GEHA Indemnity Benefit Plan

Government Employees Health Association

www.geha.com

Customer Service 800-821-6136

G.E.H.A Government Employees Health Association

2025

A Fee-for-Service Plan (Elevate Plus and Elevate Options) with a Preferred Provider Network

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details. This plan is accredited. See page 14.

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

Who may enroll in this Plan: All Postal Service Employees and Annuitants who are eligible to enroll in the Postal Service Health Benefits Program may become members of Government Employees Health Association, Inc. (GEHA). You must be or must become a member of GEHA.

To become a member: You join simply by completing your enrollment in the Plan through the PSHB System.

Membership dues: There are no membership dues for the Year 2025.

Enrollment codes for this Plan:

58A Elevate Plus Option – Self Only
58C Elevate Plus Option – Self Plus One
58B Elevate Plus Option – Self and Family

58D Elevate Option – Self Only
58F Elevate Option – Self Plus One
58E Elevate Option - Self and Family

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 16
- Summary of Benefits: Page 148

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 71-022

Important Notice

Important Notice for Medicare-eligible Active Employees from Government Employee's Health Association Inc.

About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Government Employees Health Association, Inc. prescription drug coverage for active employees is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your PSHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your PSHB plan. Refer to the part D-IRMAA section of the https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

Table of Contents

Table of Contents 1
Introduction 4
Plain Language 4
Stop Healthcare Fraud! 4
Discrimination is Against the Law 5
Preventing Medical Mistakes 7
PSHB Facts 9
Coverage Information 9
- No pre-existing condition limitation 9
- Minimum essential coverage (MEC) 9
- Minimum value standard (MVS) 9
- Where you can get information about enrolling in the PSHB Program 9
- Enrollment types available for you and your family 9
- Family Member Coverage 10
- Children's Equity Act 11

Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) 12
- When benefits and premiums start 12
- When you retire 12

When you lose benefits 12
- When PSHB coverage ends 12
- Upon divorce 12

Medicare PDP EGWP 13
- Temporary Continuation of Coverage (TCC) 13
- Converting to individual coverage 13
- Health Insurance Marketplace 13

Section 1. How This Plan Works 14
General features of our Elevate Plus and Elevate Options 14
How we pay providers 14
Health education resources 15
Your rights and responsibilities 15
Your medical and claims records are confidential 15
Section 2. New for 2025 16
Section 3. How You Get Care 17
Identification cards 17
Where you get covered care 17
Balance Billing Protection 17
- Covered providers 17
- Plan facilities 18
- Transitional care 20
- If you are hospitalized when your enrollment begins 20

You need prior Plan approval for certain services 20
- Inpatient facility admission 20
- Other services that require preauthorization 21

How to request precertification for an admission or get prior authorization for Other Services 23
- Non-urgent care claims 23
- Urgent care claims 23

- Concurrent care claims 24
- Emergency inpatient admission 24
- Maternity care 24
- If your hospital stay needs to be extended 24
- If your treatment needs to be extended 24

If you disagree with our pre-service claim decision 25
- To reconsider a non-urgent care claim 25
- To reconsider an urgent care claim 25
- To file an appeal with OPM 25

Overseas claims 25
Section 4. Your Costs for Covered Services 27
Coinsurance 27
Copayments 27
Cost-sharing 27
Deductible 27
If your provider routinely waives your cost 28
Waivers 28
Differences between our allowance and the bill 28
Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments 30
Carryover 30
If we overpay you 31
When Government facilities bill us 31
Important Notice About Surprise Billing – Know Your Rights 31
Section 5. Elevate Plus and Elevate Option Benefits 32
Elevate Plus and Elevate Overview 34
Non-PSHB Benefits Available to Plan Members 114
Section 6. General Exclusions - Services, Drugs and Supplies We Do Not Cover 115
Section 7. Filing a claim for covered services 116
Section 8. The Disputed Claims Process 119
Section 8(a). Medicare PDP EGWP Disputed Claims Process 122
Section 9. Coordinating Benefits with Medicare and Other Coverage 125
When you have other health coverage or auto insurance 125
TRICARE and CHAMPVA 125
Workers' Compensation 126
Medicaid 126
When other Government agencies are responsible for your care 126
When others are responsible for injuries 126
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) 127
Clinical trials 128
When you have Medicare 128
- The Original Medicare Plan (Part A or Part B) 128
- Tell us about your Medicare coverage 130
- Private contract with your physician 130
- Medicare Advantage (Part C) 130
- Medicare prescription drug coverage (Part D) 131
- Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) 131

When you are age 65 or over and do not have Medicare 135
When you have the Original Medicare Plan (Part A, Part B, or both) 136
Section 10. Definitions of Terms We Use in This Brochure 137

Index....146
Summary of benefits for the Elevate Plus Option of the Government Employees Health Association, Inc. - 2025....148
Summary of benefits for the Elevate Option of the Government Employees Health Association, Inc. - 2025....150
2025 Rate Information for Elevate Plus and Elevate....154

Introduction

This brochure describes the benefits of GEHA Indemnity Benefit Plan under contract (CS 2962 PS) between Government Employees Health Association, Inc. and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. This plan is underwritten by Government Employees Health Association, Inc. (GEHA, Inc.) and Surety Life Insurance Company and administered by GEHA, Inc. The Carrier of the Plan is a voluntary association comprised of GEHA, Inc. and Surety Life Insurance Company. Customer service may be reached at 800-821-6136 or through our website: www.geha.com. The address for GEHA's administrative offices is:

Government Employees Health Association, Inc.
310 NE Mulberry St.
Lee's Summit, MO 64086

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). You do not have a right to benefits that were available before January 1, 2025, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025, and changes are summarized in Section 2, *Changes for 2025.* Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means Government Employees Health Association, Inc.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89 (https://www.govinfo.gov/link/uscode/5/8901). The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c (http://www.govinfo.gov/link/uscode/5/8903c). PSHB Plan means a health benefits plan offered under the PSHBP Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium. OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the PSHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review Explanations of Benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 800-356-5803 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE

877-499-7295
Or go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain family members on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they were disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain PSHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**

   - Ask questions and make sure you understand the answers.

   - Choose a doctor with whom you feel comfortable talking.

   - Take a relative or friend with you to help you take notes, ask questions, and understand answers.

2. **Keep and bring a list of all the medications you take.**

   - Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosages that you take, including non- prescription (over-the-counter) medications and nutritional supplements.

   - Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.

   - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

   - Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.

   - Read the label and patient package insert when you get your medication, including all warnings and instructions.

   - Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.

   - Contact your doctor or pharmacist if you have any questions.

   - Understanding both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. **Get the results of any test or procedure.**

   - Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?

   - Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.

   - Ask what the results mean for your care.

4. **Talk to your doctor about which hospital or clinic is best for your health needs.**

   - Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.

   - Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. **Make sure you understand what will happen if you need surgery.**

   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

   - Ask your doctor, "Who will manage my care when I am in the hospital?"

- Ask your surgeon:

    - "Exactly what will you be doing?"
    - "About how long will it take?"
    - "What will happen after surgery?"
    - "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links
For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- https://www.jointcommission.org/resources/patient-safety/. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events".

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your PSHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct "Never Events". "Never Event" is defined by your claim's administrator using national standards. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

PSHB Facts

Coverage Information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard (MVS)**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

  See https://health-benefits.opm.gov/PSHB for enrollment information as well as:

  - Information on the PSHB Program and plans available to you and
  - A health plan comparison tool.

  Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System.

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you:

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

  We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your PSHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

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

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System location at https://health-benefits.opm.gov/PSHB/. For assistance with the PSHB system call PSHB Helpline at (844) 451-1261. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member. Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one PSHB plan you or they cannot be enrolled in or covered as a family member by another enrollee in another PSHB or FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the PSHB Program, change your enrollment, or cancel coverage using the PSHB System. For a complete list of QLEs, visit the PSHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren

Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children

Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support

Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children

Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance

Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the PSHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children.

If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no PSHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the PSHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for PSHB coverage, you must continue your PSHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

- **Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)**

  Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP.
  Please, contact CMS for assistance at 800-MEDICARE (800-633-4227).

- **When benefits and premiums start**

  The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

  If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

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

When you lose benefits

- **When PSHB coverage ends**

  You will receive an additional 31 days of coverage, for no additional premium, when:
  - Your enrollment ends, unless you cancel your enrollment; or
  - You are a family member no longer eligible for coverage.

  Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

  If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

- **Upon divorce**

  If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

  If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are **not** eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices, https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- **Medicare PDP EGWP**

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty.

Contact us for additional information at 800-821-6136.

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

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing PSHB Program coverage.

- **Converting to individual coverage**

If you leave Federal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the PSHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-821-6136 or visit our website at www.geha.com.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a fee-for-service (FFS) plan. OPM requires that PSHB plans be accredited to validate that plan operations and/or care management meet or exceed nationally recognized standards. GEHA holds the following accreditations: Health Plan Accreditation with Accreditation Association for Ambulatory Health Care (AAAHC) and Dental Network Accreditation with URAC. To learn more about this plan's accreditation(s), please visit the following websites: Accreditation Association for Ambulatory Health Care www.aaahc.org and URAC www.urac.org. You can choose your own physicians, hospitals, and other healthcare providers. We give you a choice of enrollment in the Elevate Plus Option or the Elevate Option.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

This Plan provides preventive services and screenings to you without any cost-sharing; you may choose any available in-network primary care provider for adult and pediatric care, and visits for specialists do not require a referral.

General features of our Elevate Plus and Elevate Options

We have Point of Service (POS) benefits

Our fee-for-service plan offers in-network benefits through the UnitedHealthcare Choice Plus network. This means that we designate certain hospitals and other healthcare providers as "preferred providers." Providers in the network accept a contracted payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies). On the Elevate Option, you also have benefits to receive covered services from non-participating providers; however, out-of-network benefits may have higher out-of-pocket costs than the in-network benefits. Elevate Plus does not provide benefits for non-participating providers, except in cases of emergency medical care.

To find in-network providers, use the provider search tool on the www.geha.com/Find-care website or call GEHA at 800-821-6136. When you call your provider for an appointment, please remember to verify that the physician is a UnitedHealthcare Choice Plus provider. In-network 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.

On the Elevate Option, the out-of-network benefits are the standard benefits of this Plan. Elevate Plus does not provide out-of-network benefits. On both Elevate and Elevate Plus, in-network benefits apply only when you use an in-network provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no network provider is available, or you do not use a network provider, the standard out-of-network benefits apply on the Elevate Option. However, if the services are rendered at an in-network hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If the services are rendered by out-of-network providers at an in-network hospital, we will pay up to the Plan Allowance according to the No Surprises Act. In addition, providers outside the United States will be paid at the in-network level of benefits.

How we pay providers

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

We offer Point of Service (POS) benefits through the UnitedHealthcare Choice Plus network of individual physicians, medical groups, and hospitals. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies), which may vary by plan.

We utilize Optum's Ingenix Claim Editing System (iCES) for United Health Network providers and Optum's Claims Editing System (CES) for non-United Health Network providers to review claims for bundling, unbundling, upcoding and other billing and coding edits using criteria that includes but is not limited to National Correct Initiative (NCCI) guidelines, Centers for Medicare and Medicaid Services (CMS) guidelines, and Commercial (UHC) guidelines.

We reserve the right to audit medical expenses to ensure that the provider's billed charges match the services that you received.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayment, to no more than $8,300 for Self Only enrollment, and $16,600 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount. See Section 5(f)(a) if you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Plan Waiver (EGWP).

Health education resources

GEHA offers on-site wellness events and ongoing communications by print, social media, email and web to help federal employees live healthier. This includes general health topics, healthcare news, cancer and other specific diseases, drugs/ medication interactions, children's health and patient safety information.

Your rights and responsibilities

OPM requires that all PSHB plans provide certain information to their PSHB members. You may get information about us, our networks, and our providers. OPM's PSHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below:

- GEHA was founded in 1937 as the Railway Mail Hospital Association. For over 85 years, GEHA has provided health insurance benefits to Federal employees and retirees.
- GEHA is incorporated as a General Not-For-Profit Corporation pursuant to Chapter 355 of the Revised Statutes of the State of Missouri.
- GEHA's provider network includes over 10,000 hospitals and over 4 million in-network physician locations throughout the United States. In circumstances where there is limited access to network providers, GEHA may negotiate discounts with some providers, which will reduce your overall out-of-pocket expenses.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, GEHA at www.geha.com. You can also contact us to request that we mail a copy to you.

If you wish to make a suggestion, file a formal complaint, require language translation services, or if you want more information about us, call 800-821-6136, or write to GEHA Enrollment, PO Box 21262, Eagan, MN 55121. You may also visit our website at www.geha.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website GEHA at www.geha.com/PHI to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Section 2. New for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to Section 5 Benefits.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the PSHB System enrollment confirmation.

Note: If you are enrolled in our Medicare Part D PDP EGWP, you will receive a second ID care for your prescription drug benefits.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-821-6136 or write to us at GEHA Enrollment, PO Box 21262, Eagen, MN 55121. You may also request replacement cards through our website: www.geha.com/Contact.

Where you get covered care

You can get care from "Plan providers" and "Plan facilities". You will only pay copayments, deductibles, and/or coinsurance if you use our network providers. You can also get care from non-Plan providers, but it will cost you more.

Balance Billing Protection

PSHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Covered providers**

Covered providers are physicians and other healthcare professionals in our service area that are contracted to provide covered services to our members when acting within the scope of their license or certification under applicable state law. Plan providers are credentialed according to national standards. A listing of plan providers can be found on our website at www.geha.com/Find-Care. These covered providers may include: a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.); chiropractor; nurse midwife; nurse anesthetist; audiologist; dentist; optometrist; licensed clinical social worker; licensed clinical psychologist; licensed professional counselor; licensed marriage and family therapist; podiatrist; speech, physical and occupational therapist; nurse practitioner/clinical specialist; nursing school administered clinic; physician assistant; registered nurse first assistants; certified surgical assistants; board certified behavior analyst; board certified assistant behavior analyst; registered behavior technician; certified doula; and a dietitian as long as they are providing covered services which fall within the scope of their state licensure or statutory certification.

The terms "doctor", "physician", "practitioner", “professional provider”, or “primary care provider” includes any provider when the covered service is performed within the scope of their license or certification. The term "primary care provider", as outlined in the benefit plan, includes family or general practitioners, pediatricians, obstetricians/gynecologists, medical internists, and mental health/substance use disorder treatment providers.

Telehealth with MDLIVE - Practitioners must be licensed in the state where the patient is physically located at the time services are rendered.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state’s designation as a medically underserved area.

We list network-contracted covered providers in our network provider directory, which we update periodically, and make available on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at 800-821-6136 for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that are contracted to provide covered services to our members. The plan facilities list is also on our web site at www.geha.com/Find-care. You should also contact that provider to verify that they participate with the Plan.

Covered facilities include:

- Freestanding ambulatory facility:
  - A facility which is licensed by the state as an ambulatory surgery center or has Medicare certification as an ambulatory surgical center, has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility; does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other professional.
  - If the state does not license Ambulatory Surgical Centers and the facility is not Medicare certified as an ambulatory surgical center, then they must be accredited with AAAHC (Accreditation Association for Ambulatory Health Care), AAAASF (American Association for Accreditation for Ambulatory Surgery Facilities), IMQ (Institute for Medical Quality) or TJC (The Joint Commission).
  - Ambulatory Surgical Facilities in the state of California do not require a license if they are physician owned. To be covered these facilities must be accredited by one of the following: AAAHC (Accreditation Association for Ambulatory Health Care), AAAASF (American Association for Accreditation for Ambulatory Surgery Facilities), IMQ (Institute for Medical Quality) or TJC (The Joint Commission).
- Hospital:
  - An institution, or distinct portion of an institution, that is primarily engaged in providing: (1) general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities; or (2) specialized inpatient acute medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory); or (3) comprehensive specialized services relating to the individual's specific medical, physical, mental health, and/or substance use disorder therapy needs, and has, for each patient, an individualized written treatment plan, which includes diagnostic assessment of the patient and a description of the treatment to be rendered, and provides for follow-up assessments by, or under, the direction of the supervising doctor.
  - All services must be provided on its premises, under its control, or through a written agreement with a hospital or with a specialized provider of those facilities.
  - A hospital must be operated pursuant to law, accredited as a hospital under the Hospital Accreditation Program of The Joint Commission (TJC) or meet the states' applicable licensing or certification requirements for a hospital, and is operating under the supervision of a staff of physicians with 24-hour-a-day registered nursing services.

- The term hospital does not include a convalescent home, extended care facility, skilled nursing facility, or any institution or part thereof which: a) is used principally as a convalescent facility, nursing facility, or long-term care; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operating as or is licensed as a school or residential treatment facility (except as listed in Section 5(e)).

- Hospice: A facility which meets all of the following:
  - Primarily provides inpatient hospice care to terminally ill persons;
  - Is certified by Medicare as such, or is licensed or accredited as such, by the jurisdiction it is in;
  - 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;
  - Provides 24-hour-a-day nursing services under the direction of an R.N. and has a full-time administrator; and
  - Provides an ongoing quality assurance program.
- Skilled Nursing Facility licensed by the state or certified by Medicare if the state does not license these facilities. See limitations in Section 5(c), *Services Provided by a Hospital or Other Facility, and Ambulance Services.*
- Birth Center:
  - A birth center is a health facility that is not a hospital or physician's office, where childbirth is planned to occur away from the pregnant woman's residence, that is licensed or otherwise approved by the state to provide prenatal, labor and delivery or postpartum care that is covered by the plan.
- Residential Treatment Center (RTCs):
  - An institution that is primarily engaged in providing: (1) 24-hour residential evaluation, treatment, and comprehensive specialized services relating to the individual's specific mental health, and/or substance use disorder therapy needs, all under the active participation and direction of a licensed physician who is practicing within the scope of the physician's license; and (2) specialized programs for persons who need short-term services designed to achieve predicted outcomes focused on fostering improvement or stability in mental health and/or substance use disorder, recognizing the individuality, strengths, and needs of the persons served; and (3) care that meets evidence-based treatment guidelines or criteria as determined by the plan.
  - The services are provided for a fee from its patients and include both: (1) room and board; and (2) 24-hour-a-day registered nursing services. Additionally, the RTC keeps adequate patient records which include: (1) the individualized treatment plan; and (2) the person's progress; and (3) discharge summary; and (4) follow-up programs. Benefits are available for services performed and billed by RTCs, as described in Section 5(e), *Mental Health and Substance Use Disorder Benefits.*
  - RTCs must be: (1) operated pursuant to law; and (2) accredited by a nationally recognized organization, and licensed by the state, district or territory to provide residential treatment for mental health conditions and/or substance use disorder, or (3) credentialed by a network partner.
  - The term RTC does not include a convalescent home, extended care facility, skilled nursing facility, group home, halfway house, sober home, transitional living center or treatment, or any institution or part thereof which: 1) is used principally as a convalescent facility, nursing facility, or long-term care; 2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or 3) is operating or licensed as a school.

- **Transitional care**

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

  - lose access to your specialist because your coverage changed from the FEHB to the PSHB and your health plan does not participate in the PSHB, or
  - lose access to your specialist because we drop out of the Postal Service Health Benefits (PSHB) Program and you enroll in another PSHB Plan, or
  - lose access to your in-network specialist because we terminate our contract with your specialist for reasons other than for cause,

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

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

- **If you are hospitalized when your enrollment begins**

  We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-821-6136. If you are new to the PSHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

  These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the PSHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized person's benefits under the new plan begin on the effective date of enrollment.

- **You need prior Plan approval for certain services**

  Precertification is the process by which we evaluate the medical necessity of your hospital stay and the number of days required to treat your condition. In most cases, your network physician will make necessary hospital arrangements and supervise your care. If you are using a non-network provider or facility, you are responsible for contacting the Plan at 800-821-6136.

- **Inpatient facility admission**

  Your plan physician or specialist will make necessary inpatient arrangements and supervise your care. This includes admission for a Hospital, Long Term Acute Care, Residential Treatment Center (RTC), Skilled nursing Facility (SNF) or Rehabilitation Facility stay.

  Because you are still responsible for ensuring that we are asked to precertify your care, always ask your physician or hospital whether or not they have contacted the Plan.

  If you are using a non-network provider or facility, you are responsible for contacting the Plan at 800-821-6136 to determine coverage and obtain precertification for these types of admissions.

- **Warning:**

  Network Plan physicians must provide or arrange your in-network care and get precertification or preauthorization for certain services and/or procedures, including but not limited to those noted below in *Other services that require preauthorization.* For out-of-network facilities on the Elevate Option, you are responsible for obtaining precertification for these services.

  Note: Avoid paying providers for services prior to preauthorization. It is important to assure services are authorized and provided by a covered provider or facility.

  You must get precertification for certain services prior to admission. Failure to do so will result in the following penalties, unless due to a medical emergency:

  - Out-of-network (Elevate Option only):
    - We will reduce our benefits for the Inpatient Hospital stay, Long Term Acute Care, Residential Treatment Center (RTC), Skilled Nursing (SNF), or Rehabilitation Facility by **$500 per day for each day that is not precertified prior to admission, limited to a maximum penalty of $5,000 per admission.** If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.
    - Out-of-network facilities must, prior to admission, agree to abide by the terms established by the Plan for the care of the particular member and for the submission and processing of related claims.

- **Exceptions**

  You do not need precertification in these cases:

  - You are admitted to a hospital outside the United States, or the procedure is performed outside the United States;
  - You have another group health insurance policy that is the primary payor for the hospital stay, or other services, including Medicare Part A and B or Part B only;
  - The procedure is performed when you are an inpatient in a hospital or observation stay; or
  - The procedure is performed as an emergency.

  Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payor, and you do need precertification.

- **Other services that require preauthorization**

  Some surgeries and procedures, services and equipment require a precertification or preauthorization such as, but not limited to, the following list. Please note this list is subject to change upon notification to Plan providers. Please call to verify if your procedure/services require preauthorization. Refer to the back of your member ID card under the heading *Prior Authorization* for contact information.

  Services requiring preauthorization or medical necessity determination may be reviewed with guidelines as described at www.geha.com/CriteriaSourcesElevate.

  - Abdominoplasty/ panniculectomy/ lipectomy
  - Applied Behavioral Analysis (ABA)
  - Arthroplasty
  - Artificial insemination (AI) drugs and IVF-related drugs
  - Artificial insemination procedures (intravaginal insemination, intracervical insemination, intrauterine insemination)
  - Autologous Cultured Chondrocytes (ACI)
  - Bariatric surgery - Severe obesity surgery
  - Breast reconstruction except for diagnosis of cancer
  - Bone growth stimulators

- Cellular and gene therapy
- Certain prescription drugs
- Chemotherapy and/or radiation therapy
- Clinical trials
- Cochlear and auditory implants and implant procedures
- Correction of choanal atresia and intranasal synechia
- Computed tomography (CT) scans
- Congenital anomaly repair
- Discectomy/fusion
- Durable medical equipment over $1,000
- Eyelid surgery or brow lift
- Functional Endoscopic Sinus Surgery (FESS)
- Genetic testing
- Growth hormone therapy (GHT)
- Gynecomastia treatment - cosmetic
- Harvesting of sperm/eggs and storage of sperm/embryos/eggs for iatrogenic infertility diagnosis
- Hyoid myotomy and suspension
- Hysterectomy except for diagnosis of cancer
- Implantable cardiac monitoring
- Inpatient admissions
- Intensive outpatient therapy
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiogram (MRA)
- Neurostimulation, including devices and implantation procedures for cranial, gastric, peripheral, spinal, or vagus nerve stimulation
- Non-emergency/air ambulance services
- Nuclear medicine studies including nuclear cardiology
- Orthognathic surgery
- Orthopedic and prosthetic devices over $1,000
- Osteochondral grafting (allogenic)
- Partial hospitalization
- PET scans
- Prostate implants, destruction, and removal
- Psychological and neuropsychological testing exceeding 8 hours/calendar year
- Reconstructive surgery
- Rhinoplasty
- Scar revisions
- Sinuplasty
- Sleep apnea evaluation:
  - Surgery
  - Sleep studies (in-lab) - attended or performed in a healthcare facility (home sleep studies do not require preauthorization)

- Substance use disorder treatment
- Surgical treatment of gender dysphoria
- Transcatheter aortic and pulmonary valve repair or replacement
- Transcatheter arrhythmia ablation
- Transplants
- UPPP Uvulopalatopharyngoplasty
- Vein ablation

How to request precertification for an admission or get prior authorization for Other Services

If the admission is non-urgent or to a non-network inpatient facility (Elevate Option only), you must get the admission authorized by calling the Plan at 800-821-6136. This must be done at least four business days before the admission. If the admission is an emergency or an urgent admission, you, your provider, your representative, or the hospital must notify us by calling 800-821-6136 within one business day, the same day of admission, or as soon as reasonably possible.

Provide the following information:

- Enrollee's name and plan identification number;
- Patient's name, birth date, identification number and phone number;
- Reason for hospitalization, proposed treatment, or surgery;
- Name and phone number of admitting physician doctor;
- Name of hospital or facility; and
- Number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have precertification. We will make our decision within 15 days of receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original **15-day** period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-821-6136. You may also call OPM's Postal Insurance Operations (PSIO) at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at 800-821-6136. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

A reduction or termination of care can occur due to lack of medical necessity or the member's failure to demonstrate measurable progress towards the established treatment goals and further medical professional intervention is not expected to result in a significant improvement of the patient's condition.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within one business day, the same day of admission, or as soon as reasonably possible following the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

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

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but
- For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or preauthorization of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 844-4-GEHARX or 844-443-4279.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Note: If you are enrolled in our Medical PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See section 8(a) for information about the PDP EGWP appeal process.

