G.E.H.A Benefit Plan

Government Employees Health Association

geha.com/Get-Support

Customer Care: 800-821-6136

2026

A Fee-for-Service High Deductible Health Plan Option with a Preferred Provider Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 12.

IMPORTANT
- Rates: Back Cover
- Changes for 2026: Page 15
- Summary of Benefits: Page 137

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

Who may enroll in this Plan: All Federal Employees and Annuitants who are eligible to enroll in the Federal Employees Health Benefits (FEHB) Program may become members of Government Employees Health Association, Inc. (G.E.H.A). You must be or must become a member of G.E.H.A (herein referred to as "Us", "We", or "Our")

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

Membership dues: There are no membership dues for the Year 2026.

Postal Employees and Annuitants are no longer eligible for this plan (unless currently under Temporary Continuation of Coverage).

Enrollment codes for this Plan:

High Deductible Health Plan (HDHP)

341 - Self Only

343 - Self Plus One

342 - Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice

Important Notice from Government Employees 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 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 you do not need to enroll in Medicare Part D 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 FEHB coverage.

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 FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB 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 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.socialsecurity.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 FEHB 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 FEHB plan. 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 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 Medicare at 800-633-4227, TTY 877-486-2048.

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Introduction

This brochure describes the benefits of the G.E.H.A Benefit Plan under contract (CS 1063) between Government Employees Health Association, Inc. (G.E.H.A) and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law here in referred to as the "Plan." This Plan is underwritten by Government Employees Health Association, Inc. Customer Care may be reached at 800-821-6136, TTY 800-821-4833, or through our website: geha/Get-Support. The address for the Government Employees Health Association, Inc. 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. You do not have a right to benefits that were available before January 1, 2026, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2026, and changes are summarized in Section 2, *Changes for 2026*. Rates are shown at the end of this brochure.

Plain Language

All FEHB 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. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB 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 Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB 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 claim 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 over age 26 (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 FEHB enrollment.

- If you have any questions about the eligibility of a family member, 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 FEHB 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, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

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 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 for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid 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/en-us/knowledge-library/for-patients/speak-ups. The Joint Commission's Speak Up™ patient safety program.
- www. jointcommission.org/en-us/knowledge-library/for-patients. 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 FEHB plan will incur cost 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. Never Events are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a healthcare facility. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB 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 FEHB Program**

  See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

  - Information on the FEHB Program and plans available to you;
  - A health plan comparison tool;
  - A list of agencies that participate in Employee Express;
  - A link to Employee Express; and
  - Information on and links to other electronic enrollment systems.

  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 FEHB 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 and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, disability leave, pensions, etc. you must also contact your employing or retirement office.

  Once enrolled in your FEHB 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 member. Family members include your spouse and your 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. 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 FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact your employing or retirement offices to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26. 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 FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another 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 FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, 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 marriage) and children as described 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 FEHB 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 FEHB 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 FEHB 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 FEHB coverage, you must continue your FEHB 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.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2026 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. **However,** if your prior plan left the FEHB Program at the end of 2025, you are covered under that plan's 2025 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

When you lose benefits

- **When FEHB coverage ends**

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

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

Any person covered under the 31-day extension of coverage who is confined in a facility 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.

You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **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 contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. 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 FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (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, 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 FEHB enrollment.

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

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

- **Converting to individual coverage**

If you leave Federal or Tribal 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 FEHB 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 geha.com/Get-Support.

- **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 FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. G.E.H.A 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 accreditations, please visit the following websites: Accreditation Association for Ambulatory Health Care (www. aaahc.org); URAC (www. urac.org). You can choose your own physicians, facilities, and other healthcare providers. We give you a choice of enrollment in a High Option, a Standard Option, or a High Deductible (HDHP) Health Plan.

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 primary care provider for adult and pediatric care, and visits for specialists do not require a referral.

General features of our High Deductible Health Plan (HDHP)

This plan provides traditional healthcare coverage with comprehensive medical benefits. HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans, but they also offer a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) option that gives you more flexibility and control over how to use and pay for your healthcare benefits. Please see below for more information about these savings features.

We have a Preferred Provider Organization (PPO) Network

Our fee-for-service plan offers benefits through a PPO. This means that certain facilities and other healthcare providers are "preferred providers". When you use our PPO providers, you will receive covered services at reduced cost. UnitedHealthcare Choice Plus network, which encompasses the UnitedHealthcare Select Plus network in California, is solely responsible for the selection of PPO providers in your area. 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). 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.

