and regardless of how characterized by the parties, i.e. as "pain and suffering." The Plan's lien shall be satisfied in full out of the proceeds of such recovery(ies) prior to the satisfaction of the claims(s) of any other individual, including, but not limited to, the Plan enrollee, covered family member(s), and/or that person's attorney. GEHA's lien extends to and includes payments made by any source, including but not limited to, Medpay, PIP, No-Fault, 3rd party, and uninsured or underinsured motorists provisions of any auto policy. No reduction in the 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. 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.

If you or your dependent are injured by the actions of another person or organization and a claim for benefits is submitted for the treatment of that injury, you are required to promptly notify the subrogation unit of GEHA of the date, circumstances, and all pertinent information relating to the loss. The phone number is 800/821-4742.

TRICARE

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

Workers' compensation

We do not cover services that:

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

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8. Limitations - Rules that affect your benefits *continued*

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.

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 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% 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.

Section 9. Fee-For-Service Facts

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 34-35). 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.

Section 9. Fee-For-Service Facts *continued*

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.

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 **25%** you pay for Non-PPO charges under Inpatient Hospital (Other Charges), Outpatient Hospital Charges, Other Medical, Surgical and Maternity Benefits;

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

- The $300 calendar year deductible;
- The $15 copayment for doctor's office visits;
- 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 pages 7 and 39).
- Expenses for prescription drugs purchased through retail or Mail Order Drug Program.

Mental conditions and outpatient substance abuse benefits

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.

Section 9. Fee-For-Service Facts *continued*

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 39).
- 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.

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;

Section 9. Fee-For-Service Facts *continued*

(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.

Experimental or Investigational

See page 10.

Expense

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

Group health coverage

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

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.

Section 9. Fee-For-Service Facts *continued*

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 80th 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

Sound and Natural Tooth is a whole or properly restored tooth that has no condition that would weaken the tooth, or predispose it to injury, prior to the accident, such as decay, periodontal disease, or other impairments. For purposes of the Plan, damage to a restoration, such as a prosthetic crown or prosthetic dental appliances (i.e. bridgework), would not be covered as there is no injury to the natural tooth structure.

Section 10. FEHB Facts

You have a right to the following information.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

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

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a "Guide to Federal Employees Health Benefits Plans," brochures for other plans and other materials you need to make an informed decision about:

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

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

When are my benefits and premiums effective?

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

What happens when I retire?

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

What types of coverage are available for me and my family?

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

If you have a Self-Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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

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

Are my medical and claims records confidential?

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

- OPM, this Plan, and our subcontractors when they administer this contract,
- This plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims,

Section 10. FEHB Facts *continued*

- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity, or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.

Section 10. FEHB Facts *continued*

- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

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

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice.

However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

The National Defense Authorization Act for 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set-up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is Eligible?

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

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

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

Where are the demonstration areas?

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

When can I join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 877/DOD-FEHB (877/363-3342).

You may select coverage for yourself (Self-Only) or for you and your family (Self and Family) during the 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

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

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," on the OPM web site at www.opm.gov.

Am I eligible for Temporary Continuation of Coverage (TCC)?

See Section 10, FEHB Facts, for information about TCC. Under this Demonstration Project the only individual eligible for TCC is one who ceases to be eligible as a "member of family" under your Self and Family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHBP Demonstration

Department of Defense/FEHB Demonstration Project *continued*

Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHBP Demonstration Project.

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

Do I have the 31-day extension and right to convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/821-6136 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

Penalties for Fraud
Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

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Summary of Benefits for GEHA Benefit Plan - 2000

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 $300 calendar year deductible. When Medicare A & B is primary, refer to This Plan and Medicare section on page 34 for description of waiver of deductible, coinsurance and reduced copayments.

	Benefits	Plan pays/provides	Page
Inpatient	**Hospital**	**PPO benefit: 100%** room and board; **90%** of other hospital charges **Non-PPO benefit: 100%** room and board, **75%** of other hospital charges	13-14
	Surgical	**PPO benefit: 90%*** of covered surgical charges **Non-PPO benefit: 75%*** of covered surgical charges, including oral surgery	14-17
	Medical	**PPO benefit: 90%*** of covered professional services **Non-PPO benefit: 75%*** of covered professional services	20-23
	Maternity	**PPO benefit: 100%** of covered services **Non-PPO benefit:** Same benefits as for illness or injury	17-19
	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	19-20
	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	19
Outpatient	**Hospital**	**PPO benefit: 90%*** of covered hospital charges **Non-PPO benefit: 75%*** of covered hospital charges	21-22
	Surgical	**PPO benefit: 90%*** of covered surgical charges **Non-PPO benefit: 75%*** of covered surgical charges, including oral surgery	14-17
	Medical	**PPO benefit:** $15 copay per covered office visits and **90%*** of other covered professional services including X-ray and lab **Non-PPO benefit: 75%*** of other covered professional services	20-23
	Maternity	**PPO benefit: 100%** of covered services **Non-PPO benefit:** Same benefits as for illness or injury	17-19
	Skilled Nursing Care	**PPO benefit: 90%*** limited to two hours per day for 25 visits in a calendar year **Non-PPO benefit: 75%*** limited to two hours per day for 25 visits in a calendar year	24
	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	19-20
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	24 21

Summary of Benefits for GEHA Benefit Plan - 2000 *continued*

Prescription drugs	**From a pharmacy**	Member pays **$5** for generic drugs or **$15** for brand name for 30-day supply for initial prescription and one refill. Subsequent refills are paid at **50%** 26
	By mail	Member pays **$10** for generic drugs, **$30** for brand name for 90-day supply of maintenance medications and oral contraceptives 26-27
Dental care		Routine preventive dental care and accidental injury to sound natural teeth 29
Additional		Accidental injury, Well Child Care, 24-Hour nurse phone service 24-25
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 ..... 40 **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 40-41

2000 Rate Information for Government Employees Hospital Association, Inc. (GEHA) Benefit Plan

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

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	**311**	**$78.83**	**$45.72**	**$170.80**	**$99.06**	**$93.06**	**$31.49**	**$93.26**	**$31.29**
Self and Family	**312**	**$175.97**	**$92.67**	**$381.27**	**$200.78**	**$207.74**	**$60.90**	**$201.02**	**$67.62**