Overseas claims

For covered services you receive by physicians and hospitals outside the United States and Puerto Rico, send a completed Overseas Claim Form and the itemized bills to: GEHA, Medical Claims, PO Box 21172, Eagan, MN 55121. You may obtain overseas claim forms from www.geha.com/Claim.

If you have questions about the processing of overseas claims, contact us at 800-821-6136 or by email overseas@geha.com. Covered providers outside the United States will be paid at the in-network level of benefits, subject to the plan deductible, copays and/or coinsurance. We will provide translation and currency conversion for claims for overseas (foreign) services. The conversion rate will be based on the date services were rendered.

Eligibility and/or medical necessity review is required when procedures are performed or you are admitted to a hospital, outside of the United States. Review includes the procedure/service to be performed, the number of days required to treat your condition, and any other applicable benefit criteria.

When members living abroad are stateside and seeking medical care, contact us at 800-821-6136, or visit www.geha.com/Find-care to locate an in-network provider. When you are seeking treatment stateside, all precertification and authorization requirements are applicable. If you utilize an out-of-network provider, out-of-network benefits would apply on the Elevate Option. Elevate Plus does not provide benefits for out-of-network providers, except in cases of emergency medical care.

Section 4. Your Costs for Covered Services

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your year deductible. We will base this percentage on either the billed charge or the Plan allowance, whichever is less.

Example: Under the Elevate Option, you pay 50% of our allowance for out-of-network office visits and any difference between our allowance and the billed amount.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your in-network primary care provider (PCP), under the Elevate Plus Option you pay a copayment of $30 per visit.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

Elevate Plus Option

In-Network: Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $200. Under the Self Plus One and Self and Family enrollments, once the calendar year deductible amount of $200 is satisfied for an individual, covered benefits are payable for that individual; the calendar year deductible is met for all family members when the covered expenses accumulated to the calendar year deductible for any combination of family members reaches the Self Plus One or the Self and Family limit of $400.

Out-of-Network: Elevate Plus does not provide out-of-network benefits.

Elevate Option

In-Network: Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $500. Under the Self Plus One and the Self and Family enrollments, once the calendar year deductible amount of $500 is satisfied for an individual, covered benefits are payable for that individual; the calendar year deductible is met for all family members when the covered expenses accumulated to the calendar year deductible for any combination of family members reaches the Self Plus One or the Self and Family limit of $1,000.

Out-of-Network: Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $1,000. Under the Self Plus One and the Self and Family enrollments, once the calendar year deductible amount of $1,000 is satisfied for an individual, covered benefits are payable for that individual; the calendar year deductible is met for all family members when the covered expenses accumulated to the calendar year deductible for any combination of family members reaches the Self Plus One or the Self and Family limit of $2,000.

If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your Elevate Option calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible ($500 per person under Elevate Option for in-network providers) has been satisfied.

Note: If you change PSHB plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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

If your provider routinely waives your cost

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

For example, under Elevate Plus, if your physician ordinarily charges $100 for a service but routinely waives your 15% coinsurance, the actual charge is $85. We will pay $72.25 (85% of the actual charge of $85).

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 800-821-6136 or write to GEHA Enrollment, PO Box 21262, Eagan, MN 55121.

Differences between our allowance and the bill

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

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use. For more information about out-of-area services, see We have Point of Service (POS) benefits in Section 1.

- **In-network providers** agree to limit what they will bill you. Because of that, when you use a network provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a network physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, with the Elevate Option, you pay just 25% of our $100 allowance ($25). Because of the agreement, your network physician will not bill you for the $50 difference between our allowance and the bill.
- **Out-of-network providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-network provider, you will pay your deductible and coinsurance plus any difference between our allowance and charges on the bill. Here is an example: You see an out-of-network physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so with the Elevate Option you pay 50% of our $100 allowance ($50). Plus, because there is no agreement between the non-network physician and us, the physician can bill you for the $50 difference between our allowance and the bill. Elevate Plus does not provide benefits for out-of-network providers, so you would pay 100% of the provider's billed charges.

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

EXAMPLE - Elevate

In-network physician

Physician's charge: $150

Our allowance: We set it at: $100

We pay: 75% of our allowance: $75

You owe: Coinsurance: 25% of our allowance: $25

+Difference up to charge?: No: $0

TOTAL YOU PAY: $25

Out-of-network physician

Physician's charge: $150

Our allowance: We set it at: $100

We pay: 50% of our allowance: $50

You owe: Coinsurance: 50% of our allowance: $50

+Difference up to charge: Yes: $50

TOTAL YOU PAY: $100

You should also see Section Important Notice About Surprise Billing - Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

For Elevate Plus and Elevate medical and surgical services, we pay 100% of our allowable amount for the remainder of the calendar year after out-of-pocket expenses for deductibles, coinsurance and copayments exceed:

In-Network

- For the Elevate Plus Option, the out-of-pocket maximum is $7,000 for Self Only enrollment; $14,000 when enrollment is Self Plus One or Self and Family when you use in-network providers.
- For the Elevate Option, the out-of-pocket maximum is $8,500 for Self Only enrollment; $17,000 when enrollment is Self Plus One or Self and Family if you use in-network providers.
- Only eligible out-of-pocket expenses from in-network providers count toward these limits.
- An individual under Self Plus One and Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum under a Self only enrollment.
- Elevate Plus does not provide out-of-network benefits.

Out-of-network

- For the Elevate Option, the out-of-pocket maximum is $17,000 for Self Only enrollment; $34,000 when enrollment is Self Plus One or Self and Family if you use out-of-network providers. Only eligible out-of-pocket expenses from out-of-network providers count toward these limits.
- An individual under Self Plus One and Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum under a Self only enrollment.

Out-of-pocket expenses for in-network and out-of-network benefits are the expenses you pay for covered services.

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

- Expenses you pay for non-covered services;
- Expenses in excess of our allowable amount or maximum benefit limitations;
- Charges incurred by failure to obtain pre-certification when using non-network facilities and other amounts you pay because benefits have been reduced/denied for non-compliance with the plans requirements (see Section 3);
- Expenses in excess of plan limits for dental;
- The cost for non-approved medication and drugs that we exclude; and
- The difference (Elevate Plus and Elevate Options) between the cost of the generic and brand name medication.

PDP EGWP

For members enrolled in our Plan's associated PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for covered drugs, services and supplies toward the PSHB catastrophic maximum(s), unless specifically excluded above.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After the maximum is met, we pay 100% of all eligible covered Part D prescription drug benefits. You will continue to pay a cost share for non-Medicare Part D drugs.

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit the effective date of the change is January 1, and covered expenses apply to this plan’s catastrophic protection benefit starts on January 1.

Note: if you change PSHB plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

If we overpay you

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

When Government facilities bill us

Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.geha.com or contact the health plan at 800-821-6136.

Section 5. Elevate Plus and Elevate Option Benefits

See *Summary of Benefits for the Elevate Plus Option* and *Summary of benefits for the Elevate Option* for benefit summaries of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Elevate Plus and Elevate Overview 34
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals 35
Diagnostic and treatment services 36
Telehealth 36
Lab, X-ray and other diagnostic tests 37
Preventive care, adult 39
Preventive care, children 41
Maternity care 43
Family planning 45
Infertility services 46
Allergy care 48
Treatment therapies 48
Physical, occupational, and speech therapy 50
Hearing services (testing, treatment, and supplies) 51
Vision services (testing, treatment, and supplies) 52
Foot care 53
Orthopedic and prosthetic devices 53
Durable medical equipment (DME) 54
Home health services 56
Manipulative therapy 58
Alternative treatments 58
Educational classes and programs 59
Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals 60
Surgical procedures 61
Reconstructive surgery 62
Oral and maxillofacial surgery 64
Organ/tissue transplants 65
Anesthesia 73
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services 74
Inpatient hospital 75
Outpatient hospital, clinic or ambulatory surgical center 76
Extended care benefits/Skilled nursing care facility benefits 79
Hospice/End of life care 79
Ambulance 80
Section 5(d). Emergency Services/Accidents 82
Medical emergency 82
Urgent Care Facility 83
MinuteClinic 83
Telehealth with MDLIVE 83
Ambulance 84
Section 5(e). Mental Health and Substance Use Disorder Benefits 85
Professional services 86
Applied Behavioral Analysis Therapy 87
Telehealth with MDLIVE 87

Diagnostics....88
Inpatient hospital and inpatient residential treatment centers (RTC)....88
Outpatient hospital....89
Emergency room....89
Section 5(f). Prescription Drug Benefits....91
Covered medication and supplies....96
Preventive care medications....99
Section 5(f)(a). PDP EGWP Prescription Drug Benefits....103
Covered medications and supplies....107
Preventive medications....109
Section 5(g). Dental Benefits....111
Accidental dental benefits....111
Dental benefits....111
Section 5(h). Wellness and Other Special Features....112
Flexible benefits option....112
Services for deaf and hearing impaired....112
24-Hour Nurse Advice Line....113
Summary of benefits for the Elevate Plus Option of the Government Employees Health Association, Inc. - 2025....148
Summary of benefits for the Elevate Option of the Government Employees Health Association, Inc. - 2025....150

Elevate Plus and Elevate Overview

This Plan offers both an Elevate Plus and Elevate Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Elevate Plus and Elevate Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* about these benefits at the beginning of the subsections. For more information about services, see *We have Point of Service (POS) benefits* in Section 1. Also read the *General Exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Elevate Plus and Elevate benefits, contact us at 800-821-6136 or on our website at www.geha.com.

Each option offers unique features:

Elevate Plus

- You must use in-network providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care.
- Generic drugs: $10 copay at an in-network retail pharmacy for a 30-day supply, $20 for mail order up to a 90-day supply.
- Calendar year deductible of $200 for Self Only enrollment and $400 Self Plus One or Self and Family enrollment.
- 15% Coinsurance of our allowance after the deductible for certain inpatient and outpatient services.
- Predictable out-of-pocket copayments for many in-network healthcare services:
  - Telehealth visits at $0 through MDLIVE.
  - MinuteClinic® copay of $10/visit.
  - Office visit copay of $30 to any primary care provider including family or general practitioners, pediatricians, OB/GYN and medical internists; specialist provider copay is $50.
  - Urgent Care Facility copay of $50.
- No requirement to choose a single doctor as your primary physician.
- No referral needed to see a specialist. However, you might need preauthorization for certain services.

Elevate

- Generic drugs: $4 copay at an in-network retail pharmacy for a 30-day supply. This plan does not include a benefit for mail order.
- Low cost access to a wide variety of in-network providers for wellness and acute care visits:
  - Telehealth visits at $0 through MDLIVE.
  - Copay of $10/visit for:
    - MinuteClinic®
    - Primary care provider including family or general practitioners, pediatricians, OB/GYN and medical internists
    - Chiropractic and acupuncture services
  - Specialist office visit copay is $30.
  - Urgent Care Facility copay of $50.
- Extensive provider network and freedom to choose any doctor with extra savings when you see a preferred provider.
- No requirement to choose a single doctor as your primary physician.
- No referral needed to see a specialist. However, you might need preauthorization for certain services.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under the Elevate Plus Option, the calendar year deductible is $200 per person ($400 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the calendar year deductible is $500 per person ($1,000 if enrollment is Self Plus One or Self and Family). If you use an out-of-network provider, the calendar year deductible is $1,000 per person ($2,000 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the out-of-network benefits are the standard benefits of the Plan. In-network benefits apply only when you use an in-network provider. When no in-network provider is available, out-of-network benefits apply. Under the Elevate Plus Option, the in-network benefits are the standard benefits of the Plan.
- When you use an in-network hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If the services are rendered by out-of-network providers at an in-network hospital, we will pay up to the Plan Allowance according to the No Surprises Act.
- We will provide in-network benefits if you are admitted to an out-of-network hospital due to a medical emergency. We will also provide in-network benefits for professionals who provide services in a non-network hospital, when admitted due to a medical emergency.
- **YOUR NETWORK PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME IN-NETWORK SERVICES AND/OR PROCEDURES.** You are responsible for obtaining preauthorization for out-of-network services under the Elevate Option, and failure to do so may result in penalties. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, or other outpatient facility, etc.).
- Medications may be available under the prescription drug benefit and may require prior authorization. Specialty drugs obtained outside of the pharmacy benefit may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits*.
- Benefits for certain self-injectable (self-administered) drugs are available for coverage only when dispensed by a pharmacy, under the pharmacy benefit.

Benefits Description	You pay	
Note: For both the Elevate and Elevate Plus Options, we state whether or not the calendar year deductible applies for each benefit listed in this Section.		
Diagnostic and treatment services	**Elevate Plus**	**Elevate**
Professional services of physicians • In physician's office • Office medical consultations • Home visits by a physician • Second surgical opinions • Advance care planning	In-network: $30 copayment for office visits to primary care providers (no deductible); $50 copayment for office visits to specialists (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for office visits to primary care providers (no deductible); $30 copayment for office visits to specialists (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
• During a hospital stay	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
MinuteClinic MinuteClinic is available in several states and the District of Columbia. Walk-in medical clinics are located inside select CVS pharmacy locations and no appointment is necessary. MinuteClinic is staffed by certified family nurse practitioners and physician assistants who diagnose, treat and write prescriptions for common illnesses, injuries and skin conditions. MinuteClinic also offers physical exams, routine vaccinations and screenings for disease monitoring. To locate a MinuteClinic, visit https://www.cvs.com/minuteclinic/clinic-locator/ or call 866-389-2727.	$10 copayment for office visit (no deductible) Note: Other services rendered may take additional cost share.	$10 copayment for office visit (no deductible) Note: Other services rendered may take additional cost share.
Telehealth	**Elevate Plus**	**Elevate**
MDLIVE Telehealth professional services for: • Minor acute conditions (see Section 10 for definition) • Dermatology conditions (see Section 10 for definition) Note: Services must be provided through MDLIVE at https://members.mdlive.com/geha-callmd/ or call 888-912-1183. Note: For more information on telehealth benefits, please see Section 5(h), *Wellness and Other Special Features.*	Nothing (no deductible)	Nothing (no deductible)

Telehealth - continued on next page

Benefits Description	You pay	
Telehealth (cont.)	**Elevate Plus**	**Elevate**
Telehealth visit provided by a healthcare provider other than MDLIVE.	In-network: $30 copayment for visits to primary care providers (no deductible); $50 copayment for visits to specialist (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for visits to primary care providers (no deductible); $30 copayment for visits to specialist (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Lab, X-ray and other diagnostic tests	**Elevate Plus**	**Elevate**
Diagnostic tests, such as but not limited to: • Blood tests • Urinalysis • Pathology • Non-routine Pap test Note: We cover up to 16 tests for Urine Drug Testing (UDT) per person per calendar year. Note: See Section 5(C) for any applicable outpatient facility charges. Note: On the Elevate Option, if your in-network providers uses an out-of-network lab, imaging facility or radiologist, we will pay out-of-network benefits for lab and radiology charges.	In-network: $50 copayment (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount.
Diagnostic tests, such as but not limited to: • X-rays • Ultrasound • Electrocardiogram and EEG • Non-routine mammogram • Neurological testing Note: See Section 5(c) for any applicable outpatient facility charges. Note: See Section 5(b) and 5(c) for applicable charges for non-routine colonoscopy procedures. Notes: On the Elevate Option, if your in-network provider uses an out-of-network lab, imaging facility or radiologist, we will pay out-of-network benefits for lab and radiology charges.	In-network: $50 (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Lab, X-ray and other diagnostic tests - continued on next page

Benefits Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**Elevate Plus**	**Elevate**
Diagnostic test, such as but not limited to: • Double-contrast barium enemas • Bone density tests • Diagnostic genetic testing and screening (preauthorization required for genetic testing) Note: See Section 5(c) for any applicable outpatient facility charges. Note: Preauthorization may be required for these tests.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Note: Benefits are available for diagnostic genetic testing and genetic screenings when it is medically necessary to diagnose and/or manage a patient's existing medical condition. Medical necessity is determined by the plan using evidence-based medicine. Benefits are not provided for genetic panels when some or all of the test included in the panel are experimental or investigational or are not medically necessary. Note: On the Elevate Option, if your in-network provider uses an out-of-network lab, imaging facility or radiologist, we will pay out-of-network benefits for lab and radiology charges.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Diagnostic tests, such as but not limited to: • CT, MRI, MRA, Nuclear Cardiology and PET studies Note: See Section 5(c) for any applicable outpatient facility charges. Note: Preauthorization may be required for these tests. Notes: On the Elevate Option, if your in-network provider uses an out-of-network lab, imaging facility or radiologist, we will pay out-of-network benefits for lab and radiology charges.	In-network: $100 copayment (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Sleep Study (Polysomnography) • Home • In-Lab Note: In-Lab requires preauthorization. Note: Refer to Section 5(c) for outpatient facility fees associated with in-lab sleep studies.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Lab, X-ray and other diagnostic tests - continued on next page

Benefits Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**Elevate Plus**	**Elevate**
Not covered: • *Professional fees for automated lab tests.* • *Physical, psychiatric, or psychological exams and testing required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, travel, related to judicial or administrative proceedings or orders, or required to obtain or maintain a license of any type.* • *Immunizations, boosters, and medications required for obtaining, continuing, or maintaining insurance, a license of any type, employment and/or work-related exposure, attending camps, sports physicals, or for travel; unless Section 5(a), Preventive Care coverage criteria are met.* • *Home test kits including but not limited to HIV and drug home test kits, except as specified by the brochure.* • *Testing ordered by or on behalf of third parties (e.g., schools, courts, employers, etc.)*	*All charges*	*All charges*
Preventive care, adult	**Elevate Plus**	**Elevate**
• Routine physical every year. **The following preventive services are covered at the time interval recommended at each of the links below:** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as: - Cancer - Osteoporosis - Depression - Diabetes - High blood pressure - Total blood cholesterol - HIV - Colorectal cancer - For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at www.uspreventiveservicestaskforce.org • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC); based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/ • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as:	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefits Description	You pay	
Preventive care, adult (cont.)	**Elevate Plus**	**Elevate**
- Pap smears - Gonorrhea prophylactic medication to protect newborns - Annual counseling for sexually transmitted infections - Contraceptive methods - Screening for interpersonal and domestic violence - Perinatal depression counseling and interventions - For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, when ordered by your physician for obesity (BMI greater than or equal to 30 kg/m2) • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Programs must be ordered by a physician for treatment of your own obesity, or for education and support of a family member with obesity. • Nutritional counseling for individuals with BMI greater than or equal to 30 kg/m2 is covered as outlined in Section 5(a) *Educational classes and programs*. Note: Also see Section 5(h) for information on Weight management program. • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a), if applicable for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	In-network: Nothing (no deductible) Out of network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Routine mammogram - covered, including 3D mammograms • This coverage will include breast ultrasound performed after inconclusive breast cancer screening exam. To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: See Section 5(a), under *Educational classes and programs*, for coverage of tobacco cessation treatment.	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefits Description	You pay	
Preventive care, adult (cont.)	**Elevate Plus**	**Elevate**
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Professional fees for automated lab tests* • *Physical, psychiatric, or psychological exams and testing required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, travel related to judicial or administrative proceedings or orders, or required to obtain or maintain a license of any type.* • *Immunizations, boosters, and medications required for obtaining, continuing, or maintaining insurance, a license of any type, employment and/or work-related exposure, attending camps, sports physicals, or for travel; unless Section 5(a), Preventive Care coverage criteria are met.*	*All charges*	*All charges*
Preventive care, children	**Elevate Plus**	**Elevate**
The following preventive services are covered at the time interval recommended at each of the links below. • Well-child visits examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/imz-schedules/index.html To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: See Section (a), under *Educational classes and programs*, for coverage of tobacco cessation treatment.	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Preventive care, children - continued on next page

Benefits Description	You pay	
Preventive care, children (cont.)	**Elevate Plus**	**Elevate**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: Screening and counseling for childhood obesity is covered as preventive.	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, in children and adolescents age 6 years or older with BMI greater than or equal to 95th percentile on CDC growth charts for age and sex. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider in children and adolescents age 6 years or older with BMI greater than or equal to 95th percentile on CDC growth charts for age and sex. • Nutritional counseling for individuals with BMI greater than or equal to 30 kg/m2 is covered as outlined in Section 5(a) *Educational classes and programs.* • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	In-network: Nothing (no deductible) Out of network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Professional fees for automated lab tests.* • *Physical, psychiatric, or psychological exams and testing required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, travel, related to judicial or administrative proceedings or orders, or required to obtain or maintain a license of any type.* • *Immunizations, boosters, and medications required for obtaining, continuing, or maintaining insurance, a license of any type, employment and/or work-related exposure, attending camps, sports physicals, or for travel; unless Section 5(a), Preventive Care coverage criteria are met.*	*All charges*	*All charges*

Benefits Description	You pay	
Maternity care	**Elevate Plus**	**Elevate**
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes • Prenatal and Postpartum care • Delivery professional fees • Bacteriuria screening • Screening and counseling for prenatal and postpartum depression (see Section 5(e), *Mental Health and Substance Use Disorders* for treatment) Note: Refer to Section 5(c) for applicable maternity inpatient facility fees. Note: Here are some things to keep in mind: • Hospital services are covered under Section 5(c) and *Surgical Benefits* Section 5(b). • As part of your coverage, you have access to in-network certified nurse midwives and board-certified lactation specialist during the prenatal and post-partum period. Your coverage also includes services provided by a certified doula as outlined below. • You do not need to precertify your vaginal delivery; see Section 3, *How You Get Care* for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. • Home nursing visit, intravenous/infusion therapy, and injections are covered the same as other medical (not maternity) benefits for diagnostic and treatment services as outlined in Section 5(a), *Home health services*. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. • We will cover other care of an infant who requires non-routine treatment if we cover the infant under Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. Note: When a newborn requires non-routine or definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	In-network: Nothing for routine, preventive prenatal and postpartum care (no deductible) Out-of-network: You pay all charges	In-network: Nothing for routine, preventive prenatal and postpartum care (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefits Description	You pay	
Maternity care (cont.)	**Elevate Plus**	**Elevate**
Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party according to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation. Note: Refer to Section 5(a), *Educational classes and programs* for information on Childbirth education classes. Note: See Section 5(h) for information on GEHA's Family Planning Care Program.	In-network: Nothing for routine, preventive prenatal and postpartum care (no deductible) Out-of-network: You pay all charges	In-network: Nothing for routine, preventive prenatal and postpartum care (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
A doula is a non-medical trained professional who provides emotional, physical, and informational support during pregnancy, labor/delivery, and post-partum periods. See Section 10, *Definitions* for additional information. Benefits are allowable for services of a certified doula providing support for pregnancy-related care. Coverage is limited to $1,000 per pregnancy and must include in-person support during labor and delivery when pregnancy results in birth. Services provided by a certified doula limited to: • Prenatal visits • Labor and delivery support • Postpartum visits for up to one year following birth or cessation of pregnancy • Support during and after miscarriage, including bereavement support	In-network and out-of-network: All charges in excess of $1,000 (no deductible)	In-network and out-of-network: All charges in excess of $1,000 (no deductible)
Breastfeeding and lactation support, supplies and counseling for each birth. Breast pump and supplies: • One personal use, double channel electric breast pump with double suction capability every 12 months when purchased with a prescription for birth/delivery. • An initial, all-inclusive supply kit is provided with a new pump order. Replacement supplies and supply kits are allowed when necessary for pump operation. • There is no cost to the member when the designated pump is obtained through a contracted provider. For more information visit www.geha.com/Maternity.	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefits Description	You pay	
Maternity care (cont.)	**Elevate Plus**	**Elevate**
Not covered: • *Home uterine monitoring devices* • *Services for birth coaching or labor support, except when provided by a certified doula. See Section 10, Definitions*	*All charges*	*All Charges*
Family planning	**Elevate Plus**	**Elevate**
Contraceptive counseling on an annual basis. A range of voluntary family planning services without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list: • Voluntary female sterilizations • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms Note: See additional *Family Planning* and *Prescription drug* in Section 5(f) or 5(f)(a), if applicable. Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Voluntary male sterilization	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilizations* • *Genetic counseling*	*All charges*	*All charges*

Benefits Description	You pay	
Infertility services	**Elevate Plus**	**Elevate**
Infertility is defined as the inability to conceive pregnancy within a 12-month period for individuals under age 35 (6 months for persons aged 35 or older) through unprotected intercourse or artificial insemination. Infertility may also be established through evidence of medical history and diagnostic testing. Infertility includes the need for medical intervention to conceive pregnancy either as an individual or with a partner, except following voluntary sterilization. Diagnosis and treatment of infertility is covered and is specific to procedures listed below, except as shown in the *Not covered* section below. • Artificial insemination is a surgical procedure for the introduction of sperm or semen into the vagina, cervix, or uterus to produce pregnancy. Artificial insemination procedures and related services and supplies may be covered when medically necessary, including: - Intravaginal insemination (IVI), except if preformed outside of clinical setting - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs See Section 5(f) or 5(f)(a), if applicable Note: See Section 5(a), *Lab, X-ray and other diagnostic tests* for cost share associated with diagnostic testing. Note: See Section 5(b), *Surgical procedures* for cost share associated with covered surgical services. Note: See Section 5(h) for information on GEHA's *Family Planning Care Program.* Note: Preauthorization is required, see Section 3.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Iatrogenic infertility (see definition in Section 10) • Standard fertility preservation procedures (retrieval of and freezing of eggs and sperm) for members who have been diagnosed with iatrogenic infertility include: - collection of sperm - cryopreservation of sperm - cryopreservation of embryo - collection of oocyte - cryopreservation of oocyte - benefits limited to up to 12 months of storage of sperm, oocytes and embryo • Also includes infertility associated with medical and surgical gender affirmation. Note: Requires Preauthorization. See Section 3. Note: See Section 5(c) for facility-related benefits.	In-network: $30 copayment for office visits to primary care providers (no deductible); $50 copayment for office visits to specialists (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for office visits to primary care providers (no deductible); $30 copayment for office visits to specialists (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Infertility services - continued on next page