The Optum Transplant Network is the organ/tissue transplant network for all members.

To find in-network providers, use the provider search tool on the geha.com/Locate-Care website or call G.E.H.A at 800-821-6136. When you call your provider for an appointment, please remember to verify that the physician is still an in-network provider. G.E.H.A 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.

You always have the right to choose an in-network provider or an out-of-network provider for medical treatment. When you see a provider not in the UHC Choice Plus network, G.E.H.A will pay at the out-of-network level, and you will pay a higher percentage of the cost.

The out-of-network benefits are the standard benefits of this Plan. 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 in-network provider is available, or you do not use an in-network provider, the standard out-of-network benefits apply. However, if the services are rendered at an in-network facility, the professionals who provide services to you may not all be preferred providers. If the services are rendered by out-of-network providers at an in-network facility, we will pay up to the Plan allowance according to the No Surprises Act.

Note: Members residing outside the United States and accessing providers within their area of residence without access to an in-network providers 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, facilities and other healthcare providers.

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

We offer benefits through the UnitedHealthcare Choice Plus network of individual physicians, medical groups, and facilities. 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 Coding 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.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to coinsurance, deductibles or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, excluding specific injury insurance and accident, disability, dental care, vision care, or long-term care coverage), not enrolled in Medicare, have not received VA (except for veterans with a service-connected disability) or Indian Health Service (IHS) benefits within the last three months, are not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

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 coinsurance, to no more than $8,500 for Self Only enrollment, or $17,000 for a Self Plus One or Self and Family enrollment when you use in-network providers. The out-of-pocket limit for this Plan may differ from the IRS limit but cannot exceed that amount.

Health education resources and account management tools

Our website, at geha.com/Health-Wellness-Library, offers access to our Healthy Living resources for a wide range of information on general topics, pregnancy and childbirth, diabetes management and gym discounts.

You will find facts and frequently asked questions about health savings accounts and health reimbursement arrangements on our website at geha.com/HDHP-HSA. You can access your HRA account balance in addition to complete claim payment history through our website at geha.com/My-Member-Portal. To access your HSA account balance, go to geha.com/HDHP-HSA.

Your rights and responsibilities

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

- G.E.H.A was founded in 1937 as the Railway Mail Hospital Association. For over 88 years, G.E.H.A has provided health insurance benefits to Federal employees and retirees.
- G.E.H.A is incorporated as a General Not-For-Profit Corporation pursuant to Chapter 355 of the Revised Statutes of the State of Missouri.

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.com/Member-Rights. 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 G.E.H.A Enrollment, PO Box 21262, Eagan, MN 55121. You may also visit our website at geha.com/Submit-Feedback.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at geha.com/Your-Data-Protection 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. Changes for 2026

This section is not an official statement of benefits—see Section 5. *Benefits*, for full benefit details. We also clarified language throughout the brochure; unlisted changes are clarifications only and do not affect benefits.

- Your share of the premium rate will increase for Self Only, Self Plus One and Self and Family. See 2026 Rate Information on the back of this brochure.

Deductible:

- **In-Network:** The Plan in-network deductible will increase to $1,800 Self and $3,600 Self Plus One or Self and Family from $1,650 Self and $3,300 Self Plus One or Self and Family.
- **Out-of-Network:** The Plan out-of-network deductible will increase to $4,500 Self and $9,000 Self Plus One or Self and Family from $3,300 Self and $6,600 Self Plus One or Self and Family.

Sex-Trait Modification: Medical, surgical and prescription drug services related to Sex-Trait Modification for diagnosed gender dysphoria, are no longer covered by the Plan. See Section 3, 5(b), and 5(f). The Plan will continue to provide benefits related to mental and behavioral health services, see Section 5(e).

Breast Screening: The age to obtain appropriate age and medical history breast screening will be lowered to 40-74 from age 50-74.

Health Savings Account (HSA): The IRS adjusted 2026 annual contribution limits from $4,300 to $4,400 for Self Only and from $8,550 to $8,750 for Self Plus One or Self and Family Enrollment. (See Section 5, *Savings*)

Urine Drug Screening (UDS): The test limit for Urinary Drug Screening has been removed. Previously, it was 16 tests per calendar year.