Benefits Description	You pay	
Infertility services (cont.)	**Elevate Plus**	**Elevate**
Note: See Section 5(h) for information on GEHA's Family Planning Care Program.	In-network: $30 copayment for office visits to primary care providers (no deductible); $50 copayment for office visits to specialists (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for office visits to primary care providers (no deductible); $30 copayment for office visits to specialists (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Assisted reproductive technology (ART), See Section 10, Definitions. (Procedures which involve surgically removing eggs from the ovaries, combining them with sperm in the laboratory, and returning them to the birthing person's body or donating them to another person), including:* - *In vitro fertilization (IVF), See Section 10, Definitions. (A method of assisted reproduction that involves combining an egg with sperm in a laboratory), including IVF needed due to iatrogenic infertility.* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)* • *Charges for gestational carrier or surrogacy, including antenatal appointments and labor/delivery services* • *Charges for procedures to collect, analyze, manipulate, or otherwise treat gametes (sperm and ova) when the partner or donor who produces the gamete is not a covered patient on the plan* • *Collection of unfertilized eggs/sperm and storage of fertilized and/or unfertilized eggs/sperm except in cases of iatrogenic infertility* • *Cost of donor sperm* • *Cost of donor egg* • *Elective preservation for reasons other than listed above, such as egg freezing sought due to natural aging* • *Fertility drugs, provided by facilities or physicians, including ovulation induction cycles while on injectable medication to stimulate the ovaries. Fertility drugs must be obtained through the pharmacy benefit, see Section 5(f), Prescription Drug Benefits and Specialty Drug Benefits. Medications will not be covered when dispensed by other sources, including physician offices, home health agencies and outpatient hospitals.*	*All charges*	*All charges*

Infertility services - continued on next page

Benefits Description	You pay	
Infertility services (cont.)	**Elevate Plus**	**Elevate**
• *Genetic counseling* • *Infertility services after voluntary sterilizations* • *Preimplantation diagnosis, testing, and/or screening of eggs, sperm, or embryos* • *Reversal of voluntary surgical sterilizations* • *Services and supplies related to non-covered ART procedures, such as in vitro fertilizations or home insemination procedures* • *Treatments such as artificial insemination, assisted reproductive technology, and/or in vitro fertilization prior to establishing diagnosis of infertility. See Section 10, Definitions.*	*All charges*	*All charges*
Allergy care	**Elevate Plus**	**Elevate**
• Testing and treatment, including materials (such as allergy serum) • Allergy injections Note: When billed with an office visit on the same day by the same provider, only one copay applies.	In-network: $30 copayment for primary care providers (no deductible); $50 copayment for specialists (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for primary care providers (no deductible); $30 copayment for specialists (no deductible) Out-of-network: 50% of the Plan allowance and any difference (deductible applies) between our allowance and the billed amount
Not covered: • *Clinical ecology and environmental medicine* • *Provocative food testing* • *Non-FDA approved sublingual allergy desensitization drugs*	*All charges*	*All charges*
Treatment therapies	**Elevate Plus**	**Elevate**
• Intravenous (IV)/Infusion Therapy - Outpatient and home IV/infusion and antibiotic therapy • Total Parenteral Nutrition (TPN) • Intrathecal pump refills • Enteral/Tube feeding nutrition, including Medical Foods for Inborn Errors of Metabolism (IEM). See Section 10 for definition. Note: The per diem (daily) rate for intrathecal pump refill will only be reimbursed on the day of the refill. No daily per diems will be allowed. • Chemotherapy and radiation therapy Note: See Section 5(c) for applicable outpatient facility charges for the therapies listed above.	In-network: $30 copayment for primary care providers (no deductible); $50 copayment for specialists (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefits Description	You pay	
Treatment therapies (cont.)	**Elevate Plus**	**Elevate**
Note: Preauthorization required for chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), *Surgical and Anesthesia Services* and Section 5(f), *Prescription Drug Benefits.* • Outpatient cardiac and pulmonary rehabilitation, 36 visit maximum each per year • Respiratory and inhalation therapies Note: Growth hormone therapy (GHT) is covered under the prescription drug benefit. We only cover GHT when we preauthorize the treatment. Call 800-821-6136 for preauthorization. We will ask you to submit information that establishes GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Other services that require preauthorization* in Section 3. Note: Medications required for treatment therapies may be available under the *Prescription drug benefits* in Section 5 (f). Note: Applied Behavioral Analysis Therapy is available under the Mental Health and Substance Use Disorder Benefits in Section 5(e).	In-network: $30 copayment for primary care providers (no deductible); $50 copayment for specialists (no deductible) Out-of-network: You pay all charges You pay 10% of the Plan allowance for drugs and/or medical nutrition administered or obtained in connection with your treatment (excludes drugs obtained under the Prescription drug benefit in Section 5(f)) (deductible applies) Note: Specialty drugs obtained outside of the pharmacy benefit from other sources (physicians offices, home health agencies, outpatient hospitals) may be subject to additional cost share as outlined in Section 5 (f), *Specialty drug benefits.*	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount Note: For both in-network and out-of-network, specialty drugs obtained outside of the pharmacy benefit from other sources (physician offices, home health agencies, outpatient hospitals) may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits.*
• Dialysis - hemodialysis and peritoneal dialysis • Home dialysis training for the member and a helper are covered Note: Notification for all dialysis requests is required, even when an extension is being requested. Refer to GEHA's dialysis notification form located at www.geha.com/Dialysis. Note: Medications required for treatment therapies may be available under the Prescription drug benefits in Section 5 (f).	In-network: $30 copayment for primary care providers (no deductible); $50 copayment for specialists (no deductible) Out-of-network: You pay all charges Note: Specialty drugs obtained outside of the pharmacy benefit from other sources (physicians offices, home health agencies, outpatient hospitals) may be subject to additional cost share as outlined in Section 5 (f), *Specialty drug benefits.*	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount Note: For both in-network and out-of-network, specialty drugs obtained outside of the pharmacy benefit from other sources (physicians offices, home health agencies, outpatient hospitals) may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits.*

Treatment therapies - continued on next page

Benefits Description	You pay	
Treatment therapies (cont.)	**Elevate Plus**	**Elevate**
Not covered: • *Chelation therapy except for acute arsenic, gold or lead poisoning* • *"Grocery" food items that can routinely be obtained online or in stores (e.g., gluten-free breads)* • *Maintenance cardiac and pulmonary rehabilitation* • *Topical hyperbaric oxygen therapy* • *Prolotherapy* • *ABA therapy services provided by the school are not reimbursable by the health plan*	*All charges*	*All charges*
Physical, occupational, and speech therapy	**Elevate Plus**	**Elevate**
Elevate Plus Option: Up to 60 outpatient therapy visits per person per calendar year for the combined services of each of the following: Elevate Option: Up to 30 outpatient therapy visits per person per calendar year for the combined services of each of the following: • Qualified physical therapists • Qualified occupational therapists • Qualified speech therapists Note: Inpatient therapy services are not applied to the visit limits above. Note: Combined therapy visits may be used for rehabilitative therapy or habilitative therapy. • Rehabilitative: Therapy is initiated to restore bodily function when there has been a total or partial loss of bodily function due to illness, surgery, or injury. • Habilitative: Therapy is initiated to address a genetic, congenital, or early acquired disorder resulting in significant deficit of Activities of Daily Living (ADL), fine motor, or gross motor skills. Therapy services are provided to enhance functional status and is focused on developing skills that were never present.	In-network: $30 copayment per visit to primary care providers (no deductible); $50 copayment per visit to specialists (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment per visit to primary care providers (no deductible); $30 copayment per visit to specialists (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Physical, occupational, and speech therapy - continued on next page

Benefits Description	You pay	
Physical, occupational, and speech therapy (cont.)	**Elevate Plus**	**Elevate**
Not covered: • *Long-term rehabilitative therapy* • *Maintenance therapy-measurable improvement is not expected, or progress is no longer demonstrated* • *Hot and cold packs* • *Computers, tablets, computer programs/games used in association with communication aides, internet or phone services used in conjunction with communication devices* • *Hippotherapy* • *Rehabilitative services intended to teach or enhance Instrumental Activities of Daily Living (therapy to promote skills associated with independent living, such as shopping, using a phone, cleaning, laundry, preparing meals, managing medications, driving, or managing money/finances)* • *Sensory, Auditory, or Sensory Integration Therapy* • *Biofeedback, educational, recreational or milieu therapy* • *Exercise programs*	*All charges*	*All charges*
Cognitive rehabilitation	**Elevate Plus**	**Elevate**
Provided when medically necessary following brain injury or traumatic brain injury. Services will only be covered when provided by the following while practicing within their scope of care: • Speech, occupational and/or physical therapists • Psychologists • Physicians	In-network: $30 copayment for office visits to primary care providers (no deductible); $50 copayment for office visits to specialists (no deductible) Out-of-network: You will pay charges	In-network: $10 copayment for office visits to primary care providers (no deductible); $30 copayment for office visits to specialists (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	**Elevate Plus**	**Elevate**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a), *Orthopedic and prosthetic dev*ices.	In-network: $30 copayment for office visits to primary care providers (no deductible); $50 copayment for office visits to specialists (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for office visits to primary care providers (no deductible); $30 copayment for office visits to specialists (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Hearing services (testing, treatment, and supplies) - continued on next page

Benefits Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	**Elevate Plus**	**Elevate**
• External hearing aids Note: Elevate Plus Option benefit is payable per person every 36 months for adults and every 12 months for children up to age 22. Note: See *Non-PSHB Benefits Available to Plan Members* for additional hearing aid discount program information.	All charges in excess of $1,500 (no deductible)	*All charges*
Not covered: • *Hearing services that are not shown as covered* • *Over-the-counter hearing aids, enhancement devices, accessories or supplies*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**Elevate Plus**	**Elevate**
• Diagnosis and treatment of diseases of the eye • Outpatient vision therapy for treatment of convergence insufficiency up to a maximum of 24 visits per year for ages 5- 18	In-network: $30 copayment for office visits to primary care providers (no deductible); $50 copayment for office visits to specialists (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for office visits to primary care providers (no deductible); $30 copayment for office visits to specialists (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
• First pair of contact lenses or standard ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Computer programs of any type, including but not limited to those to assist with vision therapy* • *Eyeglasses or contact lenses and examinations for them except as shown above* • *Radial keratotomy and other refractive surgery* • *Special multifocal ocular implant lenses* • *Vision therapy except as noted above*	*All charges*	*All charges*

Benefits Description	You pay	
Foot care	**Elevate Plus**	**Elevate**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	In-network: $30 copayment for office visits to primary care providers (no deductible); $50 copayment for office visits to specialists (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for office visits to primary care providers (no deductible); $30 copayment for office visits to specialists (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
• Diabetic shoes and shoe inserts individually designed and fitted to offload pressure points on the diabetic foot Note: Limited to $150 per person per calendar year.	In-network: All charges in excess of $150 (no deductible) Out-of-network: You pay all charges	In-network and out-of-network: All charges in excess of $150 (no deductible)
Not covered: • *Cutting, trimming of toenails or removal of corns, calluses, or similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**Elevate Plus**	**Elevate**
• Artificial limbs and eyes • Orthopedic braces • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers and surgically implanted breast implant following mastectomy Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) *Services provided by a hospital or other facility, and ambulance services.*	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefits Description	You pay	
Orthopedic and prosthetic devices (cont.)	**Elevate Plus**	**Elevate**
Note: We will pay only for the cost of the standard item. Coverage for specialty items is limited to the cost of the standard item. Note: Preauthorization may be required for orthopedic and prosthetic devices with a retail price of $1,000 or more. Refer to the back of your member ID card for the contact information. Call Customer Care for benefit coverage questions or assistance locating a provider. Healthcare providers are encouraged to call *Prior Authorization* number for requirements.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Over-the-counter hearing aids, enhancement devices, accessories or supplies*	*All charges*	*All charges*
Durable medical equipment (DME)	**Elevate Plus**	**Elevate**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Certain medical supplies • Rental of dialysis equipment • Standard hospital beds • Standard wheelchairs • Crutches • Walkers • Continuous Positive Airway Pressure (CPAP) machine • Braces including necessary adjustments to shoes to accommodate braces, which are used for the purpose of supporting a weak or deformed body part • Braces restricting or eliminating motion in a diseased or injured part of the body • Bone growth stimulators Note: DME is equipment and supplies that: - Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) - Are medically necessary - Are primarily and customarily used only for a medical purpose - Are generally useful only to a person with an illness or injury	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay	
Durable medical equipment (DME) (cont.)	**Elevate Plus**	**Elevate**
- Are designed for prolonged use - Serve a specific therapeutic purpose in the treatment of an illness or injury Note: For items that are available for purchase, rentals may be covered up to purchase price not to exceed rental for greater than 10 months. Note: Preauthorization may be required for Durable Medical Equipment. that has a cumulative rental and/or retail purchase price of $1,000 or more. Refer to the back of your member ID card for the contact information. Call Customer Care for benefit coverage questions or assistance locating a provider. Healthcare providers are encouraged to call *Prior Authorization* number for requirements. Note: Refer to Section 5(f), for glucose meter and diabetic supplies. Note: Refer to Section 5(a), *Maternity Care* for obtaining breast pump and supplies.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Speech generating devices Note: Electronic voice output communication aids, which are electronic augmentative and alternative communication systems used to supplement or replace speech or writing for individuals with severe speech impairments. • Preauthorization required • Used for patients suffering from severe expressive speech disorders and have a medical condition that warrants the use of such device • Requires a formal speech and language evaluation by licensed speech therapist	In-network: All charges in excess of $1,250 per calendar year (no deductible) Out-of-network: You pay all charges	In-network and out-of-network: All charges in excess of $1,250 per calendar year (no deductible)
Wigs/cranial hair prosthesis used for hair loss due to the treatment of cancer. Note: One wig/cranial hair prosthesis per lifetime	In-network and out-of-network: All charges in excess of $350 (no deductible)	In-network and out-of-network: All charges in excess of $350 (no deductible)
Not covered: • *Motorized wheelchairs and other power operated vehicles unless meeting ACA requirements and medical necessity* • *Deluxe or upgraded equipment and supplies* • *Computers, tablets, computer programs/games used in association with communication aides, internet or phone services used in conjunction with communication devices*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay	
Durable medical equipment (DME) (cont.)	**Elevate Plus**	**Elevate**
• *Air purifiers, air conditioners, heating pads, cold therapy units, whirlpool bathing equipment, sun and heat lamps, exercise devices (even if ordered by a doctor), and other equipment that does not meet the definition of durable medical equipment in Section 5(a), Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals* • *Lifts, such as seat, chair, hydraulic, or van lifts* • *Replacement of the wig/cranial hair prosthesis, maintenance and supplies* • *Hair transplants or surgical procedures that involve the attachment of hair or a wig/cranial hair prosthesis to the scalp.* • *Devices or programs to eliminate bed wetting* • *If a member is a patient in a facility other than the member's primary residence, or in a distinct part of a facility that provides services such as skilled nursing, rehabilitation services, or provides medical or nursing, DME will not be covered separately for rental or purchase*	*All charges*	*All charges*
Home health services	**Elevate Plus**	**Elevate**
50 in-home intermittent visits per person, per calendar year, not to exceed one visit up to six hours for specialty drug infusions or up to two hours per day for all other care when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) under the supervision of a registered nurse, or qualified* medical social worker (M.S.W) provides the services • The attending physician orders the care • The physician indicates the length of time the services are needed • Medical social services provided by a qualified* medical social worker may be covered under the home health service benefit when the member meets the following criteria: - Member must be in need of home health services on an intermittent basis home health skilled nursing, physical therapy, speech-language, or occupational therapy. - Member must be under the care of a physician who signs the plan of care. - The plan of care indicates how the services which are required necessitate the skills of a qualified* medical social worker to be performed safely and effectively.	In-network: $30 copayment (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Home health services - continued on next page

Benefits Description	You pay	
Home health services (cont.)	**Elevate Plus**	**Elevate**
- In-home assessment services from a qualified* medical social worker are required to support accurate diagnosis and amelioration of social determinants of health identified as an impediment to the effective treatment of the patient's medical condition or rate of recovery. * Services performed by a qualified medical social worker are only eligible for reimbursement when furnished through a licensed home health agency or under the supervision of an eligible physician actively involved in the member's care. Note: Please refer to the *Specialty drug benefits* in Section 5(f), *Prescription Drug Benefits* for information on benefits for home infusion therapy medications. Note: See *Durable medical equipment* (DME) above for coverage of DME benefit services received in the home.	In-network: $30 copayment (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medications* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care (See Section 10)* • *Long-term care (See Section 10)* • *Hourly nursing where there is no skilled need (otherwise known as private duty nursing) or the need is beyond a two hour visit per day other than for specialty drug infusions that can require up to 6 hours of skilled nursing. Also not covered is nursing provided in the acute care facility, post-acute facilities (skilled nursing facilities), rehabilitation facilities, long-term acute care facilities, long-term care facilities.* • *Ongoing licensed/unlicensed dialysis assistance in the home after initial dialysis training* • *Foods that can be obtained over-the-counter (without a prescription) even if prescribed by a physician*	*All charges*	*All charges*

Benefits Description	You pay	
Manipulative therapy	**Elevate Plus**	**Elevate**
Benefit for Manipulative therapy limited to: • Elevate Plus Option - 15 visits per person per calendar year • Elevate Option - 12 visits per person per calendar year Services limited to: • Chiropractic spinal and extremities manipulative treatment • Adjunctive procedures such as ultrasound, electrical muscle stimulation, and vibratory therapy • X-rays used to detect and determine nerve interferences due to spinal subluxations or misalignments	In-network: $30 copayment (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Any treatment not specifically listed as covered, including acupressure, aroma therapy, biofeedback, clinical ecology, cupping, dry needling, environmental medicine, hypnotherapy, massage therapy, naturopathic services and rolfing* • *Maintenance therapy - measurable improvement is not expected or progress is no longer demonstrated*	*All charges*	*All charges*
Alternative treatments	**Elevate Plus**	**Elevate**
Acupuncture: • Benefits are limited to 20 visits per person per calendar year for medically necessary acupuncture treatments by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner.	In-network: $30 copayment (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Any treatment not specifically listed as covered, including acupressure, aroma therapy, biofeedback, clinical ecology, cupping, dry needling, environmental medicine, hypnotherapy, massage therapy, naturopathic services, and rolfing.* • *Services provided by Christian Science practitioners or facilities.*	*All charges*	*All charges*

Benefits Description	You pay	
Educational classes and programs	**Elevate Plus**	**Elevate**
Coverage is limited to: • Tobacco Cessation programs - We cover counseling sessions such as proactive phone counseling, group counseling and individual counseling for adult males, pregnant and non-pregnant females, and children and adolescents. • In addition, we cover over-the-counter (with a physician's prescription) and prescription tobacco cessation drugs approved by the FDA. Note: The quantity of drugs reimbursed will be subject to recommended courses of treatment. You may obtain tobacco cessation drugs with your plan identification card, through a participating network retail Pharmacy or Elevate Plus Option members may obtain through CVS Caremark Mail Service Pharmacy. (See filing instructions in Section 5(f), *Prescription drug benefits*.)	In-network: Nothing (no deductible) for counseling for up to two attempts per person per calendar year, with up to four counseling sessions per attempt. Nothing (no deductible) for OTC and prescription drugs approved by the FDA to treat tobacco dependence. Out-of-network: You pay all charges	In-network: Nothing (no deductible) for counseling for up to two attempts per person per calendar year, with up to four counseling sessions per attempt. Nothing (no deductible) for OTC and prescription drugs approved by the FDA to treat tobacco dependence. Out-of-network: Nothing, except any difference between our Plan allowance and the billed amount (no deductible) for counseling for up to two attempts per person per calendar year, with up to four counseling sessions per attempt.
Diabetes Education The following program criteria needs to be met. • Consists of services by healthcare professionals (physicians, registered dieticians, registered nurses, registered pharmacists); • Designed to educate the member about medically necessary diabetes self-care upon initial diagnosis	In-network: Nothing up to the Plan allowance (no deductible) Out-of-network: You pay all charges	In-network: Nothing up to the Plan allowance (no deductible) Out-of-network: Nothing up to the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Nutritional Counseling Note: Provided by a dietitian with state license or statutory certification. Nutritional counseling must be ordered by a physician.	In-network: Nothing up to the Plan allowance (no deductible) Out-of-network: You pay all charges	In-network: Nothing up to the Plan allowance (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Childbirth education classes • One series of childbirth education classes per pregnancy, only when provided by a covered provider, see Section 3, *How You Get Care.* • Classes will be allowed up to $150, but not greater than the cost of the class or course. For more information visit www.geha.com/Maternity	In-network: All charges in excess of $150 (no deductible) Out-of-network: You pay all charges	In-network and out-of-network: All charges in excess of $150 (no deductible)
Not covered: • *Weight loss programs, except as specified by the brochure.*	*All charges*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under the Elevate Plus Option, the calendar year deductible is $200 per person ($400 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the calendar year deductible is $500 per person ($1,000 if enrollment is Self Plus One or Self and Family). If you use an out-of-network provider, the calendar year deductible is $1,000 per person ($2,000 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the out-of-network benefits are the standard benefits of the Plan. In-network benefits apply only when you use an in-network provider. When no in-network provider is available, out-of-network benefits apply. Under the Elevate Plus Option, the in-network benefits are the standard benefits of the Plan.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- When you use an in-network hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If the services are rendered by out-of-network providers at an in-network hospital, we will pay up to the Plan Allowance according to the No Surprises Act.
- We will provide in-network benefits if you are admitted to an out-of-network hospital due to a medical emergency. We will also provide in-network benefits for professionals who provide services in a non-network hospital, when admitted due to a medical emergency.
- **YOUR NETWORK PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME IN-NETWORK SERVICES AND/OR PROCEDURES.** You are responsible for obtaining preauthorization for out-of-network services under the Elevate Option, and failure to do so may result in penalties. Please refer to the preauthorization information shown in Section 3 or call customer service to be sure which services require preauthorization.
- Copayments for physician surgical services are limited to two per surgery when co-surgeons are utilized.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Medications may be available under the prescription drug benefit and may require prior authorization. Specialty drugs obtained outside of the pharmacy benefit may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits.*

Benefits Description	You pay	
Note: For both the Elevate and Elevate Plus Options, we state whether or not the calendar year deductible applies for each benefit listed in this Section.		
Surgical procedures	**Elevate Plus**	**Elevate**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy and non-routine colonoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies - limited to children under the age of 18 unless there is functional deficit (see below, *Reconstructive surgery*) • Insertion of internal prosthetic devices (See 5(a), *Orthopedic and prosthetic devices* for device coverage information) • Treatment of burns • Surgical treatment of severe obesity (bariatric surgery) - Eligible members must be age 18 or over; or for adolescents, have achieved greater than 95% of estimated adult height and a minimum Tanner Stage of 4, and - Have a minimum Body Mass Index (BMI) of 40 or greater than or equal to 35 (with at least one co-morbid condition present), and - Complete a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation, and - Have completed a 6-month plan of physician supervised diet documented within the last two years, and - Preauthorization is required. Note: Removal of excess skin covered only if medically necessary. Note: Post-operative care is considered to be included in the fee charged for a surgical procedure by a doctor. Any additional fees charged by a doctor are not covered unless such charge is for an unrelated condition. Note: For female and male surgical family planning procedures see Section 5(a) *Family Planning* Note: When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure based on: - Full Plan allowance • For the secondary and subsequent procedures based on: - One-half of the Plan allowance	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefits Description	You pay	
Surgical procedures (cont.)	**Elevate Plus**	**Elevate**
Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician or surgeon* • *Routine treatment of conditions of the foot (see Foot care)* • *Surgical treatment of hyperhidrosis unless alternative therapies such as Botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful*	*All charges*	*All charges*
Reconstructive surgery	**Elevate Plus**	**Elevate**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: cleft lip; cleft palate; birth marks; and webbed fingers and toes. Note: Covered for children under the age of 18 regardless of functional deficit. Covered for ages 18 and over only if there is a functional deficit. • All stages of breast reconstruction surgery following a mastectomy or lumpectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefits Description	You pay	
Reconstructive surgery (cont.)	**Elevate Plus**	**Elevate**
- breast prostheses; and surgical bras and replacements (see Section 5 (a), *Orthopedic and prosthetic devices* for coverage). Note: We pay for internal breast prostheses as hospital benefits if billed by a hospital. If included with the surgeon's bill, surgery benefits will apply. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Note: Preauthorization may be required, see Section 3.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
• Gender Affirming Surgery: - Surgical treatment of gender dysphoria such as surgical change of sex characteristics including bilateral mastectomy, breast augmentation; genital reconstructive surgeries (vulvoplasty, orchiectomy, urethroplasty, penectomy, vaginoplasty, labiaplasty and clitoroplasty), hysterectomy/ salpingo-oophorectomy, reconstruction of the fixed part of the urethra, metoidioplasty, phalloplasty, colpectomy/ vaginectomy, colpocleisis, perineoplasty, vulvectomy, scrotoplasty, implantation of erection and/or testicular prosthesis; pectoral muscle implants; hair removal including genital electrolysis, non-genital area electrolysis or laser hair removal (e.g., face, chest); liposuction/lipofilling specific to gender affirmation; facial gender affirming surgeries such as genioplasty, jaw and/or chin reshaping, rhinoplasty, blepharoplasty, brow ptosis repair, lip shortening, scalp (hairline) advancement, hair grafts; voice modification including vocal feminization and masculinization surgery. - Requirements: • Must be 18 years of age or older, and • Must have documented evidence of persistent gender dysphoria, and • Must have evidence of well-controlled physical and mental health conditions, and • Must have a letter from a qualified mental health professional supporting decision for procedure • Preauthorization is required - Additional information to above based on specific surgical requests:	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefits Description	You pay	
Reconstructive surgery (cont.)	**Elevate Plus**	**Elevate**
• Genital reconstructive surgeries require 1) 12 months of hormone therapy as appropriate for member's gender goal, and 2) 12 months living a gender role congruent with gender identity. • Augmentation mammoplasty requires 1) 12 months of hormone therapy as appropriate for member's gender goal, and 2) breast growth has been concluded, and breast size has been stable for 6 months, and 3) documentation that size is not sufficient for comfort in social role. • Facial gender affirming surgery requires clinically significant dysphoria specifically related to the feature(s) on which procedure(s) will be performed, which causes discomfort in their social role related to gender. • Voice surgery (phonosurgery) requires 1) participation in a minimum of 8 weeks of voice therapy performed by a licensed speech language pathologist, (See Section 5(a), *Physical, occupational, and speech therapy*) and 2) 12 months of appropriate hormone therapy when the desired result is lower voice pitch. • Body contouring and/or liposuction/lipofilling specific to gender affirmation requires body fat redistribution and muscle mass changes related to hormone therapy have stabilized for at least 3 months.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated promptly or as soon as the member's condition permits* • *Surgeries related to sexual dysfunction* • *Surgeries to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit* • *Charges for photographs to document physical conditions* • *Gender affirming procedures that are not medically necessary (see Section 10 for medical necessity definition)*	*All charges*	*All charges*
Oral and maxillofacial surgery	**Elevate Plus**	**Elevate**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues when unrelated to teeth and supporting structures • Excision of cysts and incision of abscesses unrelated to tooth structure • Extraction of impacted (unerupted or partially erupted) teeth	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting

Oral and maxillofacial surgery - continued on next page

Benefits Description	You pay	
Oral and maxillofacial surgery (cont.)	**Elevate Plus**	**Elevate**
• Partial or radical removal of the lower jaw with bone graft • Open reduction of dislocations and excision, manipulation, aspiration or injection of temporomandibular joints • Removal of foreign body, skin, subcutaneous areolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones and incision/excision of salivary glands and ducts • Repair of traumatic wounds • Incision of the sinus and repair of oral fistulas • Surgical treatment of trigeminal neuralgia • Orthognathic surgery for the following conditions only: - Moderate or severe sleep apnea only after conservative treatment of sleep apnea has failed - Craniofacial congenital anomalies - Severe functional malocclusion not able to be corrected by conservative treatment options - Orthognathic procedures used for reconstruction following injury or illness causing a functional deficit • Frenectomy, frenotomy, or frenuloplasty when the patient has a functional deficit unrelated to teeth and their supporting structures • Other oral surgery procedures that do not involve the teeth or their supporting structures Note: Orthognathic surgery requires preauthorization	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants; including for the treatment of accidental injury* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) including removal of tori for placement of dentures* • *Orthodontic treatment* • *Any oral or maxillofacial or orthognathic surgery not specifically listed as covered*	*All charges*	*All charges*
Organ/tissue transplants	**Elevate Plus**	**Elevate**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services that require preauthorization* in Section 3 for preauthorization procedures. Solid organ transplants are limited to: • Allogeneic islet • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting

Organ/tissue transplants - continued on next page

Benefits Description	You pay	
Organ/tissue transplants (cont.)	**Elevate Plus**	**Elevate**
• Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung single/bilateral/lobar • Pancreas	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services that require preauthorization* in Section 3 for preauthorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay	
Organ/tissue transplants (cont.)	**Elevate Plus**	**Elevate**
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Refer to *Other services that require preauthorization* in Section 3 for preauthorization procedures. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Beta Thalassemia Major - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Immune deficiency other than Severe Combined Immunodeficiency (SCID, e.g., Wiskott-Aldrich syndrome, Kostmann's Syndrome, Leukocyte Adhesion Deficiencies) not amendable to more conservative treatment - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders(i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidoses (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Multiple myeloma - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay	
Organ/tissue transplants (cont.)	**Elevate Plus**	**Elevate**
- Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Amyloidosis - Breast Cancer - Childhood rhabdomyosarcoma - Ependymoblastoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Medulloblastoma - Multiple myeloma - Multiple sclerosis - Neuroblastoma - Scleroderma - Scleroderma - SSc (severe, progressive) - Systemic sclerosis - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors - Waldenstrom's macroglobulinemia	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services that require preauthorization* in Section 3 for preauthorization procedures. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings

Organ/tissue transplants - continued on next page

Benefits Description	You pay	
Organ/tissue transplants (cont.)	**Elevate Plus**	**Elevate**
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Multiple myeloma - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle Cell disease • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
These blood or marrow stem cell transplants are covered in-network at a Plan-designated National Cancer Institute or National Institutes of health approved clinical trial facility if approved by the Plan's medical director in accordance with the Plan's protocols. These transplants include but are not limited to the diagnoses below. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care this is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay	
Organ/tissue transplants (cont.)	**Elevate Plus**	**Elevate**
• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay	
Organ/tissue transplants (cont.)	**Elevate Plus**	**Elevate**
- Systemic sclerosis	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: $250 copayment (no deductible) per performing surgeon, for surgical procedures performed in an inpatient setting In-network: 25% of the Plan allowance (deductible applies), for surgical procedures performed in all other settings Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Transportation Benefit • We will also provide up to $10,000 per covered transplant, excluding cornea, for transportation (mileage or airfare) to a plan-designated facility and reasonable temporary living expenses (i.e., lodging and meals) for the recipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 100 miles from the designated transplant facility. You must contact Customer Service at 800-821-6136 for what are considered reasonable temporary living expenses. • Transportation benefits are only payable when GEHA is the primary payor. • Transportation benefits are payable to follow-up care up to one year following the transplant.	All charges in excess of $10,000 (no deductible)	All charges in excess of $10,000 (no deductible)
Donor expenses • We will cover donor screening tests and donor search expenses for up to four potential donors of organ/tissue transplants. • We cover related medical and hospital expenses of the donor when we cover the recipient, in addition to the testing of family members. Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated below. This benefit applies only if the recipient is covered by the Plan and if the donor's expenses are not otherwise covered.	Services are paid at regular Plan benefits. Note: See Sections 5(a) through 5(f) for applicable services and benefits	Services are paid at regular Plan benefits. Note: See Sections 5(a) through 5(f) for applicable services and benefits

Organ/tissue transplants - continued on next page

Benefits Description	You pay	
Organ/tissue transplants (cont.)	**Elevate Plus**	**Elevate**
Notes: • If you are a participant in a clinical trial, please see Section 9, *Clinical Trials*, for coverage details. • We will pay for a second transplant evaluation recommended by a physician qualified to perform the transplant if, the transplant diagnosis is covered, and the physician is not associated or in practice with the physician who recommended and will perform the transplant. A third transplant evaluation is covered only if the second evaluation does not confirm the initial evaluation. • The transplant must be performed at a Plan-designated transplant facility to receive maximum benefits. • If precertification is not obtained or a Plan-designated transplant facility is not used, our allowance will be limited for hospital and surgery expenses up to a maximum of $100,000 per transplant. If we cannot refer a member in need of a transplant to a designated facility, the $100,000 maximum will not apply. • If benefits are limited to $100,000 per transplant, included in the maximum are all charges for hospital, medical and surgical care incurred while the patient is hospitalized for a covered transplant surgery and subsequent complications related to the transplant. Outpatient expenses for chemotherapy and any process of obtaining stem cells or bone marrow associated with bone marrow transplant (stem cell support) are included in benefits limit of $100,000 per transplant. Tandem bone marrow transplants approved as one treatment protocol are limited to $100,000 when not performed at a Plan-designated facility. All treatment within 120 days following the transplant is subject to the $100,000 limit. Outpatient prescription drugs are not a part of the $100,000 limit. • Chemotherapy and procedures related to bone marrow transplantation must be performed only at a Plan-designated transplant facility to receive maximum benefits. • Simultaneous transplants such as kidney/pancreas, heart/lung, heart/liver are considered as one transplant procedure and are limited to $100,000 when not performed at a Plan-designated transplant facility.	Services are paid at regular Plan benefits. Note: See Sections 5(a) through 5(f) for applicable services and benefits	Services are paid at regular Plan benefits. Note: See Sections 5(a) through 5(f) for applicable services and benefits
Not covered: • *Services or supplies for or related to surgical transplant procedures (including administration of high-dose chemotherapy) for artificial or human organ/tissue transplants not listed as specifically covered* • *Donor screening tests and donor search expenses, except those listed above*	*All charges*	*All charges*

Benefits Description	You pay	
Anesthesia	**Elevate Plus**	**Elevate**
Professional fees for the administration anesthesia in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: We cover anesthesia services related to dental procedures when necessitated by a non-dental physical impairment and the patient qualifies for dental treatment in a hospital or outpatient facility (see Section 5(c) for facility coverage). We do not cover the dental procedures.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Anesthesia related to non-covered surgeries or procedures.*	*All charges*	*All charges*

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under the Elevate Plus Option, the calendar year deductible is $200 per person ($400 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the calendar year deductible is $500 per person ($1,000 if enrollment is Self Plus One or Self and Family). If you use an out-of-network provider, the calendar year deductible is $1,000 per person ($2,000 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the out-of-network benefits are the standard benefits of the Plan. In-network benefits apply only when you use an in-network provider. When no in-network provider is available, out-of-network benefits apply. Under the Elevate Plus Option, the in-network benefits are the standard benefits of the Plan.
- Under the Elevate Option, charges billed by an out-of-network facility for implantable devices, surgical hardware, etc., are subject to the Plan allowance, which is based on the provider's cost plus 20% with submitted invoice, or two times the Medicare allowance without an invoice. Providers are encouraged to notify us on admission to determine benefits payable.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or 5(b).
- When you receive hospital observation services, we apply outpatient benefits to covered services. Inpatient benefits will apply only when your physician formally admits you to the hospital as an inpatient. It is either your provider's or your responsibility to ensure that we are contacted for precertification if you are admitted as an inpatient.
- Cost for observation care lasting 24 hours or more will not exceed the cost of inpatient care.
- When you use an in-network hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If the services are rendered by out-of-network providers at an in-network hospital, we will pay up to the Plan Allowance according to the No Surprises Act.
- We will provide in-network benefits if you are admitted to an out-of-network hospital due to a medical emergency. We will also provide in-network benefits for professionals who provide services in an out-of-network hospital, when admitted due to a medical emergency.
- **YOU MUST GET PRECERTIFICATION FOR INPATIENT STAYS UNLESS DUE TO A MEDICAL EMERGENCY. FAILURE TO DO SO WILL RESULT IN A FINANCIAL PENALTY AS OUTLINED IN SECTION 3, *How You Get Care.*** Please refer to the precertification information shown in Section 3 to be sure which services require precertification. Confinements which are considered not medically necessary will not be covered. Penalties are not subject to the catastrophic limit.
  - When requested, itemized bills with supporting documentation are required for benefit consideration.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

- Medications may be available under the prescription drug benefit and may require prior authorization. Specialty drugs obtained outside of the pharmacy benefit may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits.*

Benefits Description	You pay	
Note: For both the Elevate and Elevate Plus Options, we state whether or not the calendar year deductible applies for each benefit listed in this Section.		
Inpatient hospital	**Elevate Plus**	**Elevate**
Precertification is required in advance of admission. Note: For the Elevate Option, out-of-network facilities must, prior to admission, agree to abide by the terms established by the Plan for the care of the particular member and for the submission and processing of related claims. Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: We cover up to 16 tests for Urine Drug Testing (UDT) per person per calendar year. Note: We base payment on whether the facility or a healthcare professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay hospital benefits and when the anesthesiologist bills, we pay surgery benefits. Note: Here are some things to keep in mind regarding maternity benefits: • You do not need to precertify your normal delivery; • See Section 3, *How You Get Care* for other circumstances, such as extended stays for you or your baby.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefits Description	You pay	
Inpatient hospital (cont.)	**Elevate Plus**	**Elevate**
• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. • We will cover other care of an infant who requires non-routine treatment under regular Plan benefits if we cover the infant under a Self and Family or Self Plus One enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Any part of a hospital admission that is not medically necessary (see Section 10), such as when you do not need acute hospital inpatient (overnight) care but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting.* • *Any part of a hospital admission that is related to a non-covered surgery or procedure* • *Custodial care (see Section 10)* • *Long-term care (see Section 10)* • *Non-covered facilities such as nursing homes, schools* • *Personal comfort items such as phone, television, barber services, guest meals and beds* • *Private nursing care* • *Biofeedback, educational, recreational or milieu therapy*	*All charges*	*All charges*
Outpatient hospital, clinic or ambulatory surgical center	**Elevate Plus**	**Elevate**
• Operating, recovery, maternity (includes birth center), observation, and other treatment rooms • Prescribed drugs and medications • Administration of blood, blood plasma, and other biologicals • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Observation care	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

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

Benefits Description	You pay	
Outpatient hospital, clinic or ambulatory surgical center (cont.)	**Elevate Plus**	**Elevate**
Note: Observation care is covered as an outpatient hospital service, see Section 10. Note: We cover up to 16 tests for Urine Drug Testing (UDT) per person per calendar year. Note: Please refer to Section 5(f), *Prescription Drug Benefits* for information on benefits for Specialty drug medications dispensed by hospitals. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
• Antibiotic therapy - Intravenous (IV)/Infusion • Intravenous (IV)/Infusion Therapy - Outpatient and home IV antibiotic therapy • Total Parenteral Nutrition (TPN) • Intrathecal pumps refills Note: The per diem (daily) rate for intrathecal pump refill will only be reimbursed on the day of the refill. No daily per diems will be allowed. • Chemotherapy and radiation therapy Note: Preauthorization required for chemotherapy and radiation therapy Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5 (b), *Services Provided by a Hospital or Other Facility, and Ambulance Services.* Note: Medications required for treatment therapies may be available under the *Prescription drug benefits* in Section 5(f).	In-network: 15% of the Plan allowance (deductible applies) You pay 10% of the Plan allowance (deductible applies) for drugs administered or obtained in connection with your treatment (excludes drugs obtained under the Prescription drug benefit in Section 5(f)). Note: Specialty drugs obtained outside of the pharmacy benefit from other sources (physician offices, home health agencies, outpatient hospitals) may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits.*	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount Note: For both in-network and out-of-network, specialty drugs obtained outside of the pharmacy benefit from other sources (physician offices, home health agencies, outpatient hospitals) may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits*
Outpatient diagnostic and treatment services performed and billed by a facility, such as but not limited to: • Laboratory tests (blood tests, urinalysis, non-routine Pap tests) and pathology services	In-network: $0 (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies)

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

Benefits Description	You pay	
Outpatient hospital, clinic or ambulatory surgical center (cont.)	**Elevate Plus**	**Elevate**
Note: For Elevate, if your in-network provider uses an out-of-network lab, imaging facility or radiologist, we will pay out-of-network benefits for lab and radiology charges.	In-network: $0 (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Outpatient diagnostic testing and treatment services performed and billed by a facility, such as but not limited to: • X-rays • Ultrasound • Electrocardiogram and EEG • Non-routine mammograms • Neurological testing Note: For Elevate, if your in-network provider uses an out-of-network lab, imaging facility or radiologist, we will pay out-of-network benefits for lab and radiology charges.	In-network: $50 copayment per day per facility (no deductible) Out-of-Network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Outpatient diagnostic testing and treatment services performed and billed by a facility: • Non-routine colonoscopy	In-network: 15% of the Plan allowance (deductible applies) Out-of-Network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Outpatient diagnostic testing and treatment services performed and billed by a facility, such as but not limited to: • Double-contrast barium enemas • Bone density tests • Diagnostic genetic testing and screening (preauthorization required for genetic testing) • Psychological and Neuropsychological testing • In Lab Attended Polysomnography (sleep study) Note: Preauthorization may be required for these tests. Note: For Elevate, if your in-network provider uses an out-of-network benefits for lab, imaging facility or radiologist, we will pay out-of-network benefits for lab and radiology charges.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

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

Benefits Description	You pay	
Outpatient hospital, clinic or ambulatory surgical center (cont.)	**Elevate Plus**	**Elevate**
Outpatient diagnostic testing and treatment services performed and billed by a facility, such as but not limited to: • CT, MRI, MRA, Nuclear Cardiology and PET studies Note: Preauthorization may be required for these tests Note: For Elevate, if your in-network provider uses an out-of-network benefits lab, imaging facility or radiologist, we will pay out-of-network benefits for lab and radiology charges.	In-network: $75 copayment per day per facility (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Not covered: • *Maintenance cardiac and pulmonary rehabilitation* • *Services that are related to a non-covered surgery or procedure*	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**Elevate Plus**	**Elevate**
Precertification is required in advance of admission. Note: For the Elevate Option out-of-network facilities must, prior to admission, agree to abide by the terms established by the Plan for the care of the particular member and for the submission and processing of related claims. Elevate Plus Option: We cover skilled nursing facility (SNF) with a limit of 50 days per calendar year when the following criteria is met: • Precertification is obtained prior to admission Note: When Medicare Part A is primary, the initial days paid in full by Medicare are considered part of the 50 days per calendar year benefit.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	*All charges*
Hospice/End of life care	**Elevate Plus**	**Elevate**
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team, under the direction of a Plan-approved independent hospice administration. • We pay up to $30,000 for hospice care provided in an outpatient setting, or for room, board, and care while receiving hospice care in an inpatient setting. Services may include a combination of inpatient and outpatient care up to a maximum of $30,000. These benefits will be paid if the hospice care program begins after a person's primary doctor certifies terminal illness and life expectancy of six months or less and any services or inpatient hospice stay that is part of the program is: • Provided while the person is covered by this Plan • Ordered by the supervising doctor • Charged by the hospice care program	In-network: Charges in excess of $30,000 (deductible applies) Out-of-network: You pay all charges	Charges in excess of $30,000 (deductible applies)

Hospice/End of life care - continued on next page

Benefits Description	You pay	
Hospice/End of life care (cont.)	**Elevate Plus**	**Elevate**
• Provided within six months from the date the person entered or re-entered (after a period of remission) a hospice care program Remission is the halt or actual reduction in the progression of illness resulting in discharge from a hospice care program with no further expenses incurred. A readmission within three months of a prior discharge is considered as the same period of care. A new period begins after three months from a prior discharge with maximum benefits available. Note: See Section 5(a), *Diagnostic treatment and services,* for information on advance care planning coverage.	In-network: Charges in excess of $30,000 (deductible applies) Out-of-network: You pay all charges	Charges in excess of $30,000 (deductible applies)
Not covered: • *Charges incurred during a period of remission* • *Bereavement counseling, pastoral counseling, financial or legal counseling* • *Funeral arrangements* • *Homemaker or caretaker services*	*All charges*	*All charges*
Ambulance	**Elevate Plus**	**Elevate**
Local ambulance service, within 100 miles*, only when medically necessary and the patient cannot be transported by other means: • To the first hospital where treated • From the first hospital to the next nearest hospital or other medical facility only if necessary treatment is unavailable or medically unsuitable at the first hospital • The home, only when the patient requires the assistance of medically trained personnel during transportation *Member is responsible for all charges for 100 miles or greater when medically necessary treatment is available within 100 miles.	In-network: 15% of the Plan allowance within 100 miles* (deductible applies) Note: Out-of-network emergency care and transport is paid at the in-network level	In-network: 25% of the Plan allowance within 100 miles* (deductible applies) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount within 100 miles* (deductible applies)
Air ambulance to nearest hospital is only covered when medically necessary, and the severity of the member's condition warrants immediate evacuation, and: • The pick-up location is inaccessible by other means, or • Transportation by any other means could further endanger the member's health, and • The patient is transported to the nearest facility where medically necessary treatment is available. *Member is responsible for all charges for 100 miles or greater when medically necessary treatment is available within 100 miles. **Note: Medical necessity review is required for all air ambulance transportation.**	15% of the Plan allowance within 100 miles* (deductible applies) Note: Out-of-network emergency care and transport is paid at the in-network level	25% of the Plan allowance within 100 miles* (deductible applies)
Not covered: • *Ambulance transportation when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means*	*All charges*	*All charges*

Ambulance - continued on next page

Benefits Description	You pay	
Ambulance (cont.)	**Elevate Plus**	**Elevate**
• *All ambulance charges for 100 miles or greater when medically necessary treatment is available within 100 miles* • *Non-ambulance transportation including wheelchair van, gurney van, commercial air flights, or any other vehicle not licensed as ambulance* • *Air ambulance will not be covered if transport is beyond the nearest available medically suitable facility, but is requested by patient or physician for continuity of care or other reasons*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under the Elevate Plus Option, the calendar year deductible is $200 per person ($400 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the calendar year deductible is $500 per person ($1,000 if enrollment is Self Plus One or Self and Family). If you use an out-of-network provider, the calendar year deductible is $1,000 per person ($2,000 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the out-of-network benefits are the standard benefits of the Plan. In-network benefits apply only when you use an in-network provider. When no in-network provider is available, out-of-network benefits apply. Under the Elevate Plus Option, the in-network benefits are the standard benefits of the Plan.
- When you use an in-network hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If the services are rendered by out-of-network providers at an in-network hospital, we will pay up to the Plan Allowance according to the No Surprises Act.
- Cost for observation care lasting 24 hours or more will not exceed the cost of inpatient care.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability and requires immediate medical, surgical, or behavioral health care (includes mental health and substance use disorders). Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, sudden inability to breathe, or imminent risk of causing harm to oneself or others. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Benefits Description	You pay	
Note: For both the Elevate and Elevate Plus Options, we state whether or not the calendar year deductible applies for each benefit listed in this Section.		
Medical emergency	**Elevate Plus**	**Elevate**
Outpatient medical or surgical services and supplies billed by a hospital or physician for emergency room treatment. Note: We pay hospital benefits if you are admitted. Note: We will provide in-network benefits if you are admitted to an out-of-network hospital due to a medical emergency. We will also provide in-network benefits for professionals who provide services in an out-of-network hospital, when admitted due to a medical emergency.	15% of the Plan allowance (deductible applies) Note: Out-of-network emergency care is paid at the in-network level	25% of the Plan allowance (deductible applies)

Benefits Description	You pay	
Urgent Care Facility	**Elevate Plus**	**Elevate**
• Outpatient medical services and supplies billed by an urgent care facility Note: This applies only to urgent care facilities, not providers that offer urgent care or after-hours services.	In-network: $50 copayment (no deductible) Out-of-network: You pay all charges	In-network: $50 copayment (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
MinuteClinic	**Elevate Plus**	**Elevate**
MinuteClinic® is available in several states and the District of Columbia. Walk-in medical clinics are located inside select CVS pharmacy locations and no appointment is necessary. MinuteClinic® is staffed by certified family nurse practitioners and physician assistants who diagnose, treat and write prescriptions for common illnesses, injuries and skin conditions. MinuteClinic® also offers physical exams, routine vaccinations and screenings for disease monitoring. To locate a MinuteClinic®, visit https://www.cvs.com/minuteclinic/clinic-locator/ or call 866-389-2727.	$10 copayment for office visit (no deductible) Note: Other services rendered may take additional cost share.	$10 copayment for office visit (no deductible) Note: Other services rendered may take additional cost share.
Telehealth with MDLIVE	**Elevate Plus**	**Elevate**
Telehealth professional services for: • Minor acute conditions (see Section 10 for definition) Note: Services must be provided through MDLIVE at https://members.mdlive.com/geha-callmd/landing_home or call 888-912-1183. Note: For more information on telehealth benefits, please see Section 5(h), *Wellness and Other Special Features*.	Nothing (no deductible)	Nothing (no deductible)
Telehealth visit provided by a primary care or specialist healthcare provider other than MDLIVE.	In-network $30 copayment for visits to primary care providers (no deductible); $50 copayment for visits to specialists (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for visits to primary care providers (no deductible): $30 copayment for visits to specialists (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Benefits Description	You pay	
Ambulance	**Elevate Plus**	**Elevate**
Local ambulance service, within 100 miles*, only when medically necessary and the patient cannot be transported by other means: • to the first hospital where treated • from the first hospital to the next nearest hospital or other medical facility only if necessary treatment is unavailable or medically unsuitable at the first hospital • the home, only when the patient requires the assistance of medically trained personnel during transportation *Member is responsible for all charges for 100 miles or greater when medically necessary treatment is available within 100 miles.	In-network: 15% of the Plan allowance within 100 miles* (deductible applies) Note: Out-of-network emergency care and transport is paid at the in-network level	25% of the Plan allowance within 100 miles* (deductible applies)
Air ambulance to nearest hospital is only covered when medically necessary, and the severity of the member's condition warrants immediate evacuation, and: • the pick-up location is inaccessible by other means, or • transportation by any other means could further endanger the member's health, and • the patient is transported to the nearest facility where medically necessary treatment is available. * Member is responsible for all charges for 100 miles or greater when medically necessary treatment is available within 100 miles. **Note: Medical necessity review is required for all air ambulance transportation.**	15% of the Plan allowance within 100 miles* (deductible applies) Note: Out-of-network emergency care and transport is paid at the in-network level	25% of the Plan allowance within 100 miles* (deductible applies)
Not covered: • *Ambulance transportation when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means* • *All ambulance charges for 100 miles or greater when medically necessary treatment is available within 100 miles* • *Non-ambulance transportation including wheelchair van, gurney van, commercial air flights, or any other vehicle not licensed as ambulance* • *Air ambulance will not be covered if transport is beyond the nearest available medically suitable facility, but is requested by patient or physician for continuity of care or other reasons*	*All charges*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under the Elevate Plus Option, the calendar year deductible is $200 per person ($400 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the calendar year deductible is $500 per person ($1,000 if enrollment is Self Plus One or Self and Family). If you use an out-of-network provider, the calendar year deductible is $1,000 per person ($2,000 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in this section.
- Under the Elevate Option, the out-of-network benefits are the standard benefits of the Plan. In-network benefits apply only when you use an in-network provider. When no in-network provider is available, out-of-network benefits apply. Under the Elevate Plus Option, the in-network benefits are the standard benefits of the Plan.
- When you receive hospital observation services, we apply outpatient benefits to covered services. Inpatient benefits will apply only when your physician formally admits you to the hospital as an inpatient. It is your provider's or your responsibility to ensure that we are contacted for precertification if you are admitted as an inpatient.
- **YOU MUST GET PREAUTHORIZATION FOR SOME SERVICES AND/OR PROCEDURES AND PRECERTIFICATION FOR INPATIENT STAYS, UNLESS DUE TO A MEDICAL EMERGENCY. FAILURE TO DO SO WILL RESULT IN A FINANCIAL PENALTY AS OUTLINED IN SECTION 3,** *How You Get Care.* Please refer to the preauthorization and precertification information shown in Section 3 or call customer service to be sure which services require preauthorization. Confinements which are considered not medically necessary will not be covered. Penalties are not subject to the catastrophic limit.
  - When requested, itemized bills with supporting documentation are required for benefit consideration for hospital stays.
- **Note: Avoid paying providers for services prior to preauthorization. It is important to assure services are authorized and provided by a covered provider or facility.**
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- Medications may be available under the prescription drug benefit and may require prior authorization. Specialty drugs obtained outside of the pharmacy benefit may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits*.
- **Precertification/Preauthorization**: To be eligible to receive full benefits for mental health and substance use disorder treatment, you must call the Plan at 800-821-6136.

Benefits Description	You pay	
Note: For both the Elevate and Elevate Plus Options, we state whether or not the calendar year deductible applies for each benefit listed in this Section.		
Professional services	**Elevate Plus**	**Elevate**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of behavioral health conditions including psychiatric conditions, mental illness, or disorders, and substance use disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Treatment and counseling (including individual, group or in-home therapy visits) • Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling • Professional charges for intensive day treatment in a provider's office or other professional setting (requires preauthorization) • Electroconvulsive therapy (facility fees may also apply)	In-network: $30 copayment per office visit (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment per office visit (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Non-surgical inpatient professional services during a covered hospital stay.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
• First primary care or specialist visit for the management of a mental health condition as a follow up within 30 days of a mental health inpatient confinement.	In-network: Nothing (no deductible) Out-of-network: You pay all charges	In-network: Nothing (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Professional services - continued on next page

Benefits Description	You pay	
Professional services (cont.)	**Elevate Plus**	**Elevate**
Professional services for the first 5 visits per year, per pregnancy for office-based treatment of prenatal and postpartum depression. Services include: • Diagnostic evaluation • Medication evaluation and management (pharmacotherapy) • Treatment and counseling (including individual, group, or in-home therapy visits)	In-network: Nothing for the first 5 visits for treatment of prenatal and postpartum depression, after which the $30 copayment applies (no deductible) Out-of-network: You pay all charges	In-network: Nothing for the first 5 visits for treatment of prenatal and postpartum depression, after which the $10 copayment applies (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Applied Behavioral Analysis Therapy	**Elevate Plus**	**Elevate**
Applied Behavioral Analysis Therapy • Inclusive of the services of the Board-Certified Behavior Analyst (BCBA) Board Certified Assistant Behavior Analyst (BCaBA), and Registered behavior technician. • Note: Here are some things to keep in mind: - Preauthorization required. - Required diagnosis of ASD (Autism Spectrum Disorder) by a provider qualified to make the diagnosis: Board Certified Behavior Analyst (BCBA), psychiatrist, or pediatrician. - Initiation of treatment and ongoing treatment and intensity of treatment must be medically necessary and appropriate for the child. - A functional behavioral assessment must be submitted prior to treatment and must demonstrate appropriateness of ABA Therapy. - Services must be directed by a Board-Certified Behavior Analyst (BCBA) and services may be provided by Board Certified Assistant Behavior Analysts (BCaBA) or Registered Behavior Technicians (RBTs). - Approval of ongoing services requires demonstrated involvement by family.	In-network: $30 copayment per office visit (no deductible) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Telehealth with MDLIVE	**Elevate Plus**	**Elevate**
Behavioral health professional telehealth services for: • Mental health counseling • Substance use disorder counseling Note: Services must be provided through MDLIVE at https://members.mdlive.com/geha-callmd/ or call 888-912-1183.	Nothing (no deductible)	Nothing (no deductible)

Telehealth with MDLIVE - continued on next page

Benefits Description	You pay	
Telehealth with MDLIVE (cont.)	**Elevate Plus**	**Elevate**
Note: For more information on telehealth benefits, please see Section 5(h), *Wellness and Other Special Features*.	Nothing (no deductible)	Nothing (no deductible)
Telehealth visit provided by a healthcare provider other than MDLIVE.	In-network: $30 copayment for office visits to primary care providers (no deductible); $50 copayment for office visits to specialist (no deductible) Out-of-network: You pay all charges	In-network: $10 copayment for office visits to primary care providers (no deductible): $30 copayment for office visits to specialist (no deductible) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Diagnostics	**Elevate Plus**	**Elevate**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility Note: Preauthorization may be required. Note: We cover up to 16 tests for Urine Drug Testing (UDT) per person per calendar year.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. See diagnostic tests Section 5(a) and 5(c).	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. See diagnostic tests Section 5(a) and 5(c).
Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment Note: Preauthorization may be required for testing **exceeding 8 hours/calendar year.** Note: See Section 5(c), for any applicable outpatient facility charges.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Inpatient hospital and inpatient residential treatment centers (RTC)	**Elevate Plus**	**Elevate**
Precertification is required in advance of admission. Note: For the Elevate Option out-of-network facilities must, prior to admission, agree to abide by the terms established by the Plan for the care of the particular member and for the submission and processing of related claims. Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount

Inpatient hospital and inpatient residential treatment centers (RTC) - continued on next page

Benefits Description	You pay	
Inpatient hospital and inpatient residential treatment centers (RTC) (cont.)	**Elevate Plus**	**Elevate**
• Ancillary charges • Covered therapy services when billed by the facility (see Section 5(c), *Professional Services* and Section 5(e), *Mental Health and Substance Use Disorder Benefits* and for services billed by professional providers) Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate. Note: We limit covered facilities for medically necessary treatment to a hospital and/or RTC.	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Outpatient hospital	**Elevate Plus**	**Elevate**
Services such as: • Partial hospitalization or intensive day treatment programs (preauthorization required) • Electroconvulsive therapy • Transcranial Magnetic Stimulation (TMS)	In-network: 15% of the Plan allowance (deductible applies) Out-of-network: You pay all charges	In-network: 25% of the Plan allowance (deductible applies) Out-of-network: 50% of the Plan allowance (deductible applies) and any difference between our allowance and the billed amount
Emergency room	**Elevate Plus**	**Elevate**
• Outpatient services and supplies billed by a hospital for emergency room treatment Note: We pay hospital benefits if you are admitted.	15% of the Plan allowance (deductible applies) Note: Out-of-network emergency care is paid at the in-network level	25% of the Plan allowance (deductible applies)
Services we do not cover	**Elevate Plus**	**Elevate**
Not covered: • *ABA therapy services provided by the school are not reimbursable by the health plan.* • *Pastoral, marital, educational counseling or training services* • *Therapy for sexual dysfunction or inadequacy* • *Services performed by a non-covered provider* • *Travel time to the member's home to conduct therapy* • *Services rendered or billed by schools or sober homes, or billed by their staff*	*All charges*	*All charges*

Services we do not cover - continued on next page

Benefits Description	You pay	
Services we do not cover (cont.)	**Elevate Plus**	**Elevate**
• *The following services are not covered as a part of any inpatient or outpatient mental health or substance use disorder treatment services: respite care; outdoor residential programs; recreational therapy; educational therapy or classes; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long-term care.* • *Testing ordered by or on behalf of third parties (e.g., schools, courts, employers, etc.)* • *Hypnotherapy* • *Physical, psychiatric, or psychological exams, and testing, and required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, travel, related to judicial or administrative proceedings or orders, or required to obtain or maintain a license of any type.*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in this section.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some medications must be approved by GEHA and/or CVS Caremark, our Pharmacy Benefit Manager, before they are a covered benefit. Your prescribers must obtain preauthorizations for certain prescription drugs and supplies before coverage applies. Medication may be limited as to its quantity, total dose, duration of therapy, age, gender or specific diagnosis. Preauthorizations must be renewed periodically.
- **Federal Law prohibits the return of prescription medications.** Medication cannot be returned to dispensing pharmacies, and you will be responsible for the cost. Be sure to check the cost of your medication before filling the prescription.
- There is no calendar year deductible for prescription drugs processed under the prescription benefit. Copayments and coinsurance for prescription drugs go toward the annual out-of-pocket limit except for the difference between the cost of the generic and brand name medication.
- If you need an extra supply of medications in emergency situations such as if you are called to active military duty or as a part of the government's continuity of operations, you may receive an extra 30-day supply at retail. Call CVS Caremark Customer Care at 844-4-GEHARX or 844-443-4279 so we can assist with your emergency prescription needs.
- As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including names of your prescribing physicians, to any treating physician or dispensing pharmacies.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Benefits for certain self-injectable (self-administered) drugs are available for coverage only when dispensed by a pharmacy, under the pharmacy benefit.
- Some specialty and non-specialty medications may not be available in a 30-day supply, your coinsurance will be based on days of therapy.

Prescription Drug Benefits

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

- **Your plan participates in the Exclusive Choice Pharmacy Network.** All prescriptions need to be purchased through an in-network pharmacy. Out-of-network claims are not eligible for benefits.
- **Drug coupon/copay cards:** We do not honor or coordinate benefits with drug coupon/copay cards. You are responsible for your copay or coinsurance as indicated in this brochure.
- **Who can write your prescription:** A licensed physician or dentist, and in states allowing it, licensed or certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. In addition, your mailing address must be within the United States or include an APO address.
- **Where you can obtain them:** You may fill the prescription at a participating network retail pharmacy or for Elevate Plus Option members, CVS Caremark Mail Service Pharmacy. CVS Specialty Pharmacy is the exclusive provider for specialty medications. You may contact the Specialty Pharmacy at 800-237-2767.

Prescription Drug Benefits - continued on next page

Prescription Drug Benefits (cont.)

- **How to submit a prescription reimbursement claim:** Include original drug receipts and submit to:

  CVS Caremark
  P.O. Box 52136
  Phoenix, AZ 85072-2136

You may also submit prescription reimbursement requests online via Caremark web portal (www.caremark.com) or Caremark mobile app (available for Android and Apple).

Reimbursement will be based on GEHA's costs had the participating pharmacy submitted the claim electronically. Members are responsible for their applicable copayment and/or coinsurance, and the difference between our allowance and the cost of the drug.

- **How to obtain preauthorization:** If you are filling a medication requiring a preauthorization for medical necessity, please call 855-240-0536. For Elevate Plus Option members using mail service, CVS Caremark will conduct the preauthorization for medical necessity review.
- **Our prescription benefit includes a step therapy program.** GEHA's preauthorization process includes step therapy which requires you to use a generic/preferred medication(s) before a brand and/or non-preferred medication is covered. If you are filling a brand and/or non-preferred medication and have already tried a generic/preferred medication(s), the brand and/or non-preferred medication will be dispensed for the applicable plan copayment/coinsurance. When you try to fill a brand and/or non-preferred medication and you have not tried a generic/preferred medication(s), the pharmacist will contact your physician to notify them of the generic/preferred alternative. If the physician approves, a generic/preferred medication will be dispensed for the applicable plan copayment/coinsurance. If the physician does not approve, a preauthorization review will be initiated to determine the medical necessity of the brand and/or non-preferred drug. If the preauthorization for the brand and/or non-preferred medication is approved, you will be responsible for the applicable plan copayment/coinsurance. If not, you will be responsible for 100% of the cost of the brand and/or non-preferred drug, which will not apply to your annual out-of-pocket maximum.
- **Select therapies are included in the Starter Fill Program.** For these medications, you will receive 14 or 15 day supplies for the first 2 months of therapy. Your coinsurance will be prorated based on the days of therapy.
- **Recurring oral non-specialty and specialty medications must be obtained through the pharmacy benefit.** Medications will not be covered when dispensed by other sources, including physician offices, home health agencies and outpatient hospitals.
- **Compound Medication:** A compound drug is a medication made by combining, mixing or altering ingredients to create a customized drug. Some ingredients often found in compounds including, but not limited to, over-the-counter (OTC) products, experimental or investigational agents, bulk powders, bulk chemicals, and certain bases, are not covered. Coverage for other ingredients commonly found in compound prescriptions may require preauthorization.

Claim pricing is based on the contractual discounts plus a professional fee and any applicable sales tax. Pharmacies must submit all ingredients in a compound prescription for online and paper claim submissions. At least one of the ingredients must require a physician's prescription in order to be covered by the Plan. You are responsible for the appropriate brand or generic copay, or coinsurance based on the ingredients. Preauthorization may be required. If the compound includes an experimental or investigational drug, the compound will not be covered. Compound medications are limited to a 30-day supply.

Ask the pharmacist to submit your claim electronically. If the participating retail pharmacy is unable to submit the claim electronically, you will pay the full cost and must submit for reimbursement. Make sure the pharmacy provides a list of the National Drug Codes (NDCs), quantity and cost for every ingredient in the compound medication and include this information on your claim.

- **We use a formulary drug list** that excludes coverage for certain medications unless we determine they are medically necessary. Refer to www.geha.com/Prescriptions for a list of drugs that require preauthorization for medical necessity.

Prescription Drug Benefits - continued on next page

Prescription Drug Benefits (cont.)

- **We divide prescription drugs into categories or tiers.** When an approved generic equivalent is available, that is the drug you will receive, unless you or your physician specifies the prescription must be dispensed as written. When an approved generic equivalent is not available, you will pay the brand name drug's applicable plan copayment/ coinsurance. If an approved generic equivalent is available, but you or your physician specifies that the prescription must be dispensed as written with the brand name medication, you will pay the generic copayment plus the difference between the cost of the generic drug and the brand name drug dispensed. Your physician may request the brand name drug be reviewed and if approved as medically necessary, you will pay the applicable brand name copayment/ coinsurance.
  - **Generic drugs** are FDA approved prescription medications. They are chemically and therapeutically equivalent to the corresponding brand name drug but are available at a lower price. The FDA requires that generic equivalent medications contain the same active ingredients and be equivalent in strength and dosage to brand name drugs.
  - **Preferred drugs** are FDA approved prescription medications included on the Preferred Drug List developed by CVS Caremark.
  - **Non-Preferred drugs** are FDA approved prescription medications that may or may not be covered by GEHA, however they are not included on the CVS Caremark Preferred Drug List. Most commonly utilized medications have generic or preferred medications available.

CVS Caremark Formulary

Your prescription drug program includes use of the CVS Caremark Formulary which is developed by an independent panel of doctors and pharmacists who ensure the medications are clinically appropriate and cost-effective. In an effort to continue to help promote affordable and clinically appropriate products, there are a select number of drugs that are excluded from the formulary and/or not covered by the Plan closed formulary. For these drugs, generics and/or therapeutic alternative medications are available. If one of these excluded drugs is medically necessary, a preauthorization for medical necessity is required. New drugs and supplies may require a review for medical necessity until the formulary status is determined.

Our benefit includes the Advanced Control Specialty Formulary (ACSF). The ACSF may reduce your out-of-pocket costs yet may limit your options due to a strict formulary. The ACSF focuses on specialty medications that are similar to one another, with similar effectiveness and safety. The formulary incorporates step therapy, where a generic/preferred medication is used prior to a brand and/or non-preferred medication.

Formularies are reviewed quarterly, and medications may change formulary status. You will receive notification if your cost share increases due to a formulary change. Please visit our website at www.geha.com/Prescriptions to view formulary medications and the most current list of specialty drugs. You may also call CVS Caremark at 844-4-GEHARX or 844-443-4279 or CVS Specialty at 800-237-2767.

Your physician may be contacted to discuss your prescriptions for drugs that are excluded by the Plan’s formulary. No change in the medication prescribed will be made without your physician’s approval.

Refills cannot be obtained until **80%** of the drug has been used. Next available refill date may be provided; however, the date is an estimate. Cumulative "refill too soon" logic also applies, which looks back at prescription history and considers the amount of medication on hand. Refills for maintenance medications are not considered new prescriptions except when the doctor changes the strength, or the prescription has expired.

Coordinating with other drug coverage

For other commercial coverage: If you also have drug coverage through another group health insurance plan and we are your secondary insurance, follow these procedures:

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

1. Present prescription ID cards from both your primary insurance plan and GEHA.
2. If able, the pharmacy will electronically process both your primary and secondary claims and the pharmacist will tell you if you have any remaining copay/coinsurance to pay.

Coordinating with other drug coverage - continued on next page

Coordinating with other drug coverage (cont.)

3. If the pharmacy cannot electronically process the secondary claim, purchase your prescription using the prescription ID card issued by your primary insurance carrier and pay any copay/coinsurance required by the primary insurance. Then, mail your pharmacy receipt and primary Explanation of Benefits (EOB) to CVS Caremark for consideration of possible reimbursement through your GEHA, secondary benefit. Submit these claims to CVS Caremark, PO Box 52136, Phoenix, AZ 85072-2136 or submit for reimbursement online via Caremark web portal (www.caremark.com) or Caremark mobile app (available for Android and Apple).

If you obtain your prescription from a mail service pharmacy using your primary insurance plan, your GEHA reimbursement will be based on the GEHA retail Plan benefit:

1. Purchase your prescription using the prescription ID card issued by your primary insurance carrier and pay any copay/coinsurance required by the primary insurance.
2. Then, mail your pharmacy receipt and primary EOB to CVS Caremark for consideration of possible reimbursement through your GEHA, secondary benefit. Submit these claims to CVS Caremark, PO Box 52136, Phoenix, AZ 85072-2136 or submit for reimbursement online via Caremark web portal (www.caremark.com) or Caremark mobile app (available for Android and Apple).

If your primary insurance does not provide a prescription ID card:

1. Purchase your drug from the pharmacy and submit the bill to your primary insurance.
2. When the primary insurance has made payment, file the claims and the primary EOB with CVS Caremark for consideration of possible reimbursement using your secondary benefit. Submit these claims to CVS Caremark, PO Box 52136, Phoenix, AZ 85072-2136 or submit for reimbursement online via Caremark web portal (www.caremark.com) or Caremark mobile app (available for Android and Apple).

In any event, if you use GEHA's plan ID card when another insurance plan is primary, you will be responsible for reimbursing GEHA any amount in excess of our secondary benefit. If another insurance plan is primary, you should use their drug benefit.

When coordination of benefits apply, reimbursement is based on GEHA's retail Plan allowable benefit. Our secondary and tertiary claim payment is the lesser of:

- what GEHA would have paid in the absence of other primary coverage or,
- the balance due after the primary carrier's payment.

Note: GEHA secondary and tertiary member responsibility could be higher than GEHA's primary copay/coinsurance, depending upon the primary plan's allowable and the primary payment.

Should Medicare rules change on prescription drug coverage, we reserve the right to require you to use your Medicare coverage as the primary insurance for these drugs.

For Medicare Part B insurance coverage: If Medicare Part B is primary, discuss with the retail pharmacy and/or CVS Caremark the options to submit Medicare covered medications and supplies to allow Medicare to pay as the primary carrier. Prescriptions typically covered by Medicare Part B include diabetes supplies (test strips, meters), specific medications used to aid tissue acceptance from organ transplants, certain oral medications used to treat cancer, and ostomy supplies.

Retail - When using a retail pharmacy for eligible Medicare Part B medication or supplies, present the Medicare ID card. Request the retail pharmacy bill Medicare as primary. Most independent pharmacies and national chains are Medicare providers. To locate a retail pharmacy that is a Medicare Part B participating provider, visit the Medicare website at www.medicare.gov/supplier/home.asp or call Medicare Customer Service at 800-633-4227.

Mail Order – Elevate Plus Option members also have the opportunity to receive Medicare Part B-eligible medications by mail. The CVS Caremark Mail Service Pharmacy will review the prescriptions to determine whether it could be eligible for Medicare Part B coverage and submit to Medicare if appropriate. Please note, the CVS Caremark Mail Service Pharmacy is not a Medicare Part B provider for diabetic supplies. You must use a retail pharmacy willing to bill Medicare as primary.

Coordinating with other drug coverage - continued on next page

Coordinating with other drug coverage (cont.)

For Medicare Part D insurance coverage: GEHA supplements the coverage you get with your Medicare Part D prescription drug plan. Your Medicare drug plan provides your primary prescription drug benefit. GEHA provides your secondary prescription drug benefit. To ensure that you maximize your benefits, use a pharmacy in network for both the GEHA Plan and your Medicare Part D plan, and provide both the plan ID cards when filling a prescription allowing the pharmacy to coordinate coverage on your behalf.

Exclusive Choice Pharmacy Network

You must fill your prescription at a participating network retail pharmacy. Pharmacies in the network include CVS Pharmacy, Walmart Pharmacy, Sam's Club Pharmacy, Cardinal Health affiliated pharmacies, select independent pharmacies, VA Pharmacy, IHS Pharmacy, CVS Caremark Mail Service Pharmacy (Elevate Plus Option only), CVS Specialty Pharmacy, Longs Drugs, and Navarro Discount Pharmacy. Claims (electronic or paper) processed through a non-network pharmacy will not be paid unless they are filled outside of the United States and United States territories. To locate participating pharmacies, call CVS Caremark at 844-4-GEHARX or 844-443-4279 or visit www.caremark.com.

How to use CVS Caremark Mail Service Pharmacy for Elevate Plus Option

Through this service, Elevate Plus Option members may receive up to a 90-day supply of maintenance medications for drugs which require a prescription. Some medications may not be available in a 90-day supply from CVS Caremark Mail Service Pharmacy even though the prescription is for 90 days. Although insulin, syringes, diabetic supplies and ostomy supplies do not require a physician's prescription, to obtain through CVS Caremark Mail Service Pharmacy you should obtain a prescription (including the product number for ostomy and insulin pump supplies) from your physician for a 90-day supply.

Not all drugs are available through CVS Caremark. In order to use CVS Caremark Mail Service Pharmacy, your prescriptions must be written by a licensed prescriber in the United States. In addition, your mailing address must be within the United States or include an APO address.

To order new prescriptions, ask your physician to prescribe needed medication for up to a 90-day supply, plus refills, if appropriate. Complete the information on the Ordering Medication Form found at www.geha.com/Medication; enclose your prescription and the correct copayment.

If you have any questions or need an emergency consultation with a registered pharmacist, you may call CVS Caremark at 844-4-GEHARX or 844-443-4279 available 24 hours a day, 7 days a week. Forms necessary for refills will be provided each time you receive a supply of medication.

Mail to:
CVS Caremark
PO Box 659541
San Antonio, TX 78265-9541

Fax: You can ask your physician to fax your prescriptions to CVS Caremark Mail Service Pharmacy. To do this, provide your physician with your ID number (located on your ID card) and ask him or her to fax the prescription to the CVS Caremark Mail Service Pharmacy fax number: 800-378-0323.

Electronic transmission: You can ask your physician to transmit your prescriptions electronically to CVS Caremark Mail Service Pharmacy.

Refilling your medication: To be sure you never run short of your prescription medication, you should re-order on or after the estimated refill date or when you have approximately 18 days of medication left.

To order by phone: Call Member Services at 844-4-GEHARX or 844-443-4279. Have your prescription bottle with the prescription information ready.

To order by mail: Simply mail the GEHA Mail Order Form and copayment to CVS Caremark, PO Box 659541, San Antonio, TX 78265-9541.

To order online: Go to www.caremark.com.