Updates to Covered Services:

- Language describing how services are covered has been edited throughout the Brochure. Covered Services such as Home Health, Genetic Testing related to Maternity services, and Iatrogenic Infertility have been updated (See Section 5) as well as clarifications for Computer Applications and Software, and Chemical and Surgical Sex-Trait Modification in the Exclusions provisions located in Sections 5 and 6.
- When you obtain services with Specialty medications the applicable cost share will apply based on where you obtained those services either Outpatient or through a Specialty Pharmacy.

General Plan Revisions: See Section 10, *Definitions of Terms,* for clarifications to several terms, including Plan, Experimental and Investigational, Medical Necessity, Surprise Billing, Advanced Care Planning, and Calendar Year Deductible.

The Plan allowance for covered services received from out-of-network providers, including Physicians or health care facilities, are determined by the ClearHealth CRS program and is based on a methodology as explained in Section 10 under Definitions for *Plan Allowance*.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-821-6136 or write to us at:

G.E.H.A Enrollment
PO Box 21262
Eagan, MN 55121

You may also request replacement cards through our website: geha.com/My-Member-Portal.

Where you get covered care

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

Balance Billing Protection

FEHB 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 medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill or are paid for their healthcare services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

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.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

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

- **Covered facilities**

Covered facilities include:

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

- 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: (1) is used principally as a convalescent facility, nursing facility, or long-term care facility; (2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or (3) 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 Centers (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: You may continue seeing your specialist and receiving any PPO benefits for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:

- we drop out of the Program and you enroll in another Plan (or become covered as a family member under another Plan), or
- we terminate our contract with your PPO specialist for reasons other than for cause.

Contact us at 800-821-6136 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 will continue until the end of your postpartum care, even if it is beyond the 90 days.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

Sex-Trait Modification: If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. Ongoing sex-trait modification hormone treatment is not a covered benefit under this plan as of 1/1/2026. Our exception process is as follows: To initiate the exception process, contact Customer Care at 800-821-6136, Monday-Friday between 8 a.m. - 8 p.m. E.T. If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process.

Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.

- **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 Care department immediately at 800-821-6136. If you are new to the FEHB 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 us, 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 FEHB 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

The pre-service claim approval processes for inpatient facility admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

- **Inpatient facility admission**

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

In most cases, your physician or facility will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or facility whether or not they have contacted us.

We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semi- private accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate.

- **Warning**

You must get precertification for certain services prior to admission. Failure to do so will result in the following penalties:

- **In-network:**
  - We will reduce our benefits for the Inpatient Hospital, Long-Term Acute Care, Residential Treatment Center (RTC), Skilled Nursing Facility (SNF), or Rehabilitation Facility stay by $500 if precertification is not obtained prior to 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:**
  - We will reduce our benefits for the Inpatient Hospital, Long-Term Acute Care, Residential Treatment Center (RTC), Skilled Nursing Facility (SNF), or Rehabilitation Facility stay by $500 per day for each day that is not precertified prior to 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 have another group health insurance policy that is the primary payor for the facility stay; or
- Medicare Part A is the primary payor for the facility stay.

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

Other Services

Some surgeries and procedures, drugs, tests, services and equipment require precertification or preauthorization. Specific services requiring preauthorization or precertification are indicated in Section 5, when applicable. Please note this list is subject to change, please call to verify if your procedure requires preauthorization. Refer to the back of your member ID card under the heading Prior Authorization for the contact information.

Services requiring preauthorization or medical necessity determination may be reviewed with guidelines as described at geha.com/Coverage-Criteria. G.E.H.A has coverage policies for many services and procedures; refer to geha.com/Provider-Policies for a complete list of policies.

Transplants services require more extensive reviews. The transplant must be performed in a 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.

- 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.
- 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.
- Chemotherapy and procedures related to bone marrow transplantation must be performed only at a Plan-designated transplant facility to receive maximum benefits.

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.

How to pre-certify an admission for Other services

First, you, your representative, your physician, or your facility must call to obtain preauthorization before an inpatient facility admission, Residential Treatment Center (RTC) admission, or for services requiring precertification are rendered. Refer to the back of your member ID card under the heading Prior Authorization for the contact information.

For admissions to Skilled Nursing Facilities, Long-Term Acute Care, or Rehabilitation facilities, please refer to the back of your member ID card under the heading Prior Authorization for the contact information.

Next, provide the following information:

- enrollee's name and plan identification number;
- patient's name, birth date, and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting doctor;
- name of hospital or facility; and
- number of days requested for hospital stay.

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

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or facility 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 or not 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 the 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 FEHB at 202-606-3818 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 facility must notify us within two business days following the day of the emergency admission, even if you have been discharged from the facility.

- **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 facility must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the facility must contact us for precertification of additional days for your baby.

  Note: When a newborn requires definitive treatment during or after the mother's 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 facility stay needs to be extended**

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

- **Other services that require preauthorization**

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

  Services requiring preauthorization or medical necessity determination may be reviewed with guidelines as described at geha.com/Coverage-Criteria. G.E.H.A has coverage policies for many services and procedures; refer to geha.com/Provider-Policies for a complete list of policies.

  - Advanced wound therapy including negative pressure therapy/wound vac;
  - Applied behavioral analysis (ABA) therapy;
  - Arthroplasty, including revisions to a prior arthroplasty;

- Certain back and spinal procedures, surgeries, and pain management treatments;
- Bariatric and metabolic surgical procedures (obesity surgery);
- Bone growth stimulators;
- Certain breast and chest surgeries;
- Certain cardiac and vascular procedures;
- Cartilage Implants;
- Cellular and gene therapy;
- Certain prescription drugs, including but not limited to:
  - Artificial insemination (AI) drugs and IVF-related drugs
  - Botox Injections
  - Chemotherapy Drugs
  - Growth hormone therapy (GHT)
  - Injectable drugs for arthritis, psoriasis or hepatitis
  - Injectable hematopoietic drugs (drugs for anemia, low white blood count);
- Cochlear and auditory implants and implant procedures;
- Durable medical equipment (DME) over $1,000;
- Experimental/investigational surgery or treatment, including clinical trials;
- Facility admissions (including hospitals, long term acute care, rehabilitation facilities, residential treatment centers, and skilled nursing facilities; see above*)
- Fertility procedures and drugs;
- Genetic testing;
- High tech outpatient radiology/imaging including:
  - Computed tomography (CT) scans
  - Low dose computed tomography (LDCT)
  - Magnetic resonance imaging (MRI)
  - Magnetic resonance angiogram (MRA)
  - Nuclear medicine studies including nuclear cardiology
  - PET scans;
- Hysterectomy except for diagnosis with cancer;
- Intensive day treatment programs for behavioral health, including partial hospitalization and intensive outpatient therapy programs;
- Neurostimulation, including devices and implantation procedures for cranial, gastric, peripheral, spinal, or vagus nerve stimulation;
- Non-emergency air ambulance transportation;
- Non-surgical cancer treatment, including chemotherapy and radiation;
- Orthognathic surgery (jaw), including TMJ;
- Orthopedic and prosthetic devices over $1,000;
- Prostate implants, destruction, and removal;
- Psychological testing and neuropsychological testing exceeding 8 hours/calendar year;
- Reconstructive or potentially cosmetic procedures;
- Residential treatment facility admissions;
- Skilled nursing facility admissions;
- Sleep studies (in-lab) attended or performed in a healthcare facility (home sleep studies do not require preauthorization);

- Speech generating devices;
- Surgical treatment of airway obstructions including sleep apnea;
- Transplants

- **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 844-443-4279.

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 preauthorization 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.

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:

G.E.H.A Medical Claims
PO Box 21172
Eagan, MN 55121

Obtain Overseas Claim form from geha.com/Health-Overseas-Access.

Eligibility and/or medical geha.com/Health-Overseas-Access 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.

If you have questions about the processing of overseas claims, contact us at 800-821-6136. Covered providers outside the United States will be paid at the in-network level of benefits, subject to deductible and 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.

When members living abroad are stateside and seeking medical care, contact us at 800-821-6136, or visit geha.com/Health-Overseas-Access to locate an in-network provider. If you utilize an out-of-network provider, out-of-network benefits would apply.

Section 4. Your Costs for Covered Services

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

Cost-sharing

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

Copayments

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

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. 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.

- **In-network:**The calendar year deductible is $1,800 per person under the High Deductible Health Plan. 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 $1,800. Under Self Plus One or a Self and Family enrollment, once the calendar year deductible is considered satisfied, and benefits are payable for you and other eligible family member(s) when the combined covered expenses accumulated to the calendar year deductible for any combination of family member(s) reaches the Self Plus One or the Self and Family limit of $3,600. Only plan allowance paid for services or supplies from in-network providers counts toward this amount.
- **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 $4,500. Under Self Plus One or a Self and Family enrollment, once the calendar year deductible is considered satisfied, and benefits are payable for you and other eligible family member(s) when the combined covered expenses accumulate to the calendar year deductible for any combination of family member(s) reach the Self Plus One or Self and Family limit of $9,000. Only plan allowance paid for services or supplies from out-of-network providers counts towards this amount.