Benefits Description	You pay	
Covered medication and supplies	**Elevate Plus**	**Elevate**
Network Retail Pharmacy You must fill your prescription at a participating network retail pharmacy. • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by Federal Law of the United States require a physician's prescription for their purchase, except those listed as not covered; • FDA approved contraceptive drugs and devices for women; • Diabetic medications and supplies, such as: - Insulin; - Needles and syringes for the administration of covered medications; - Blood glucose meter to be provided at no charge by the manufacturer. • Elevate Plus Option members may contact CVS Caremark Mail Service Pharmacy: 877-418-4746; • Elevate Option members may contact their participating retail pharmacy or CVS Caremark Customer Care for specifics on how to obtain a free meter: 844-4-GEHARX or 844-443-4279. • Drugs to treat gender dysphoria (gonadotropin releasing hormone (GnRH) antagonists and testosterone) • Drugs associated with artificial insemination and/or drugs associated with up to **three (3)** cycles of invitro fertilization (IVF) treatment. Prior authorization is required. • Medications prescribed to treat obesity. Prior authorization is required. • Prescription prenatal vitamins; • Covered ostomy supplies (please include the manufacturer's product number to ensure accurate fill of the product).	**Generic:** • $10 for up to a 30-day supply • $20 for a 31-60-day supply • $30 for a 61-90-day supply • or the retail pharmacy's usual and customary cost of the drug, whichever is less **Preferred:** • $80 for up to a 30-day supply • $160 for a 31-60-day supply • $240 for a 61-90-day supply • or the retail pharmacy's usual and customary cost of the drug, whichever is less **Non-Preferred:** 50% of Plan allowance for up to a 90-day supply	**Generic:** • $4 for up to a 30 day supply • $8 for a 31-60 day supply • $12 for a 61-90 day supply • or the retail pharmacy's usual and customary cost of the drug, whichever is less **Preferred:** • 50% of Plan allowance up to a maximum of $500, for up to a 30-day supply • 50% of Plan allowance up to a maximum of $1,000, for a 31-60 day supply • 50% of Plan allowance up to a maximum of $1,500, for a 61-90 day supply **Non-Preferred:** You pay 100% of all charges
Non-Network Retail Pharmacy	You pay 100% of all charges	You pay 100% of all charges

Covered medication and supplies - continued on next page

Benefits Description	You pay	
Covered medication and supplies (cont.)	**Elevate Plus**	**Elevate**
CVS Caremark Mail Service Pharmacy All copayments are for up to a 90-day supply per prescription. • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by Federal Law of the United States require a physician's prescription for their purchase, except those listed as not covered. • FDA approved contraceptive drugs and devices for women; • Diabetic medications and supplies, such as: - Insulin; - Needles and syringes for the administration of covered medications; - Blood glucose meter to be provided at no charge by the manufacturer. • Elevate Plus Option members may contact CVS Caremark Mail Service Pharmacy: 877-418-4746; • Elevate Option members may contact their participating retail pharmacy or CVS Caremark Customer Care for specifics on how to obtain a free meter: 844-4-GEHARX or 844-443-4279. • Prescription prenatal vitamins; • Covered ostomy supplies (please include the manufacturer's product number to ensure accurate fill of the product).	**Generic**: $20 or the cost of the drug, whichever is less **Preferred**: $200 or the cost of the drug, whichever is less **Non-Preferred:** 50% of Plan allowance, for up to a 90-day supply	Not available
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. **Network and Non-Network Retail** **CVS Caremark Mail Service Pharmacy** Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Over-the counter (prescription required) and prescription drugs approved by the FDA to prevent an unintended pregnancy are included.	Nothing (no deductible)	Nothing (no deductible)

Covered medication and supplies - continued on next page

Benefits Description	You pay	
Covered medication and supplies (cont.)	**Elevate Plus**	**Elevate**
Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described on GEHA's website at www.geha.com/Contraception or by calling CVS Caremark at 844-4-GEHARX or 844-443-4279. Exception requests for contraceptive coverage will be processed within 24 hours of receiving complete information. Reimbursement for over-the-counter contraceptives (prescription required) can be submitted by sending in your original prescription receipt obtained from your pharmacy to: CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 You may also submit prescription reimbursement requests online via Caremark web portal (www.Caremark.com) or Caremark mobile app (available for Android and Apple). Note: Members are encouraged not to use an HSA, health FSA, or HRA (including any related debit card) to purchase contraception for which the individual intends to seek reimbursement from their PSHB plan. Note: For more information regarding prescription contraceptives, please refer to *Preventive care medications* in this section. Some contraceptives and services are covered under the medical benefit; see Section 5(a), *Family planning*.	Nothing (no deductible)	Nothing (no deductible)

Specialty drug benefits

CVS Specialty Pharmacy is the exclusive provider for specialty medications. CVS Specialty Pharmacy provides not only your specialty medications, but also personalized pharmacy care management services. If you have questions, visit www.CVSSpecialty.com or call Specialty Customer Care at 800-237-2767.

Specialty medications are certain pharmaceuticals which may be biotech or biological drugs. Specialty medications are oral, injectable or infused, and/or may require special handling. To maximize patient safety, most specialty medications require preauthorization. These drugs are used in the treatment of complex, chronic medical conditions which include but are not limited to hemophilia, multiple sclerosis, hepatitis, cancer, rheumatoid arthritis, pulmonary hypertension, transplant, HIV, osteoarthritis, and immune deficiency. If you are new to select specialty therapies (i.e., oral oncology, hepatitis B, Parkinson's disease psychosis and hematological disorders), you will receive a 14 or 15 day supply for the first 2 months of therapy. Your copayment will be prorated. If you continue on this therapy, you may receive up to a 30-day supply of the medication.

Specialty drug benefits - continued on next page

Specialty drug benefits (cont.)

Your benefit includes the Advanced Control Specialty Formulary (ACSF); please see Section 5(f), *CVS Caremark formulary* for additional information. Most specialty drugs require preauthorization. See "How to obtain preauthorization" under *Prescription drug benefits*. For certain, specialty therapies, you are required to use the generic unless your physician demonstrates medical necessity for the brand.

Outpatient, non-surgical cancer treatments require preauthorization by calling 855-690-0359.

*Your specialty benefit is limited to a 30-day supply. However, some specialty medications may not be available in a 30-day supply. Your coinsurance/copayment will be based on days of therapy (length of time medication remains in your system).

Benefits Description	You pay	
Specialty drug benefits	**Elevate Plus**	**Elevate**
CVS Pharmacy All copayments are for up to a 30-day supply per prescription. Specialty Plan benefits apply to limited distribution specialty medications when CVS Specialty Pharmacy does not have access to dispense.	**Generic and Preferred:** 40% of Plan allowance up to a maximum of: • $500 for up to a 30-day supply • $1,000 for up to a 60-day supply* • $1,500 for up to a 90-day supply* **Non-preferred:** 50% of Plan allowance for up to a 30-day supply*	**Generic and Preferred:** 50% of Plan allowance up to a maximum of: • $500 for up to a 30-day supply • $1,000 for up to a 60-day supply* • $1,500 for up to a 90-day supply* **Non-preferred:** You pay 100% of all charges
Non-CVS Specialty Pharmacy retail purchase	**When GEHA is primary:** You pay 100% of all charges	**When GEHA is primary:** You pay 100% of all charges
Specialty medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals may be paid under the medical benefit. If Medicare denies coverage, GEHA does not waive the coinsurance. Recurring oral medications must be obtained through the pharmacy benefit.	You pay after the calendar year deductible, if applicable: • **Generic and Preferred:** $500 copayment applies per prescription fill and 40% of the Plan allowance, up to a 30- day supply. • **Non-Preferred:** $500 copayment applies per prescription fill and 60% of the Plan allowance, up to a 30- day supply.	You pay after the calendar year deductible: • **Generic and Preferred:** $500 copayment applies per prescription fill and 50% of the Plan allowance, up to a 30-day supply. • **Non-Preferred:** You pay 100% of all charges
Preventive care medications	**Elevate Plus**	**Elevate**
Preventive Care - The following preventive medications are covered as recommended under the Patient Protection and Affordable Care Act (ACA).	Nothing (no deductible)	Nothing (no deductible)

Preventive care medications - continued on next page

Benefits Description	You pay	
Preventive care medications (cont.)	**Elevate Plus**	**Elevate**
Preventive Medications with USPSTF A and B recommendations are covered with no cost-sharing at a participating pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org. Age restrictions apply. To receive preventive care benefits, a prescription from a doctor must be presented to the pharmacy. • Aspirin - All single ingredient generic oral dosage forms<81mg OTC only (requires a prescription) for the prevention of pre-eclampsia after 12 weeks of gestation. Limit of 100 units per fill. • Fluoride supplements (not toothpaste or rinses) - Single ingredient brand name and generic prescription products in an oral dosage form < 0.5mg for children 5 years of age and younger. • Folic acid supplements - Single ingredient generic 0.4mg and 0.8mg tabs. OTC only (requires a prescription) for women 55 years of age and younger. Limit of 100 units per fill. • Generic metformin 850mg tablets for individuals age 35-70 years with no prior use of anti-diabetic medications. • Generic Naloxone is offered as an opioid rescue agent under this Plan with no cost sharing when obtained from a network pharmacy with a prescription. Limited to three doses annually (requires a prescription). Prior authorization may be required on some formulations. For more information, consult the FDA guidance at: https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose. Or call SAMHSA's National Helpline 800-662-HELP (4357) or go to https://findtreatment.gov/. • Generic tamoxifen, raloxifene, exemestane and anastrozole - with prescription for women ages 35 and over for the prevention of breast cancer. • HIV Pre-Exposure Prophylaxis - Prior authorization may be required for coverage. CVS Specialty Pharmacy is GEHA's exclusive Specialty Pharmacy. • Iron supplements - Single ingredient pediatric oral liquids (requires a prescription) for children age 6-12 months.	Nothing (no deductible)	Nothing (no deductible)

Preventive care medications - continued on next page

Benefits Description	You pay	
Preventive care medications (cont.)	**Elevate Plus**	**Elevate**
• Colorectal Cancer Prevention - Bowel prep products - generic Rx, and brand name only when generic or over the counter (OTC) equivalent is not available, requires a prescription, age 45-75 years. • Womens Preventive Service - Contraceptives - oral, emergency, injectable, patch, barrier, and misc. - generic RX or OTC (requires a prescription) and brand name only when generic is not available. If the brand name is medically necessary, a preauthorization for medical necessity is required. Women only and limits may apply. • Statins - Certain statins for individuals age 40-75 years. • Immunizations: Vaccines; childhood and adult, Rx only - Coverage dependent on vaccine type. - GEHA members can go to a participating retail pharmacy to receive certain vaccinations. Influenza vaccine is commonly administered by retail pharmacies. Other vaccines, such as those for pneumococcal pneumonia (Pneumovax), varicella/shingles (Shingrix) and hepatitis B may also be available through retail pharmacies. Note: Members may call CVS Caremark at 844-4-GEHARX or 844-443-4279 to identify a participating vaccine pharmacy or go to www.caremark.com. GEHA members should check with the retail pharmacy to ensure availability of a pharmacist who can inject vaccines and availability of the vaccine product before going to the pharmacy. GEHA members should also ask retail pharmacies if there is an age requirement for vaccines that can be administered at that pharmacy. Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered when purchased at a participating pharmacy. For additional information on Tobacco Cessation Educational Classes and Programs, see Section 5(a).	Nothing (no deductible)	Nothing (no deductible)

Benefits Description	You pay	
Non-covered medications and supplies	**Elevate Plus**	**Elevate**
Not covered under the prescription drug benefit: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements (alone or in combination) not listed as a covered benefit or that do not require a prescription are not covered, including enteral formula/tube feeding nutrition available without a prescription* • *Hyperinflated medications* • *Nonprescription medications unless specifically indicated elsewhere* • *Services or supplies for the administration of a non-covered medication* • *Medical devices or supplies such as dressings and antiseptics* • *Drugs which are investigational* • *Drugs to treat impotency* • *Certain prescription drugs that have an over-the-counter (OTC) equivalent drug or treatment are not covered* • *Certain compounding chemicals including, but not limited to, OTC products, experimental, investigational, bulk powders, bulk chemicals, and certain bases*	*All charges*	*All charges*

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at 800-821-6136.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in Medicare Part D plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are non-preferred or excluded from those enrolled in our standard non-PDP EGWP Prescription Drug Program.
  - Generally, we cover a 30-day supply of drugs filled at a non-preferred pharmacy only when you are not able to use a preferred pharmacy. Please check first with Customer Care (at 833-250-3241 or visit our website at https://info.caremark.com/oe/gehapdp) to see if there is a preferred pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the non-preferred pharmacy and the cost that we would cover at a preferred pharmacy.
  - Other PDP EGWP features include access to preferred pharmacy for additional cost savings, $35 copay on insulin, and $2,000 out-of-pocket maximum on Part D drugs.
- Here are the circumstances when we would cover a 30-day supply of prescriptions filled at a non-preferred pharmacy:
  - The prescription is for a medical emergency or urgent care.
  - You are unable to get a covered prescription drug in a time of need because there are no 24-hour preferred pharmacies within a reasonable driving distance.
  - The prescription is for a drug that is out of stock at an accessible preferred retail or mail-service pharmacy (including high-cost and unique prescription drugs).
  - If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.
  - The vaccine is administered in your doctor's office.

We cover drugs, medications, and supplies as described below and on the following pages.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/ authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- You must get prior authorization for certain drugs including, but not limited to, preferred and non-preferred brand name drugs when a generic equivalent is available, oncology drugs and Specialty drugs. For more information about prior authorization, please call us at 833-250-3241 or visit our website at https://info.caremark.com/oe/gehapdp.

- Federal law prohibits the return of **drugs, medications and supplies**. Medication cannot be returned to dispensing pharmacies, and you will be responsible for the cost. Be sure to check the cost of your medication before filling the prescription.
- There is no Medicare Part D calendar year deductible for prescription drugs. Once you have reached the Out-of-Pocket Maximum of $2,000, all Part D drugs will be $0 copay.
- Be sure to read Section 4, Y*our Cost for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage.
- If you are covered by Medicare and Medicare Part A or B or Parts A and B is primary and you are not enrolled in any Medicare Advantage Plan or other Medicare plan, we will automatically enroll you in our SilverScript Employer Prescription Drug Plan (PDP) under Medicare Part D. This plan enhances your PSHB coverage by offering lower cost sharing on covered drugs. You can find more details about this plan and the opt out process in Section 9, Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP). The PDP is subject to Medicare rules. If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact SilverScript for assistance with the PDP EGWP opt out and disenrollment process at 833-250-3241.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can obtain coverage by:

1. Re-enroll into our PDP EGWP by calling GEHA Customer Service at 800-821-6136 and ask about re-enrollment options.

2. Join our MAPD (Medicare Advantage Plan) by calling UnitedHealthcare GEHA Customer Service line to elect the GEHA Medicare Advantage Plan. Call toll-free at 844-491-9898, TTY 711, 8am - 8pm, Monday-Friday.

3. Or after a qualified life event, (QLE), consider changing to GEHA's High or Standard health plan to be eligible for Medicare Advantage which includes prescription drug coverage. Once your enrollment into the GEHA Standard or High health plan has been processed by OPM, you can call UnitedHealth Care GEHA Customer Service line to elect the GEHA Medicare Advantage Plan. Call toll-free at 844-491-9898, TTY 711, 8am - 8pm, Monday-Friday. Or visit www.geha.com/MedicareAdvantage.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance, 800-821-6136.

Prescription Drug Benefits

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

- **Materials you will receive:** Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a prescription drug card, Confirmation of Enrollment, online documents notice (where to find the EOC, Formulary, and Pharmacy Directory), a mail order form, Multi Language/ Non-Discrimination notice and Notice of Privacy Practices.
- **Drug coupon/copay cards:** We do not honor or coordinate benefits with drug coupon/ copay cards. You are responsible for your copay or coinsurance as indicated in this brochure.
- **Who can write your prescription:** A licensed physician or dentist, and in the states allowing it, licensed or certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.

Prescription Drug Benefits - continued on next page

Prescription Drug Benefits (cont.)

- **Where you can obtain them:** You may fill the prescription at a preferred pharmacy, a non-preferred pharmacy, or by mail for certain drugs. We pay a higher level of benefits when you use a preferred pharmacy.
  - Preferred pharmacy – Present your Plan identification card at a preferred pharmacy to purchase your prescriptions and have the claim be filed electronically for you.
  - Non-preferred pharmacy –You pay the full cost and manually file a claim for reimbursement by sending in your original prescription to:
    - SilverScript Insurance Company
      Prescription Drug Plans
      Medicare Part D Paper Claim
      PO Box 52066
      Phoenix, AZ 85072-2066
  - Mail order –To obtain more information about the mail order drug program, order refills, check order status and request additional mail service envelopes and claim forms, or to ask questions call SilverScript at 1-833-250-3241 or visit our website, https://info.caremark.com/oe/gehapdp.

    Note: Remember to use a preferred pharmacy whenever possible and show your SilverScript ID card to receive the maximum benefits and the convenience of having your claims filed for you. For assistance locating a PDP EGWP preferred pharmacy, visit our website at www.caremark.com or call us at 833-250-3241 / TTY 711.
- **We use a managed formulary.** A formulary is a list of generic and preferred drugs (see below) that are available through this plan. It places all FDA approved drugs into categories based on their clinical effectiveness, safety and cost and is designed to control costs for you and the Plan. Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. The categories include:
  - Tier 1: Generic drug category includes primarily generic drugs;
  - Tier 2: Preferred drug category (also called "formulary") includes preferred brand name drugs;
  - Tier 3: Non-Preferred drug category (also called "non-formulary") includes non-preferred brand name drugs;
  - Tier 4: Specialty drug category (see description of Specialty drugs below).

Occasionally, drugs may change from one category to another category, which can affect your cost-share amount. We will attempt to notify you when this occurs. While all FDA-approved drugs are available to you, we may have formulary restrictions on certain drugs, including but not limited to, quantity limits, age limits, dosage limits, brand exception and preauthorization. To request a copy of our current formulary, call us at 1-833-250-3241 or visit our website, https://info.caremark.com/oe/gehapdp.

- **Utilization Management strategies: Preauthorization, trial and step therapy:** We require preauthorization (PA) for certain drugs to ensure safety, clinical appropriateness and cost effectiveness. PA criteria are designed to determine coverage and help to promote safe and appropriate use of medications. Drugs subject to PA are screened at the point of service and the dispensing pharmacy is advised to have the prescriber contact the SilverScript PA department. SilverScript will obtain the relevant information from the prescriber to determine whether the drug use meets the established criteria for the requested drug. In certain circumstances, a preauthorization may require the trial or step of a more appropriate first line agent before the drug being requested is approved.
- **A generic equivalent will be dispensed if it is available** unless your physician specifically requires a brand name drug. If you receive a brand name drug when an FDA approved generic drug is available, and your physician has not specified Dispense as Written for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- Why use generic drugs: By choosing Generic or Preferred category drugs, you may decrease your out-of-pocket expenses.

Prescription Drug Benefits - continued on next page

Prescription Drug Benefits (cont.)

- **You may request a Formulary Exception:**
  - Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception**.
  - Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception**.
  - Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**
  - Start by calling, writing or faxing SilverScript to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through caremark.com website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request form. You, your doctor, (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf.
- **When you do have to file a claim.** Please be sure to include your name, contact information, and information identifying which denied claim is being appealed.
- **If we deny your claim and you want to appeal:** You; your representative, or your prescriber must request an appeal following the process described in Section 8(a). *Medicare PDP EGWP Disputed Claims process.* The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.
  - A standard appeal is usually made within 7 days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

Benefits Description	You pay	
Covered medications and supplies	**Elevate Plus Option with EGWP**	**Elevate Option with EGWP**
You may purchase the following medications and supplies prescribed by a physician from SilverScript network pharmacies or through the mail order program: • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs to treat gender dysphoria: Such as Estradiol; Testosterone Note: This prescription drug plan offers a formulary which covers Part D drugs required by CMS and additional drug coverage as outlined below: • Non-Part D Supplemental Benefit including but not limited to: - Agents when used for the symptomatic relief of cough and colds. - Agents when used for weight loss (Prior Authorization applies) - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations. Note: For access to our formulary, please visit: https://info.caremark.com/oe/gehapdp Note: Prior authorization may be required for certain drugs, call us at 1-833-250-3241 if you have any questions regarding preauthorization, quantity limits, or other issues.	Retail Pharmacy, up to a 30-day supply: • Generic (Preferred Pharmacy): $9 copay • Generic (Non-Preferred Pharmacy): $10 copay • Preferred brand: $47 copay • Non-Preferred brand: 50% of Plan allowance Mail order Pharmacy, up to 90-day supply: • Generic (Preferred Pharmacy): $20 copay • Generic (Non-Preferred Pharmacy): $30 copay • Preferred brand (Preferred Pharmacy): $141 copay • Preferred brand (Non-Preferred Pharmacy): $141 copay • Non-Preferred brand (Preferred Pharmacy): 50% of Plan allowance • Non-Preferred brand (Non-Preferred Pharmacy): 50% of Plan allowance Specialty drugs, up to 30-day supply: • 33% of Plan allowance; limited to $500	Retail Pharmacy, up to a 30-day supply: • Generic (Preferred Pharmacy): $3 copay • Generic (Non-Preferred Pharmacy): $4 copay • Preferred brand: 25% of Plan allowance; limited to $500 • Non-Preferred brand: 25% of Plan allowance; limited to $500 Mail order Pharmacy, up to 90-day supply: • Generic (Preferred Pharmacy): $9 copay • Generic (Non-Preferred Pharmacy): $12 copay • Preferred brand (Preferred Pharmacy): 25% of Plan allowance; limited to $1,500 • Preferred brand (Non-Preferred Pharmacy): 25% of Plan allowance; limited to $1,500 • Non-Preferred brand (Preferred Pharmacy): 25% of Plan allowance; limited to $1,500 • Non-Preferred brand (Non-Preferred Pharmacy): 25% of Plan allowance; limited to $1,500 Specialty drugs, up to 30-day supply: • 33% of Plan allowance; limited to $500

Covered medications and supplies - continued on next page

Benefits Description	You pay	
Covered medications and supplies (cont.)	**Elevate Plus Option with EGWP**	**Elevate Option with EGWP**
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. In our PDP EGWP, contraceptive coverage is available at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described on GEHA's website at www.geha.com/Contraception or by calling SilverScript at 833-250-3241. Exception requests for contraception coverage will be processed within 24 hours of receiving complete information. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted by sending in your original prescription receipt obtained by your pharmacy to: SilverScript Insurance Company Prescription Drug Plans Medicare Part D Paper Claim PO Box 52066 Phoenix, AZ 85072-2066 Note: For additional Family Planning benefits see Section 5(a). Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a).	Nothing (no deductible)	Nothing (No deductible)
Insulin, one-month supply	$35 copay	$35 copay
Tier 1 ACE Inhibitors/ Beta Blockers (blood pressure medications), 30-day supply	$3 copay	$3 copay

Benefits Description	You pay	
Preventive medications	**Elevate Plus Option with EGWP**	**Elevate Option with EGWP**
Preventive medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to: www.uspreventiveservicestaskforce.org/BrowseRec/Index/Browse-recommendations Note: Your doctor must write a prescription for these preventive services to be covered by the plan, even if they are listed as over-the-counter. Changes can occur throughout the year.	Preferred pharmacy: Nothing (no deductible) Member is responsible for charges above allowable when using a non-preferred pharmacy.	Preferred pharmacy: Nothing (no deductible) Member is responsible for charges above allowable when using a non-preferred pharmacy.
Physician prescribed over-the-counter and prescription naloxone, opioid rescue agents, available as nasal sprays are covered under this Plan at no cost. For more information consult the FDA guidance at: www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose, or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www.findtreatment.samhsa.gov/	Preferred pharmacy: Nothing (no deductible) Member is responsible for charges above allowable when using a non-preferred pharmacy.	Preferred pharmacy: Nothing (no deductible) Member is responsible for charges above allowable when using a non-preferred pharmacy.
Not covered: • *Drugs and supplies for cosmetic purposes.* • *Prescriptions written by a non-covered provider.* • *Vitamins, nutrients and food supplements that do not require a physician's prescription, even if a physician prescribes or administers them, except as indicated.* • *Total parenteral nutrition (TPN) products and related services, except as noted under Section5(a), Treatment therapies.* • *Continuous glucose monitors (CGMs) and supplies, except as noted under Section 5(a), Durable Medical Equipment.* • *Over-the-counter medications even if prescribed by a physician, unless otherwise stated in this section.* • *Nonprescription medications unless specifically indicated elsewhere.* • *Topical analgesics, including patches, lotions,and creams.* • *Erectile dysfunction drugs.* • *Drugs and supplies when Medicare Part B is primary payor. For Part B diabetic continuous glucose meters, see Section 5(a), Durable medical equipment. For Medicare Part B covered drugs and diabetic supplies, see Section 5(f), Coordinating with other drug coverage.*	*All charges*	*All charges*

Preventive medications - continued on next page

Benefits Description	You pay	
Preventive medications (cont.)	**Elevate Plus Option with EGWP**	**Elevate Option with EGWP**
• *Any amount in excess of the cost of the generic drug when a generic is available, and a brand exception has not been obtained by the prescribing physician.* • *Drugs obtained from a retail pharmacy in excess of a 30-day supply, except maintenance medication obtained at a CVS retail pharmacy.* • *Drugs obtained from a foreign pharmacy in excess of a 90-day supply.*	*All charges*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9 *Coordinating benefits with other coverage.***
- Under the Elevate Plus Option, the calendar year deductible is $200 per person ($400 if enrollment is Self Plus One or Self and Family). We state whether or not the calendar year deductible applies for each benefit listed in the applicable section.
- Under the Elevate Option, the calendar year deductible is $500 per person ($1,000 if enrollment is Self Plus One or Self and Family). If you use an out-of-network provider, the calendar year deductible is $1,000 per person ($2,000 if enrollment is Self Plus One or Self and Family).
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you other coverage, or if you are age 65 or over.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5 (c) for *Inpatient hospital benefits*.