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 in-network provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your 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 of $1,800 for Self Only has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change enrollment options from one qualified High Deductible Health Plan to another qualified High Deductible Health Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

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

Example: Under the HDHP, you pay 5% of our allowance for in-network office visits.

If your provider routinely waives your cost

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

For example, if your physician ordinarily charges $100 for a service but routinely waives your 35% coinsurance, the actual charge is $65. We will pay $42.25 (65% of the actual charge of $65).

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 G.E.H.A 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.

- **In-network providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance. Here is an example about coinsurance: You see an in-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 HDHP, you pay 5% of our $100 allowance ($5). Because of the agreement, your in-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 an out-of-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 HDHP you pay 35% of our $100 allowance ($35). Plus, because there is no agreement between the out-of-network physician and us, the physician can bill you for the $50 difference between our allowance and the bill.

The following illustrates the examples of how much you have to pay out-of-pocket, under HDHP, for services from an in-network physician vs. an out-of-network physician. The table uses our 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.

EXAMPLES:

In-network physician

Physician's charge: $150
Our allowance: We set it at: $100
We pay: 95% of our allowance: $95
You owe: 5% of our allowance: $5
+Difference up to charge: No: $0
TOTAL YOU PAY: $5

Out-of-network physician

Physician's charge: $150
Our allowance: We set it at: $100
We pay: 65% of our allowance: $65
You owe: 35% of our allowance: $35
+Difference up to charge: Yes: $50
TOTAL YOU PAY: $85

Your catastrophic protection out-of-pocket maximum

After your (deductible, copayments and coinsurance) reaches the out-of-pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum.

- **In-network**
  - The HDHP out-of-pocket maximum is $6,000 for Self Only enrollment; $12,000 when enrollment is Self Plus One or Self and Family when you use in-network providers.
  - Only out-of-pocket expenses from in-network providers count toward these limits.
  - An individual under Self Plus One or 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-network**
  - The HDHP 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 out-of-network providers.
    Only eligible out-of-pocket expenses from out-of-network providers count towards those limits. Out-of-network coinsurance will only accumulate to the in-network maximum if meeting criteria to be reimbursed at the in-network rate (reference the No Surprise Act).
  - An individual under Self Plus One or 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 Plan requirements (see Section 3);
- Expenses in excess of plan limits for dental;
- The cost for non-approved medications and drugs that we exclude; and
- The difference between the cost of generic and brand name medication.

Carryover

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

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 covered 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 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 non-participating providers with respect to patient visits to participating healthcare facilities, or for
- air ambulance services furnished by non-participating providers of air ambulance services.

Balance billing happens when you receive a bill from the non-participating provider, facility, or air ambulance service for the difference between the non-participating 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 geha.com/Plan-Transparency or contact the health plan at 800-821-6136.

Healthcare FSA (HCFSA)

- **Healthcare FSA (HCFSA)** – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for the participant and their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).
- **Federal Flexible Spending Account Program (FSAFEDS)** - offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High Deductible Health Plan Benefits

See Section 2 for how our benefits changed this year and page 137 for a benefits summary.

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Section 5. High Deductible Health Plan Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the *General Exclusions* in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 800-821-6136 or on our website at geha.com/Get-Support.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment. To ensure that G.E.H.A pays for the set-up and administrative fees, it is important that you follow the instructions you receive in the mail about how to set up your HSA.

With this Plan, preventive care is covered in full if rendered by preferred providers. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described in Section 5, *Traditional Medical Coverage Subject to the Deductible*. You can choose to use funds available in your HSA to make payments toward the deductible, or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: savings; preventive care; traditional medical coverage healthcare that is subject to the deductible; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

Preventive care

The Plan covers preventive care services from preferred providers, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., cancer screenings, cardiac screenings, and mammograms), well-child care, child and adult immunizations, and tobacco cessation programs. These services are covered at 100% if you use an in-network provider and the services are described in Section 5, *Preventive care*. Preventive care for children is covered at 100%. Y*ou do not have to meet the deductible before using these services.*

This Plan also provides vision care and dental coverage. *You do not have to meet the deductible before using these services.*

The calendar year deductible ***does not*** apply to the following services:

- Supplemental vision care, go to geha.com/HDHP-Vision to learn more;
- Dental benefits (100% of Plan allowance for diagnostic and preventive services twice per person per calendar year).