Benefits Description	You pay	
Accidental dental benefits	**Elevate Plus**	**Elevate**
We cover restorative services and supplies necessary to promptly repair sound natural teeth. The need for these services must result from an accidental injury. • Repair to sound natural teeth such as: expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. Note: We may review X-rays and/or treatment records in order to determine benefit coverage.	Services are paid at regular medical Plan benefits. Note: See Sections 5 (a) through 5(f) for applicable services and benefits	Services are paid at regular medical Plan benefits. Note: See Sections 5 (a) through 5(f) for applicable services and benefits
Not covered: • *Oral implants and transplants* • *Masticating (biting or chewing) incidents are not considered to be accidental injuries.*	*All charges*	*All charges*
Dental benefits	**Elevate Plus**	**Elevate**
We have no other dental benefits.	N/A	N/A

Section 5(h). Wellness and Other Special Features

Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf and hearing impaired	TTY service is available at 800-821-4833 for members who are hearing impaired.
Health Rewards/Health Assessment	Earn rewards for healthy actions with GEHA's Wellness Pays program. Total annual rewards are limited to $500 each for the subscriber and covered spouse. Maximum reward amounts are not guaranteed. Rewardable activities include, but may not be limited to, the following: 1. Health assessment (must complete to be eligible for additional rewards) 2. Annual physical 3. Preventive cancer screenings (Cervical, Colorectal, Breast) 4. Health and Wellness Webinars Members will be issued a rewards account with a reloadable debit card, which can be used for eligible medical expenses. For detailed information about eligibility requirements, how to access the health assessment and all available rewards, visit https://www.geha.com/WellnessPays
Telehealth	Telehealth is available at a reduced cost through MDLIVE. Go to https://members.mdlive.com/geha-callmd or call 888-912-1183 to access on demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions (see Section 10 for definition), dermatology conditions (see Section 10 for definition), and counseling for mental health and substance use disorder. Note: This benefit is available at a reduced cost only through the MDLIVE contracted telehealth provider network. Note: Practitioners must be licensed in the state the patient is physically located at the time services are rendered.

Member Portal	Your family's healthcare resources, in your hands whether at home or on the go. The online member portal provides instant access to your family's critical health information – anytime and anywhere. Whether you want to find a physician near you, check the status of a claim or speak directly with a healthcare professional, the portal is your go-to resource. Key features include: • Search for physicians or facilities by location or specialty • Store favorite physicians and facilities • View and share health plan ID card information • Utilize MDLIVE for virtual visits as an alternative to seeing a physician onsite • Check reward program status and activities • Can be personalized with individual member avatar, notes and reminders • Complete confidentiality • Check health-related financial account balance • Locate nearby convenience clinics, urgent care facilities, and ER's • Check status of deductible and out-of-pocket spending For more information, visit https://www.geha.com
Weight Management	GEHA offers programs and tools for weight management. - 24/7 Access to digital tools - Goal setting and progress tracking - Online video sessions
GEHA maternity program	GEHA makes various maternity resources available to you or your covered dependent. Visit www.geha.com/Maternity to order your packet on pregnancy and prenatal care and to learn more about the maternity program.
24-Hour Nurse Advice Line	Call the GEHA 24-Hour Nurse Advice Line number 888-257-4342 and speak with a registered nurse – any time, 24 hours a day. The nurse can help you understand your symptoms and determine appropriate care for your needs. The Nurse Advice Line allows you to conveniently manage your symptoms and treatment anywhere you have access to a phone.
Personal Health Record	Our Personal Health Record helps you track health conditions, allergies, medications and more. This program is voluntary and confidential.
Value Added Programs and Services	GEHA offers a number of programs and services to members to assist with special conditions and needs. Members with these conditions or needs can work with health professionals, such as a nurse or health coach. Visit www.geha.com for a list of programs, program criteria, and contact information.
Family Planning Care Program	GEHA Care Management resources and guidance are available to assist members or covered dependents through the infertility process. Visit www.geha.com/FamilyPlanning. Note: Infertility coverage is limited. See Section 5(a), *Infertility services* for covered services.
Preconception Program	GEHA Care Management resources and guidance are available to members or covered dependents who are considering a future pregnancy and want to optimize their own health and well-being prior to conception. Visit www.geha.com/Preconception.

Non-PSHB Benefits Available to Plan Members

The benefits on this page are not part of the PSHB contract or premium, **and you cannot file a PSHB disputed claim about them.** Fees you pay for these services do not count toward PSHB deductibles or catastrophic protection (out-of-pocket maximums). These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 800-821-6163 or visit their website at www.geha.com.

Connection Hearing® powered by TruHearing® - 844-513-0890 - www.TruHearing.com

GEHA members save 30% to 60% off the average retail price of hearing aids with TruHearing, making it affordable to address your unique hearing needs. GEHA also offers you a hearing aid allowance of $1,500 on the Elevate Plus Option (see the Hearing Services section of this brochure). You can apply your allowance to the cost of hearing aids through TruHearing to further minimize your out-of-pocket cost. TruHearing will submit the claim on your behalf, and you will only be responsible for charges in excess of your allowance.

Connection Vision® powered by EyeMed® - 877-808-8538 - www.geha.com/Vision

Free to all GEHA Elevate Plus and Elevate Plan members, you receive vision exam coverage for no additional premium. Through Connection Vision powered by EyeMed, you and your covered family members each pay $0 for an annual routine eye exam when you use an in-network EyeMed participating provider. Or, if you seek services from a non-participating provider, you can be reimbursed up to $45 for your annual eye exam. You also receive discounts on lenses and frames. For a list of participating locations, select Connection Vision on the GEHA website at www.geha.com/Vision.

Connection Fitness® powered by Active&Fit Direct™ - 800-821-6136 - www.geha.com/Fitness

GEHA promotes healthy lifestyles and fitness activities. All GEHA health plan members can take advantage of our Connection Fitness program including discounts on gym memberships, access to online tools, and activity tracking. Access to more than 12,200 nationwide participating fitness centers and more than 9,700 digital workout videos for a minimal monthly fee (plus a small, one-time enrollment fee and applicable taxes).

Connection Dental® - 800-296-0776 - www.geha.com

Free to all GEHA health plan members, Connection Dental® can reduce your costs for dental care. Connection Dental is a network of more than 190,000 provider locations nationwide. Participating providers have agreed to limit their charges to reduced fees for GEHA health plan members. To find a participating Connection Dental provider in your area, call 800-296-0776 or visit www.geha.com.

CONNECTION Dental Plus® - 888-434-2988 - www.geha.com/CDplus

Available for an additional premium, Connection Dental Plus® is a supplemental dental plan that pays benefits for a wide variety of procedures. Enrollment is open to all current and former Postal employees, retirees and annuitants, including those who are not members of the GEHA health plan. Parents can cover their unmarried dependent children up to their 26th birthday.

Smile Brilliant® - 855-944-8361 - www.smilebrilliant.com/geha
GEHA members save up to 70% off a premium electric toothbrush by cariPRO® and 20% off of the lowest-published price for professional teeth-whitening. Smile Brilliant's custom-fitted trays, teeth whitening gel and desensitizing gel can be ordered online at www.smilebrilliant.com/geha.

Section 6. General Exclusions - Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining preauthorization for specific services, such as transplants, see Section 3, *How You Get Care*.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services or supplies we are prohibited from covering under the Federal Law.
- Services, drugs, or supplies furnished, ordered or billed by yourself, 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 non-covered 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.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see Section 9, *Coordinating Benefits with Medicare and Other Coverage),* doctor's charges exceeding the amount specified by the Department of Health *Coordinating Benefits with Medicare and Other Coverage),* or State premium taxes however applied.
- Services, drugs, or supplies ordered or furnished by a non-covered provider.
- Services, drugs, or supplies related to a sexual dysfunction or sexual inadequacy.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring Plan preauthorization), including urgent care claims procedures.

How to claim benefits

To obtain claim forms, claims questions or assistance, or answers about our benefits, contact us at 800-821-6136, or at our website at www.geha.com.

In most cases, providers and facilities file claims for you. Your provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. Submit claims to the network address on the back of the GEHA ID card, for both in-network and out-of-network claims.

Note: The Elevate Plus Option does not provide out-of-network benefits except in cases of emergency.

Submit dental claims, or out-of-network charges that you have paid in full to:

GEHA Dental Claims
PO Box 21191
Eagan, MN 55121

Submit medical and Medicare primary claims, or out-of-network charges that you have paid in full to:

GEHA Medical Claims
PO Box 21172
Eagan, MN 55121

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below or visit www.geha.com/Claim. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee;
- Patient's Plan identification number;
- Name and address of person or company providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; itemized bill including valid codes such as ADA, CPT, HCPCS (including NDC numbers for all Drug type charges); and
- Charge for each service or supply
- We will provide translation and currency conversion services for claims for overseas (foreign) services. The conversion rate will be based on the date services were rendered.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. Many direct-to-consumer program models do not support claim submissions to insurance carriers. They do not provide enough detailed, itemized, information to meet this claim submission criteria.

In addition:

- If another health plan is your primary payor, you must send a copy of the Explanation of Benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.

- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse and should include nursing notes.
- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing provider name, date, and charge. A copy of the provider's script must be included with prescription drugs purchased outside the United States.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records

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

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

Overseas claims

For covered services you receive by providers and hospitals outside the United States and Puerto Rico, send a completed International Claim Form and the itemized bills to: GEHA Medical Claims, PO Box 21172, Eagan, MN 55121. Obtain International Claim Forms from: www.geha.com/Claim.

If you have questions about the processing of overseas claims, contact 800-821-6136 or by email overseas@geha.com. Covered providers outside the United States will be paid at the in-network level of benefits, subject to the plan deductible, copays and/or coinsurance. We will provide translation and currency conversion for claims for overseas (foreign) services. The conversion rate will be based on the date services were rendered.

Eligibility and/or medical necessity review is required when procedures are performed, or you are admitted to a hospital outside of the United States. Review includes the procedure/service to be performed, the number of days required to treat your condition, and any other applicable benefit criteria.

When members living abroad are stateside and seeking medical care, contact us at 800-821-6136, or visit www.geha.com/Find-Care to locate an in-network provider. When you are seeking treatment stateside, all precertification and authorization requirements are applicable. If you utilize an out-of-network provider, out-of-network benefits would apply on the Elevate Option. The Elevate Plus Option does not provide out-of-network benefits except in cases of emergency.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10% of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Program (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8(a). Medicare PDP EGWP Disputed Claims Process.

Please follow this Postal Service Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3, *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing GEHA Post-Service Appeals, PO Box 21324, Eagan, MN 55121 or calling 800-821-6136.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: 1. Write to us within 6 months from the date of our decision; 2. To do so you may log in at www.geha.com and complete the online appeal submission form or send your request to us at: GEHA Pre-Service Appeals, PO Box 400046, San Antonio, TX 78229 or GEHA Post-Service Appeals, PO Box 21324, Eagan, MN 55121; and 3. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and 4. Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms. 5. Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

	We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: 1. Pay the claim or 2. Write to you and maintain our denial or. 3. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, NW, Room 3443, Washington, DC 20415. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; • Your daytime phone number and the best time to call; and • Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM’s review within 60 days. There are no other administrative appeals.

	If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or preauthorization. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-821-6136. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM's PSIO so they can quickly review your claim on appeal. You may call PSIO at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8(a).

Section 8(a). Medicare PDP EGWP Disputed Claims Process

Medicare Non Part D Prescription - See Section 8. *The Disputed Claims Process*

When a claim is denied in whole or in part, you may appeal the denial. Our Plan follows the **Medicare Part D appeals** process.

Level of appeal	Steps to be taken
Level 1	**Step 1:** Decide if you need a standard appeal or a fast appeal. A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. **Step 2:** You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. • For standard appeals, submit a written request to: SilverScript Insurance Company Prescription Drug Plans Coverage Decisions and Appeals Department PO Box 52000, MC 109 Phoenix, AZ 85072-2000 • For fast appeals, either submit your appeal in writing or call us 833-250-3241. • We must accept any written request. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request. • You must make your appeal request within **65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. **Step 3**: We consider your appeal, and we give you our answer. Deadlines for a fast appeal: • For fast appeals, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it. - If we don't give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. • If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provided within 72 hours after we receive your appeal. • If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision. Deadlines for a standard appeal for a drug you have not received. Deadlines for standard appeal: • For standard appeals, we must give you our answer within 7 calendar days after we receive your appeal. • If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process where it will be reviewed by an independent review organization. • If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provided within 7 calendar days after we receive your appeal. • If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision. Deadlines for a standard appeal about payment for a drug you have already bought.

	Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal. • If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.
Level 2	**Step 1:** You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case. • If we say no to your Level 1 appeal, the written notice we send you will include instructions on how to make a Level 2 appeal with the independent review organization. **Step 2:** The independent review organization reviews your appeal. Deadlines for fast appeal • If your health requires it, ask the independent review organization for a fast appeal. • If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal within 72 hours after it receives your appeal request. Deadlines for standard appeal • For standard appeals, the review organization must give you an answer to your Level 2 appeal within 7 calendar days after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal within 14 calendar days after it receives your request. **Step 3**: The independent review organization gives you their answer. For fast appeals: • If the independent review organization says yes to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization. For standard appeals: • If the independent review organization says yes to part or all of your request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization. • If the independent review organization says yes to part or all of your request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization. • If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called upholding the decision. It is also called turning down your appeal.) In this case, the independent review organization will send you a letter. Step 4: If your case meets the requirements, you choose whether you want to take your appeal further. • The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator.
Level 3	An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer. • If the answer is yes, the appeals process is over. We must authorize or provide the drug coverage that was approved by the Administrative Law Judge or attorney adjudicator within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision. • If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.

Level of appeal	Steps to be taken
Level 4	The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government. • If the answer is yes, the appeals process is over. We must authorize or provide the drug coverage that was approved by the Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision. • If the answer is no, the appeals process may or may not be over.
Level 5	A judge at the Federal District Court will review your appeal. • A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage or auto insurance

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.geha.com/COB.

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

In certain circumstances when we are secondary, we will also take advantage of any provider discount arrangements your primary plan may have. For medical and dental services, we will coordinate benefits to the allowable expense of your primary plan.

- Refer to Section 5(f), *Coordinating with other drug coverage,* when you have other primary prescription coverage.

If your primary payor requires preauthorization or requires you use designated facilities or provider for benefits to be approved, it is your responsibility to comply with these requirements. In addition, you must file the claim to your primary payor within the required time period. If you fail to comply with any of these requirements and benefits are denied by the primary payor, we will pay secondary benefits based on an estimate of what the primary carrier would have paid if you followed their requirements.

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

This plan always pays secondary to:

- Any medical payment, PIP or No-Fault coverage under any automobile policy available to you.
- Any plan or program which is required by law.

You should review your automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended PSHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your PSHB coverage to enroll in one of these programs, eliminating your PSHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

- **Medicaid**

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

Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHBProgram, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

If GEHA pays benefits for an illness or injury for which you accrue a right of action, are entitled to compensation, or receive a settlement, judgment, or recovery from another party, you must agree to the provisions below. All GEHA benefit payments in these circumstances are a condition of and a limitation on the nature, provision, or extent of coverage or benefits under the Plan, and remain subject to all of our contractual benefit limitations, exclusions, and maximums. By accepting these conditional benefits, you agree to the following:

- You or your representative must contact GEHA's Subrogation Vendor, The Rawlings Company, LLC, at 855-967-6609 as soon as possible after the event(s) that resulted in the illness or injury, and provide all requested information, including prompt disclosure of the terms of all settlements, judgments, or other recoveries. You must sign any releases GEHA requires to obtain information about any claim(s) for compensation from other sources you may have.
- You must include all benefits paid by GEHA in any claim for compensation you or your representative assert against any tortfeasor, insurer, or other party for the injury or illness, and assign all proceeds recovered from any party, including your own and/or other insurance, to GEHA for up to the amount of the benefits paid.
- When benefits are payable under the Plan in relation to the illness or injury, GEHA may, at its option:

Enforce its right of subrogation, that is, take over your right to receive payments from other parties. You will transfer to GEHA any rights you or your representative may have to take legal action arising from the illness or injury, and to recover any sums paid on your behalf as a result of that action; or

Enforce its right of reimbursement, that is, recover any sums paid on your behalf from any payment(s) you or your representative obtain from other parties. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
You must cooperate in doing what is reasonably necessary to assist us, and you must not take any action that may prejudice, these rights of recovery. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your PSHB plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

- To reimburse GEHA on a first priority basis (i.e., before any other party) in full, up to the amount of benefits paid, out of any and all settlements, judgments, or other recoveries that you or your representative obtain from any source and no matter how characterized, designated, or apportioned (for example, as "pain and suffering only"). GEHA enforces this right of reimbursement by asserting a lien against any and all recoveries obtained, including, but not limited to, first party Medpay, Personal Injury Protection, No-Fault coverage, Third-Party liability coverage, Uninsured and Underinsured coverage, personal liability umbrella coverage, and a workers compensation program or insurance policy. GEHA's lien consists of the total benefits paid to diagnose or treat the illness or injury. GEHA's lien applies first, regardless of the "make whole" and "common fund" doctrines. Your plan is not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

GEHA's lien extends to all expenses incurred prior to the settlement or judgment date, even if those expenses were not submitted to GEHA for payment at the time you reimbursed GEHA. The lien remains your obligation until it is satisfied in full. Failure to refund GEHA or cooperate with our recovery efforts may result in an overpayment that can be collected from you.

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, heirs or beneficiaries, administrators, legal representatives, successors, assignees, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the plan.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.gov or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan ***does not*** cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan ***does not*** cover these costs.

Note: Requires preauthorization.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact 800-821-6136.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-821-6136 or see our website at www.geha.com.

For members enrolled in the Elevate Option, we do NOT waive deductibles, coinsurance, or copayments for Medicare members.

For members enrolled in Elevate Plus Option we waive some costs if the Original Medicare Plan is your primary payor as follows:

- Inpatient hospital benefits: If you are enrolled in Medicare Part A, we waive the copayment or the deductible and coinsurance.
- Outpatient facility benefits: If you are enrolled in Medicare Part B, we waive the copayment or the deductible and coinsurance.
- Medical and surgery benefits and mental health/substance use disorder care: If you are enrolled in Medicare Part B, we waive the copayment or the deductible and coinsurance.
- Office visit providers and MinuteClinic (where available): If you are enrolled in Medicare Part B, we waive the copayment or the deductible and coinsurance for office visits.

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B and the Elevate Plus Option. If you purchase Medicare Part B, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible

You Pay without Medicare: In-Network: $200

You Pay without Medicare: Out-of-Network: N/A

You Pay with Medicare Part B: In Network: $0

You Pay with Medicare Part B: Out-of-Network: $0

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum

You Pay without Medicare: In-Network: $7,000 self only /$14,000 family

You Pay without Medicare: Out-of-Network: N/A

You Pay with Medicare Part B: In Network: $7,000 self only $14,000 family

You Pay with Medicare Part B: Out-of-Network: N/A

Benefit Description: Part B Premium Reimbursement Offered

You Pay without Medicare: In-Network: N/A

You Pay without Medicare: Out-of-Network: N/A

You Pay with Medicare Part B: In Network: N/A

You Pay with Medicare Part B: Out-of-Network: N/A

Benefit Description: Primary Care Provider

You Pay without Medicare: In-Network: $30

You Pay without Medicare: Out-of-Network: N/A

You Pay with Medicare Part B: In Network: $0

You Pay with Medicare Part B: Out-of-Network: $0

Benefit Description: Specialist

You Pay without Medicare: In-Network: $50

You Pay without Medicare: Out-of-Network: N/A

You Pay with Medicare Part B: In Network: $0

You Pay with Medicare Part B: Out-of-Network: $0

Benefit Description: Inpatient Hospital

You Pay without Medicare: In-Network: 15% of Plan allowance

You Pay without Medicare: Out-of-Network: N/A

You Pay with Medicare Part B: In Network: $0

You Pay with Medicare Part B: Out-of-Network: $0

Benefit Description: Outpatient Hospital

You Pay without Medicare: In-Network: 15% of Plan allowance

You Pay without Medicare: Out-of-Network: N/A

You Pay with Medicare Part B: In Network: $0

You Pay with Medicare Part B: Out-of-Network: $0

Benefit Description: Incentives offered

You Pay without Medicare: In-Network: N/A

You Pay without Medicare: Out-of-Network: N/A

You Pay with Medicare Part B: In Network: N/A

You Pay with Medicare Part B: Out-of-Network: N/A

You can find more information about how our plan coordinates benefits with Medicare as outlined in Medicare Benefit Guide at www.geha.com/Medicare.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

  If you are enrolled in Medicare Part B, a physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. Regardless of whether the physician requires you to sign an agreement, we will still limit our payment to the coinsurance amount we would have paid after Original Medicare's payment based on our Plan allowable and the type of service you receive. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you;

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, if you do go outside the Medicare Advantage plan's network or service area, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

Members will be eligible for Part D coverage if they meet the eligibility criteria below:

1. The individual is entitled to Medicare Part A and/or enrolled in Part B.
2. The individual has current Part D eligibility in CMS system.
3. The individual permanently resides in service area.
4. The individual is a US citizen or lawfully present in the United States.

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

Individual Medicare Part D coverage: You cannot be covered under two Part D plans at the same time. If you elect to opt out of GEHA SilverScript Prescription Drug Plan (PDP), you WILL NOT be eligible for PSHB pharmacy benefits.

Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)

If you are enrolled in Medicare Part A and/or Part B, and are not enrolled in our Medicare Advantage Prescription Drug Plan (MAPD), you will be automatically group enrolled into our Medicare PDP EGWP.

Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members.

This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. Note: You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

This Plan and our PDP EGWP:

- If you are enrolled in Medicare, you and/or eligible dependents will not need to take action to be automatically enrolled in the GEHA Prescription Drug Plan (PDP) provided by SilverScript for PSHB covered annuitants and their PSHB covered family member who are eligible for Medicare. You will continue to remain enrolled in our PSHB plan.
- This allows you to receive benefits that will never be less than your coverage that is available to members with only PSHB, but more often you will receive benefits that are better than members with only PSHB.
- Participants who are enrolled in GEHA Prescription Drug (PDP) will receive a separate prescription ID card to use for filling prescriptions.

The following are your enhanced prescription benefits:

- No deductible
- Catastrophic Protection Out-of-Pocket Maximum of $2,000 per person annually (included in the Plan's integrated medical and prescription drug overall out-of-pocket maximum)

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium. The plan does not collect the Part D-IRMA as part of the premium. Failure to pay an accessed IRMAA amount, could result in automatic disenrollment by Medicare from PDP EGWP.

For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at https://www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY 800-325-0778. You may also contact SilverScript at the toll-free number (833-250-3241)

The PDP EGWP opt out process:

- If you were automatically group enrolled into our PDP EGWP and do not wish to remain enrolled in GEHA Prescription Drug Plan (PDP), you may "opt-out" of the enrollment by following the instructions mailed to you. To avoid automatic enrollment, you will have 21 days from receiving the letter to contact SilverScript at the toll-free number (833-250-3241) to decline Part D coverage. GEHA is not limited when you can opt out or opt in to our PDP EGWP plan. After the initial enrollment period, you may opt out after the first of any month and the change will not be effective until the first day of the following month.

The PDP EGWP disenrollment process:

When you are enrolled in our PDP EGWP, you may choose to disenroll at any time by sending SilverScript a written request to disenroll (GEHA 2025 Disenrollment form). You can obtain it by:
1. Visit https://www.geha.com/plans/prescriptions/prescription-drug-plan under Forms and Documents
2. Contact SilverScript's Customer Care (833-250-3241)
3. Or Medicare at 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week and ask to be disenrolled. TTY users should call 877-486-2048.

The disenrollment form needs to be either faxed (833-806-0689 Attn: Group Disenrollment) or mailed to Group Aetna Medicare, PO Box 7082, London KY 40742.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in GEHA's High or Standard medical plans with MAPD during Open Season or for a QLE and receive PSHB Program Prescription Drug Coverage.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance by calling 800-821-6136.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation		✓*
8) Are a Postal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30-month coordination period)**		✓
• Medicare based on ESRD **(after the 30-month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

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

Under the FEHB law, which includes the PSHB program, we must limit our payments for inpatient hospital care and physician care to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the PSHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

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

Then, for your inpatient hospital care:

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

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

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

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

If your physician:
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our network,
Then you are responsible for:
your deductibles, coinsurance, and copayments.

If your physician:
Participates with Medicare and is not in our network,
Then you are responsible for:
your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.

If your physician:
Does not participate with Medicare,
Then you are responsible for:
your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

If your physician:
Does not participate with Medicare and is not a member of our network
Then you are responsible for:
your out-of-network deductibles, coinsurance, copayments and any balance up to 115% of the Medicare approved amount

If your physician:
Opts-out of Medicare via private contract
Then you are responsible for:
your deductibles, coinsurance, copayments, and any balance your physician charges.

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

Physicians who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a non-participating doctor, and we recommend you ask your physician if they have opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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

When you have the Original Medicare Plan (Part A, Part B, or both)	We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare. We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility. If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim. For the Elevate Plus option, if your physician accepts Medicare assignment, we waive some of your deductibles, copayments and coinsurance for covered charges. If your physician **does not accept** Medicare assignment, you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment. It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the “limiting charge.” The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of Terms We Use in This Brochure

Accidental injury

An injury caused by an external force or element such as a blow or fall that requires immediate medical attention. Also included are animal bites, poisonings, and dental care required to repair injuries to sound natural teeth as a result of an accidental injury, not from biting or chewing.

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Advance care Planning

The process of making decisions about future healthcare options in the event of a medical crisis. This might involve the appointment of a substitute decision maker or the completion of an advance care directive or similar document.

Artificial insemination

Artificial insemination is a surgical procedure for the introduction of sperm or semen into the vagina, cervix, or uterus to produce pregnancy.

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Assisted reproductive technology

Assisted reproductive technology (ART) includes all fertility treatments in which either eggs or embryos are handled. In general, ART procedures involve surgically removing the eggs from the ovaries, combining them with sperm in the laboratory, and returning them to the birthing person's body or donating them to another person. They do NOT include treatments in which only sperm are handled (i.e., intrauterine - or artificial- insemination) or procedures in which a birthing person takes medicine only to stimulate egg production without the intention of having eggs retrieved.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan *does not* cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are generally covered by the clinical trials. This Plan *does not* cover these costs.