Traditional medical coverage

After you have paid the Plan's deductible, we pay benefits under **Traditional Medical Coverage** described in Section 5. The Plan typically pays 95% for in-network and 65% for out-of-network care.

Covered services include:

- Medical services and supplies provided by physicians and other healthcare professionals;
- Surgical and anesthesia services provided by physicians and other healthcare professionals;
- Hospital services; other facility or ambulance services;
- Emergency services/accidents;
- Mental health and substance use disorder treatment; and
- Prescription drug benefits.

Savings

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see Section 5. *Savings - HSAs and HRAs* for more details).

Health Savings Accounts (HSAs)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits within the last three months or do not have other health insurance coverage other than another High Deductible Health Plan. In 2026, for each month you are eligible for an HSA premium pass through, we will contribute $83.33 per month to your HSA for a Self Only enrollment or $166.66 per month for a Self Plus One or Self and Family enrollment. For 2026, a monthly premium pass through that is not a whole number will have any remaining balance included in the final monthly contribution**.** In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $4,400 for an individual and $8,750 for Self Plus One or Self and Family. See maximum contribution information in Section 5, *Savings - HSAs and HRAs*. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments (not G.E.H.A's pass through contributions) are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying qualified medical expenses from tax-free HSA dollars or after-tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by FDIC-insured HSA Bank™.
- Your contributions to the HSA are tax deductible.
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).
- Your HSA earns tax-free interest.
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS Publication 502 for a complete list of eligible expenses).
- Your unused HSA funds and interest accumulate from year-to-year.
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire.
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Healthcare Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA) and start or become covered by a **HCFSA** (such as FSAFEDS offers – see Section 3), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you are not eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA. Contact us at 800-821-6136.

In 2026, we will give you an HRA credit of $1,000 per calendar year for a Self Only enrollment and $2,000 per calendar year for a Self Plus One or Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by G.E.H.A.
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year-to-year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans. Members leaving G.E.H.A mid-year will be expected to return a portion of the annual contribution to G.E.H.A only if they have filed claims against the funds (prorated based on the number of months in the Plan) and will forfeit their remaining HRA account balance at that time.
- An HRA does not affect your ability to participate in an FSAFEDS Healthcare Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

Net deductible after pass through

"Net deductible after pass through" means the remaining deductible amount if you use the G.E.H.A premium pass-through contribution to help pay your health plan deductible. By using the premium pass through to pay first dollar costs for qualified medical expenses, your out-of-pocket deductible cost on this plan is substantially reduced.

Annual In-Network Deductible: Self Only $1,800; Self Plus One or Self and Family $3,600

G.E.H.A's HSA/HRA premium pass-through contribution: Self Only $1,000; Self Plus One or Self and Family $2,000

Net deductible after pass-through: Self Only $800; Self Plus One or Self and Family $1,600

Catastrophic protection for out-of-pocket expenses

Your annual maximum for out-of-pocket expenses (deductibles and coinsurance) for covered services is limited to $6,000 per person for Self Only or $12,000 for Self Plus One or Self and Family enrollment (any combination of family members, not to exceed $6,000 per person) when you use in-network providers.

If you use an out-of-network provider the annual maximum for out-of-pocket expenses is $8,500 for Self Only or $17,000 for Self Plus One or Self and Family enrollment (any combination of family members, not to exceed $8,500 per person).

However, certain expenses do not count toward your out-of-pocket maximum, and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4, *Your catastrophic protection out-of-pocket maximum,* and Section 5, *Traditional medical coverage subject to the deductible*, for more details.

Health education resources and account management tools

Section 5(g), *Wellness and Other special features,* describes the health education resources and account management tools available to you to help you manage your healthcare and your healthcare dollars.

Section 5. Savings - HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) provided when you are ineligible for an HSA
Administrator	The Plan will provide you the documents required to establish an HSA for you with HSA Bank™ (PO Box 939, Sheboygan, WI 53082-0939, 866-471-5964, www.hsabank.com). This is the HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS).	G.E.H.A is the HRA fiduciary for this Plan. G.E.H.A Enrollment, PO Box 21262, Eagan, MN 55121-9930, 800-821-6136, geha.com/My-Member-Portal.
Fees	Set-up and monthly administrative fees are paid by the G.E.H.A HDHP.	None
Eligibility	Eligibility for an HSA is determined on the first day of the month coincident to or following your effective date of enrollment. You must: • Enroll in this HDHP; • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision, or long-term care coverage); • Not be enrolled in Medicare; • Not be claimed as a dependent on someone else's tax return; • Not have received VA (except for veterans with a service-connected disability) benefits in the last three months; • Not have received Indian Health Services (IHS) benefits in the last three months; and • Complete and return all banking paperwork. If you do not set up your health savings account with HSA Bank within 90 days, we will enroll you in the HRA.	Eligibility is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment. You must enroll in this HDHP. If you enroll in our HDHP and do not qualify for an HSA, we will establish an HRA for you. If your eligibility changes mid-year, please contact G.E.H.A at 800-821-6136.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass-through contributions are based on the effective date of your enrollment in the HDHP.	The entire amount of your HRA will be available to you upon your enrollment. Eligibility for the annual credit will be determined on the last day of the month following your effective date of enrollment and will be prorated for length of enrollment.

	Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month. If you are new to this Plan based on an Open Season change, your first premium pass through will be made available no earlier than February as new enrollees and terminations from Open Season are still being received in January. Your last HSA pass-through contribution for the current plan year will fund in January of the following plan year as long as you maintain eligibility through the end of the current plan year. For 2026, a monthly premium pass through that is not a whole number will have any remaining balance included in the final monthly contribution. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	Members leaving G.E.H.A mid-year will be expected to return a portion of the annual contribution only if they have filed claims against the funds (prorated based on the number of months in the Plan) and will forfeit their remaining HRA account balance at that time.
• **Self Only enrollment**	For 2026, a monthly premium pass through of $83.33 will be made by the HDHP directly into your HSA.	For 2026, your HRA annual credit is $1,000 (prorated for mid-year enrollment). Members leaving G.E.H.A mid-year will be expected to return a portion of the annual contribution only if they have filed claims against the funds (prorated based on the number of months in the Plan) and will forfeit their remaining HRA account balance at that time.
• **Self Plus One enrollment**	For 2026, a monthly premium pass through of $166.66 will be made by the HDHP directly into your HSA.	For 2026, your HRA annual credit is $2,000 (prorated for mid-year enrollment). Members leaving G.E.H.A mid-year will be expected to return a portion of the annual contribution only if they have filed claims against the funds (prorated based on the number of months in the Plan) and will forfeit their remaining HRA account balance at that time.
• **Self and Family enrollment**	For 2026, a monthly premium pass through of $166.66 will be made by the HDHP directly into your HSA.	For 2026, your HRA annual credit is $2,000 (prorated for mid-year enrollment). Members leaving G.E.H.A mid-year will be expected to return a portion of the annual contribution only if they have filed claims against the funds (prorated based on the number of months in the Plan) and will forfeit their remaining HRA account balance at that time.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) provided when you are ineligible for an HSA
Contributions/ credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and your contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $4,400 for an individual and $8,750 for Self Plus One or Self and Family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. Contact: HSA Bank™ (P. O. Box 939, Sheboygan, WI 53082-0939, 866-471-5964, geha.com/HDHP-HSA) for more details. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Additional contributions are discussed under *If you have an HSA* after this section.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. Members leaving G.E.H.A mid-year will be expected to return a portion of the annual contribution only if they have filed claims against the funds (prorated based on the number of months in the Plan) and will forfeit their remaining HRA account balance at that time.
• **Self Only enrollment**	You may make an annual maximum contribution of $4,400.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an annual maximum contribution of $8,750.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $8,750.	You cannot contribute to the HRA.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) provided when you are ineligible for an HSA
Access funds	You can access your HSA by the following methods: • Debit card • Withdrawal form • Checks • Online banking	For qualified medical expenses covered by your health plan, your provider is automatically reimbursed when claims are submitted through our HDHP. For expenses not covered by the HDHP, such as orthodontia, our Health Reimbursement Arrangement Claim Form is located online at geha.com/My-Member-Portal or by request to Customer Care at 800-821-6136. This form is used to get reimbursement from your HRA for qualified out-of-pocket medical expenses that are not submitted to Us by your doctor, hospital, dentist or pharmacy. It can also be used to request reimbursement for paid Medicare premiums.
Distributions/ withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your family members (even if they are not covered by the HDHP) from the funds available in your HSA. These distributions are tax-free if used for qualified medical expenses. Note: Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HSA until the first of the month following the effective date of your enrollment in this HDHP and the date your HSA account is established. See IRS Publications 502 and 969 for information on eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publications 502 and 969 for information on eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable - distributions will not be made for anything other than non-reimbursed qualified medical expenses. Medicare premiums are reimbursable.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed:	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.