Coinsurance

See Section 4, *Your Costs for Covered Services.*

Compound medications

A compound medication includes more than one ingredient and is custom made by a pharmacist according to your doctor's instructions. Compound prescriptions must contain a Federal legend drug and the ingredients must by covered be the GEHA benefit.

Congenital anomaly

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

Copayment

See Section 4, *Your Costs for Covered Services.*

Cosmetic

Any procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Cost-sharing

See Section 4, *Your Costs for Covered Services.*

Covered services

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

Custodial care

We do not provide benefits for custodial care, regardless of who recommends the care or where it is provided. The Carrier or its delegated medical professionals determine which services are custodial care.

Custodial care includes treatment, supplies or services, that are provided to a patient mainly to help with activities of daily living. These activities include but are not limited to:

- Service, supplies, and treatment that are designed mainly to train or assist the patient in personal hygiene, or other activities of daily living rather than provide therapeutic treatment; or
- Personal care such as help ambulating getting in and out of bed, eating by spoon, tube or gastrostomy, exercise, and dressing;
- Homemaking, such as preparing meals or special diets;
- Acting as companion or sitter;
- Supervising medication that can usually be self-administered;
- Physical, emotional, or behavioral treatment or services that can be provided by non-licensed caregivers with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems; and

- Services or treatment where further medical professional intervention is not expected to result in significant improvement in the member's condition. The member's condition is no longer demonstrating measurable progress towards established treatment goals that have been documented in the patient's treatment record.

Deductible

See Section 4, *Your Costs for Covered Services.*

Dermatology conditions (telehealth)

Under the telehealth benefit, dermatologic conditions seen and treated include but are not limited to acne, rashes, eczema, suspicious spots/moles, warts and other abnormal bumps, rosacea, inflamed or enlarged hair follicles, psoriasis, cold sore, alopecia, insect bites.

Doula

A doula is a non-medical trained professional who provides emotional, physical, and informational support during pregnancy, labor/delivery, and post-partum periods.

Doulas must be certified to provide doula services to meet the Plan requirements of a covered provider. Doulas eligible to provide services for any state Medicaid program in the United States or certified by any organization recognized as providing acceptable training by any state Medicaid program will be considered a certified doula and eligible for reimbursement for services from the Plan. Training organizations include, but are not limited to:

- Childbirth and Postpartum Professional Association (CAPPA)
- Childbirth International
- Commonsense Childbirth Institute
- Doulas of North America (DONA)
- Doula Trainings International (DTI)
- International Childbirth Education Association
- National Black Doulas Association

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

Durable medical equipment

Equipment and supplies that:

- Are prescribed by your attending doctor;
- Are medically necessary;
- Are primarily and customarily used only for a medical purpose;
- Are generally useful only to a person with an illness or injury;
- Are designed for prolonged use; or
- Serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your effective date begins on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

Elective surgery

Any non-emergency surgical procedure that may be scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

Expense

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

Experimental or investigational services

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other healthcare services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States American Hospital Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition.
- Subject to review and approval by any institution review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Group health coverage Healthcare 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 healthcare services or supplies, including extension of any of these benefits through COBRA.

Healthcare professional A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

Iatrogenic infertility An impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs including gonadotoxic therapies, or ovary or testicle removal for treatment of disease; also includes infertility associated with medical and surgical gender affirmation.

Infertility Infertility is defined as the inability to conceive pregnancy within a 12-month period for individuals under age 35 (6 months for persons aged 35 or older) through unprotected intercourse or artificial insemination. Infertility may also be established through evidence of medical history and diagnostic testing. Infertility includes the need for medical intervention to conceive pregnancy either as an individual or with a partner, except following voluntary sterilization.

Inpatient care Inpatient care is care rendered to a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even if it later develops that the patient can be safely discharged or transferred to another hospital and not actually use a hospital bed overnight. See Section 3, *How You Get Care, Covered facilities,* for the definition of an Acute Inpatient and Residential Treatment Center.

In vitro fertilization In vitro fertilization (IVF) is a method of assisted reproduction that involves combining an egg with sperm in a laboratory dish. If the egg fertilizes and begins cell division, the resulting embryo may be transferred into the uterus where it may implant in the uterine lining and further develop, or be cryopreserved for later transfer. A cycle of IVF is defined as stimulation of ovaries, oocyte retrieval, and embryo transfer or preservation.

Long-term acute care Often referred to as LTCH or LTAC, these facilities provide services for patients who need extended intensive or critical, hospital-level of care beyond that of the traditional short hospital stay. LTCH's specialize in treating patients who have more than one serious condition yet have the potential to improve with time and care and return to their previous health status. Generally, services are focused on respiratory therapy, head trauma treatment, and pain management.

Long-term care We do not provide benefits for long-term care, regardless of who recommends the care or where it is provided. The Carrier or its delegated medical professionals determine which services are long-term care.

A range of services and support provided to meet personal care needs on a long-term basis. While some medical care may be necessary, most of the care provided is not and does not require a licensed caregiver. This encompasses a spectrum of services provided in a variety of settings for people who do not have full independence because of a medical condition, injury, or chronic and/or behavioral illness.

Long-term care is often used to provide custodial care as well as instrumental activities of daily living necessary for safety and health.

Long-term care is usually custodial care that has lasted for 90 days or more yet can begin prior to 90 days dependent on the member's response to professional intervention.

Long-term care and long-term acute care are not one and the same. See the definition of long-term acute care for more information about those services.

Medical foods for a diagnosis of Inborn Errors of Metabolism (IEM)

Inborn errors of metabolism are rare genetic (inherited) disorders in which the body cannot properly turn food into energy. The disorders are usually caused by defects in specific proteins (enzymes) that help break down (metabolize) parts of food. GEHA will cover medical food for a diagnosis of IEM. Medical Food is defined as a food which is recommended by a physician after an evaluation and is intended to provide for the dietary management of a disease or condition that has specific nutritional requirements. GEHA will not cover "grocery" food items that can routinely be obtained online or in stores (e.g., gluten-free breads).

Medical necessity

Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder or its symptoms, that are all of the following as determined by us or our designee, within our discretion.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other healthcare provider.
- Not more costly than an alternate drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms.
- Is not custodial or long-term care (see the Plan's definition on the previous page).

If no credible scientific evidence is available, then standards are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether healthcare services are Medically Necessary.

Medicare Part A

Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

Medicare Part B

Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C

Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Part C plans also include Medicare Part D coverage.

Medicare Part D

Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Prescription Drug Plan (MAPD).

Medicare Part D EGWP

A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of a Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWP's, which only cover the prescription drug benefit.

Mental health/substance use disorder

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by the Plan; or disorders listed in the ICD requiring treatment for use or dependence upon substances such as alcohol, narcotics, or hallucinogens; may also be collectively referred to as Behavioral Health conditions. Prior authorization is required for all of the following services and must be provided by a covered facility or covered provider as defined in Section 3, *How You Get Care.*

Inpatient Behavioral Health (includes mental health and substance use disorders):

- Acute Care Hospital: See Section 3, Plan facilities.
- Residential Treatment Center (RTC): See Section 3, Plan facilities.

Intensive Day Treatment:

Intensive day treatment programs are outpatient services that must be rendered on an outpatient basis. Regardless of where services are rendered, the provider and/or the facility, must be licensed to provide intensive day mental health and/or substance use treatment and must meet GEHA's definition of a covered provider in Section 3. GEHA does not cover room and board during intensive day treatment programs. Under the direction of a physician, services must be provided for at least two hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive psychiatric medication management.

- Partial Hospitalization Program (PHP): A facility-based outpatient treatment program for mental health and/or substance use disorder conditions not requiring 24-hour care. Twenty or more hours of care per week is usually delivered at a minimum of four hours a day, five days a week. Time frames and frequency will vary based on condition, severity, and individual treatment plan.
- Intensive Outpatient Program (IOP): A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions for mental health and/or substance use disorders conditions. It is an intermediate level of care between traditional outpatient therapy and partial hospitalization, delivered in an outpatient facility or outpatient professional office setting. Nine or more hours of care per week is usually delivered at a minimum of three hours a day, three days a week. Time frames and frequency will vary based on condition, severity, and individual treatment plan.

Minor acute conditions

Common, non-emergent conditions. Examples of common conditions include sinus problems, rashes, allergies, cold and flu symptoms, etc.

Never event policies

Federal or State policies that bar healthcare providers from charging patients for care that is attributable to certain avoidable complications or errors, such as wrong site surgery.

Observation care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our Plan allowance as follows:

Allowable expense (plan allowance) is a healthcare expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

In-network providers: Our network allowances are negotiated with each provider who participates in the network. Network allowances may be based on a standard reduction or on a negotiated fee schedule. For these allowances, the in-network provider has agreed to accept the negotiated reduction and you are not responsible for this discounted amount. In these instances, the benefit paid plus your coinsurance equals payment in full.

Out-of-network providers: Applies to Elevate Option only; Elevate Plus does not offer out-of-network benefits except in cases of emergency.

We will determine the out-of-network Plan allowance by applying the following rules:

1. For emergent services, air ambulance, and services performed by certain out-of-network providers rendered at in-network facilities, the Plan allowance will be the "recognized amount" as defined by federal law.
2. Reimbursement for covered services received from out-of-network providers, including Physicians or health care facilities, are determined based on a methodology which considers the following:
   - The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or devices received by the member; or
   - Current publicly available data (including but not limited to pricing data published by the US Department of Veteran Affairs, RJ Health, and Medicare) reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor above cost;
   - Or, fee(s) that are negotiated with the Physician or facility.

To estimate our maximum Plan allowance for a non-network provider before you receive services from them, call us 800-821-6136. For more information, see *Differences between our allowance and the bill* in Section 4.

You should also see Important Notice About Surprise Billing - Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims 1) that require precertification or preauthorization and 2) where failure to obtain precertification or preauthorization results in a reduction of benefits.

Preauthorization	A decision made by your health plan that a healthcare service, treatment plan, drug, surgery, or durable medical equipment is medically necessary after review of medical information. Sometimes called prior approval.
Precertification	The process of collecting information and obtaining authorization from the health plan prior to an inpatient admission or other selected ambulatory procedures and services.
Primary care provider	For the purposes of the office visit copayment for the Elevate Plus and Elevate benefits, primary care providers are individual doctors (M.D. or D.O.) whose medical practice is limited to family/general practice, internal medicine, pediatrics/adolescent medicine, obstetrics/gynecology (OB/Gyn) or geriatrics, psychiatrists, licensed clinical psychologists, licensed clinical social worker, licensed professional counselors or licensed marriage and family therapists. Doctors listed in provider directories or advertisements under any other medical specialty or sub-specialty area (such as internal medicine doctors also listed under cardiology, or pediatric sub-specialties such as pediatric allergy) are considered specialists, not primary care providers. Chiropractors, eye doctors, dentists and audiologists, are not considered primary care providers.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Sound natural tooth	A sound 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 appliance (i.e., bridgework), would not be covered as there is no injury to the natural tooth structure.
Specialty medication	Specialty medications are biotech or biological drugs that are oral, injectable or infused, or may require special handling. To maximize patient safety, all specialty medications require prior authorization. These drugs are used in the treatment of complex, chronic medical conditions such as hemophilia, multiple sclerosis, hepatitis, cancer, rheumatoid arthritis, pulmonary hypertension, osteoarthritis, and immune deficiency.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surgery	Surgery may include procedures such as but not limited to cutting (incision); removing (excision); abrading; manipulating (e.g., setting bones); stitching; probing; injections (e.g., intraarticular, trigger point); exposing to heat, cold, chemicals, light/laser energy, or certain forms of radiation (e.g., radiofrequency ablation, gamma knife); or other techniques designed to structurally alter tissue within the body for the purpose of diagnosing and treating diseases, injuries, or deformities.
Surprise bill	An unexpected bill you receive for: • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.

Telehealth

Online/virtual doctor visits provided remotely by means of telecommunications technology.

Unproven

Unproven services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific healthcare services. These medical and drug policies are subject to change without prior notice.

Please note: If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise unproven service to be a covered health service for that sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 800-821-6136. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Government Employees Health Association, Inc.

You

You refers to the enrollee and each covered family member.

Index

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

Abortion.....115
Accidental injury.....52, 111, 137
Acupuncture.....34, 58
Advanced Control Specialty Formulary (ACSF).....98-99
Allergy tests.....48
Alternative treatment.....58
Ambulance.....21-23, 31, 53-54, 76-81, 84
Anesthesia.....48-50, 73, 76-79
Applied Behavioral Analysis Therapy (ABA).....21-23, 87
Artificial insemination...21-23, 46-48, 137, 140
Assignment.....137
Assisted reproductive technology...46-48, 137
Autologous bone marrow transplant...48-50, 76-79
Biopsy.....61-62, 64-65
Blood and blood plasma.....75-76
Breast prostheses.....53-54, 62-64
Breast pump and supplies.....43-45, 54-56
Calendar year.....137
Cardiac rehabilitation.....48-50
Casts.....75-79
Catastrophic protection out-of-pocket maximum.....30, 128-130, 151
Changes for 2025.....4
Chemotherapy...21-23, 48-50, 65-72, 76-79, 140
Cholesterol tests.....39-41
Circumcision.....43-45, 75-76
Claims...4-5, 14-15, 21, 23-26, 34, 93-95, 104-106, 116-117, 119-120, 125, 128-130, 143, 145
Clinical trials.....65-72, 128, 137-138
Coinsurance.....27-30, 34, 104-106, 143
Compound medication.....91-93, 138
Congenital anomalies.....61-65, 138
Contraceptive devices and drugs...96-98, 107-108
Coordination of benefits.....93-95
Copayment.....27, 143
Cosmetic.....62-64, 138
Cost-sharing.....27, 35, 86-88
Coverage information.....61-62
Covered charges.....28-29, 128-130
Covered facilities.....18-19
Covered providers.....17-18
Covered services.....17-18, 20
Crutches.....54-56
Deductible.....27-29, 34-35, 143
Definitions.....137-145
Dental care.....114, 137, 149, 151
Diabetic supplies.....95, 107-108
Disputed claims review.....25
Doula.....17-18, 43-45, 139
Dressings.....75-79
Durable medical equipment...21-23, 54-56, 109-110, 139
Educational classes and programs.....59
Effective date of enrollment.....12, 20, 139
Emergency.....21-24, 82, 89, 148, 150
Expense.....143
Experimental or investigational.....139-140
Eyeglasses.....52
Family planning.....45, 113
Family planning.....45, 113
Flexible benefits option.....112
Foot care.....53, 61-62
Fraud.....4-5
Gamete intrafallopian transfer.....46-48
GEHA 24-Hour Health Advice Line.....113
Gender...5-6, 17-18, 21-23, 62-64, 107-108
Gender affirming care services.....62-64
General exclusions.....115
Group health coverage.....140
Healthcare professional.....17-18, 118, 140
Hearing services.....51-52
Home health services.....56-57
Home nursing care.....116-117
Home uterine devices.....43-45
Hospice care.....18-19, 79-80
Immunizations.....39-42, 99-101
Infertility.....21-23, 46-48, 113, 140
Inpatient hospital benefits...75-76, 88-89, 140
Insulin.....95-98, 103-104, 107-108
Intensive day treatment.....86-87, 89, 142
Lab and pathological services.....37-39
Magnetic Resonance Imagings (MRIs) 21-23, 37-39, 76-79
Mail order prescription drugs...34, 107-108, 148, 150-151
Mammogram.....37-41, 76-79
Manipulative Therapy.....58
Maternity.....24, 43-45, 113
Maternity benefits.....24, 43-45, 75-76
Medicaid.....126
Medically necessary.....35, 60, 80-81, 141
Medicare...1, 12-13, 124, 128-133, 141-142, 149-151
Members...1, 4-5, 7-12, 14-15, 17-18, 27-31, 35-73, 83, 87-88, 91-98, 103-104, 112-115, 117, 128, 140
Mental Health Substance use disorder...17-26, 82, 85-90, 112, 128-130, 142, 148, 150
Never Events.....7-8
Newborn care.....10-11, 24, 43-45, 75-79
No Surprises Act (NSA).....31
No-fault.....125-127
Non-PSHB benefits.....114
Nurse.....7-8, 17-18, 35-59, 75-76, 83, 113
- Licensed Practical Nurse...56-57, 116-117
- Nurse Anesthetist.....17-18, 75-76
- Registered Nurse...17-18, 56-57, 59, 113

Observation care.....74-82
Occupational therapy.....56-57, 115
Ocular injury.....52
Office visits.....27, 35-59, 87-88
Oral and maxillofacial surgery.....64-65
Orthopedic devices.....21-23, 53-54, 62-64
Ostomy and catheter supplies.....91-102
Out-of-pocket expenses.....14-15, 27-31
Overseas claim.....25-26, 117
Oxygen.....48-50, 54-56, 75-79
Pap test.....35-59, 76-79
PDP EGWP...12-13, 30, 103-104, 107-108, 131, 149-151
Physical and occupational therapies...17-18
Physical examinations...35-59, 83, 89-90, 112
Physician...14-15, 17-31, 34-73, 76-79, 82, 85, 91-93, 95, 103-110, 113, 119-121, 128-130, 135-136, 140
Plan allowance...14-15, 27-31, 35-73, 75-90, 95-98, 107-110
Point of service (POS).....14-15, 27-31
Post-service claims.....116-117
Pre-service claims.....116
Preauthorization.....21-23, 144
Precertification...17-26, 65-72, 75-76, 79, 85, 88-89, 143-144
Preferred Provider Organization (PPO)...14--15, 34-35
Prescription drugs...21-23, 59, 65-72, 91-110, 115
Preventive care.....39-42, 51-52, 99-101
Preventive care, children.....41-42
Primary care provider...14-15, 17-18, 27, 34-59, 82-90
Prior approval.....25, 103-104, 144
Private room.....75-76, 88-89
Prosthetic devices.....17-26, 53-54, 61-62
Psychologist.....17-18, 51, 86-87, 144
Radiation therapy.....21-23, 48-50, 76-79
Radiology/ imaging.....37-39, 76-79
Room and board...18-19, 75-76, 88-89, 135-136
Second surgical opinion.....36
Skilled nursing facility.....17-26, 79
Sleep studies.....17-26, 37-39
Social worker.....17-18, 56-57, 86-87, 144
Specialty drugs...48-50, 76-79, 98-99, 103-104, 107-108
Speech therapy.....50-51
Splints.....75-79
Sterilization procedures...45-48, 61-62, 140
Subrogation.....126-127, 144
Substance use disorder...17-19, 21-23, 82, 85-90, 112, 128-130, 142
Surgery...7-8, 18-19, 21-23, 60-73, 75-79, 139, 144
- Anesthesia.....7-8, 73, 76-79
- Assistant Surgeon.....7-8, 60
- Oral.....64-65
- Outpatient.....34, 74-84, 89, 128-130
- Reconstructive.....21-23, 62-64

Syringes.....95-98, 107-108
Take-home items.....75-76
Temporary Continuation of Coverage (TCC) 4-5, 9-13
Tobacco cessation...39-42, 59, 99-101, 107-108
Transplants...17-26, 48-50, 65-72, 76-79, 93-95, 115
Urgent care claims.....23-24, 116-118, 120
Vision services.....52, 111, 114, 127, 141
Wheelchairs.....54-56
X-rays.....37-39, 75-79, 111

Summary of benefits for the Elevate Plus Option of the Government Employees Health Association, Inc. - 2025

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHBbrochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.geha.com/SBC.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Elevate Plus does not offer out-of-network benefits except in cases of emergency.

Below, an asterisk (*) means the item is subject to the $200 Self Only or $400 Self Plus One or Self and Family calendar year deductible.

Elevate Plus Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	In-network: Nothing for preventive care; $30 copay primary care provider; $50 copay specialist	36
Services provided by a hospital: Inpatient	In-network: 15%* of the Plan allowance	75
Services provided by a hospital: Outpatient	In-network: 15%* of the Plan allowance	76
Emergency benefits: Medical emergency	In-network: 15%* of the Plan allowance Out-of-network: Emergency care is paid at the in-network level	82
Mental health and substance misuse disorder treatment:	Regular cost-sharing	86
Prescription drugs:	In-network benefits only	
• Retail pharmacy	Network pharmacy 30-day supply: • Generic: Member pays lesser of $10 or pharmacy's usual and customary cost • Preferred Brand: Member pays lesser of $80 or pharmacy's usual and customary cost • Non-preferred Brand: 50% of Plan allowance	96
• Mail order	Mail order network 90-day supply: • Generic: Member pays lesser of $20 or the cost of the drug • Preferred Brand: Member pays lesser of $200 or the cost of the drug • Non-preferred Brand: 50% of Plan allowance	96

Elevate Plus Option Benefits	You pay	Page
• Specialty drugs	Generic and Preferred**:** 40% of Plan allowance up to a maximum of: • $500 for up to a 30-day supply • $1,000 for up to a 60-day supply* • $1,500 for up to a 90-day supply* Non-preferred**:** 50% of Plan allowance for up to a 30-day supply*	99
• Medicare PDP EGWP Elevate Plus	Retail pharmacy, up to a 30-day supply: • Generic (Preferred Pharmacy): $9 copay • Generic (Non-Preferred Pharmacy): $10 copay • Preferred brand: $47 copay • Non-Preferred brand: 50% of Plan's allowance Mail order pharmacy, up to 90-day supply: • Generic (Preferred Pharmacy) $20 copay • Generic (Non-Preferred Pharmacy) $30 copay • Preferred brand (Preferred Pharmacy): $141 copay • Preferred brand (Non-Preferred Pharmacy): $141 copay • Non-Preferred brand (Preferred Pharmacy) brand: 50% of Plan's allowance. • Non-preferred (Non-Preferred Pharmacy) brand: 50% of Plan's allowance. Specialty drug's up to 30-day supply • 33% of Plan's allowance; limited to $500.	107
Dental care:	Accidental Dental coverage only. Services are paid at regular medical Plan benefits.	111
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $7,000 Self Only ($14,000 Self Plus One or Self and Family) per year for in-network providers.	30

Summary of benefits for the Elevate Option of the Government Employees Health Association, Inc. - 2025

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.geha.com/SBC. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means item is subject to the $500 Self Only or $1,000 Self Plus One or Self and Family calendar year deductible when you use in-network providers; or subject to the $1,000 Self Only or $2,000 Self Plus One or Self and Family calendar year deductible when you use out-of-network providers. And, for most out-of-network services, you pay 50% of the Plan allowance plus any difference between the Plan allowance and the billed amount.

Elevate Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	In-network: Nothing for preventive care; $10 copay primary care provider; $30 copay specialist	36
Services provided by a hospital: Inpatient	In-network: 25%* of the Plan allowance	75
Services provided by a hospital: Outpatient	In-network: 25%* of the Plan allowance	76
Emergency benefits: Medical Emergency	In-network: 25%* of the Plan allowance	82
Mental health and substance use disorder treatment:	Regular cost-sharing	86
Prescription drugs:	In-network benefits only	
• Retail pharmacy	Network pharmacy 30-day supply: • Generic: Member pays lesser of $4 or pharmacy's usual and customary cost • Preferred Brand: Member pays 50% of Plan allowance up to a maximum of $500 • Non-preferred Brand: 100% of all charges	96
• Mail order	Not available	
• Specialty Drugs	Generic and Preferred**:** 40% of Plan allowance up to a maximum of: • $500 for up to a 30-day supply • $1,000 for up to a 60-day supply* • $1,500 for up to a 90-day supply* Non-preferred**:** 50% of Plan allowance for up to a 30-day supply*	99
• Medicare PDP EGWP Elevate	Retail pharmacy, up to 30-day supply: • Generic (Preferred Pharmacy): $3 copay • Generic (Non-Preferred Pharmacy): $4 copay • Preferred Brand: 25% of Plan's allowance, limited to $500.	107

	• Non-Preferred Brand: 25% of Plan's allowance, limited to $500. Mail order pharmacy, up to 90-day supply: • Generic (Preferred Pharmacy): $9 copay • Generic (Non-Preferred Pharmacy) $12 copay • Preferred brand (Preferred Pharmacy): 25% of Plan's allowance, limited to $1,500 maximum. • Preferred brand (Non-Preferred Pharmacy): 25% of Plan's allowance, limited to $1,500 maximum. • Non-Preferred brand (Preferred Pharmacy): 25% of Plan's allowance, limited to $1,500 maximum. • Non-Preferred brand (Non-Preferred Pharmacy): 25% of Plan's allowance, limited to $1,500 maximum. Specialty drugs, up to 30-day supply: • 33% of Plan's allowance; limited to $500.	
Dental care:	Accidental Dental coverage only. Services are paid at regular medical Plan benefits.	111
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $8,500 Self Only ($17,000 Self Plus One or Self and Family) per year for in-network providers. Nothing after $17,000 Self Only ($34,000 Self Plus One or Self and Family) per year for out-of-network providers.	30

Notes

Notes

2025 Rate Information for Elevate Plus and Elevate

To compare your PSHB health plan options, please go to https://health-benefits.opm.gov/PSHB/.

To review premium rates for all PSHB health plan options please go to https://www.opm.gov/healthcare-insurance/pshb/premiums/.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Elevate Plus Option Self Only	58A	$286.09	$162.69	$619.86	$352.50
Elevate Plus Option Self Plus One	58C	$618.40	$364.67	$1,339.87	$790.12
Elevate Plus Option Self and Family	58B	$672.95	$406.16	$1,458.06	$880.01
Elevate Option Self Only	58D	$204.41	$68.14	$442.90	$147.63
Elevate Option Self Plus One	58F	$493.16	$164.38	$1,068.50	$356.17
Elevate Option Self and Family	58E	$600.37	$200.12	$1,300.80	$433.60