	• Your enrollment in this HDHP is effective (effective date is determined by your agency in accordance with the event permitting the enrollment change); • You must complete and send the HSA application to HSA Bank™. You complete the HSA application process either online or via paper forms; • The fiduciary receives your application and sends record of the account to G.E.H.A; and • G.E.H.A contributes funds by the 15th of the month following the month of your effective date.	
Account owner	FEHB enrollee	HDHP health plan
Portable	You can take this account with you when you change plans, separate or retire from federal service. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See Section 1, *Health Savings Account (HSA),* or the beginning of this section for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.
Account management	You may access your HSA on-line at geha.com/HDHP-HSA.	Your HRA account balance will be available on-line through your Member Account at geha.com/My-Member-Portal; and To request reimbursement from your HRA account for qualified out-of-pocket medical expenses that are not submitted to G.E.H.A by your doctor, hospital, dentist or pharmacy, call G.E.H.A's Customer Care at 800-821-6136 or go to geha.com/My-Member-Portal to obtain our Health Reimbursement Arrangement Claim Form. This form is also used to request reimbursement from your HRA for Medicare premiums.

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in either case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15th of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective date is after January 1st, or if you enroll any time and have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost, and a 10% penalty is imposed. There is an exception for death or disability. Contact HSA Bank™ (PO Box 939, Sheboygan, WI 53082-0939, 866-471-5964, www.hsabank.com) for more details.

- **Over age 55 additional contributions**

  If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable additional contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS website at www.irs.gov or request a copy of IRS Publication 969 by calling 800-829-3676.

- **If you die**

  If you have not named a beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses" as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For detailed information of IRS-allowable expenses, request a copy of IRS Publications 502 and 969 by calling 800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Instructions." Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You will receive a periodic statement that shows the "premium pass through" and other contributions, withdrawals, and interest earned on your account.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount. Just like a normal bank account, you cannot reimburse yourself for expenses that are greater than the balance in the account.

If you have an HRA

- **Why an HRA is established**

If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

Please review the chart at the beginning of this section, which details the differences between an HRA and an HSA. The major differences are:

- You cannot make contributions to an HRA;
- Funds in your HRA are forfeited if you leave the HDHP;
- An HRA does not earn interest; and
- HRAs can only be used to pay for qualified medical expenses, such as deductibles and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Preventive Care

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 any applicable medical or payment policies. Policies may be found on our website geha.com/Provider-Policies. In some instances, additional services may be rendered, and additional cost shares may apply.
- Benefits are applied based on how your provider bills Us. You must reference all Sections in this Brochure depending on where your care is obtained. For example, but not limited to, any procedure, injection, diagnostic service, laboratory, or x-ray service done in a hospital in conjunction with a physician office examination may apply separate cost share depending on where you obtain your care.
- 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.
- When you visit an in-network facility, the professionals who provide services to you may not all be in-network providers. If you receive out-of-network services at an in-network facility, we will pay up to the plan allowance according to the No Surprises Act.
- Medications may be available under the Prescription drug benefit and may require prior authorization.
- Benefits for certain prescription medications and supplies (e.g., self-injectable or self-administered) are only eligible for coverage when dispensed by a pharmacy under the pharmacy benefit even if you obtain these medications from your provider.
- **YOU MUST GET PREAUTHORIZATION FOR SOME SERVICES.** Please refer to the preauthorization information shown in Section 3, *How You Get Care*, 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, *Coordinating Benefits with Medicare and Other Coverage,* for information about how we pay if you have other coverage, or if you are age 65 and 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.).
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB plan will be First/Primary payor of any Benefit payments and your FEDVIP plan is secondary to your FEHB plan. See Section 9, *Coordinating Benefits with Medicare and Other Coverage*.
- There is no calendar year deductible for the dental benefits listed below.

Benefit Description	You pay
Note: The calendar year deductible does not apply to in-network benefits in this Section.	
Preventive care, adult	**HDHP**
Routine physical every year. The following preventive services are covered at the time interval recommended at each of the links below. Please consult with your healthcare provider to determine if the services below are appropriate for you. • 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, age and frequency limitations, go to the U.S. Preventive Services Task Force (USPSTF) website at https ://www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. • Adult Immunizations endorsed by the Centers for Disease Control and Prevention (CDC) are 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/vaccines/imz-schedules/index.html. • Individual counseling on prevention and reducing health risks • For a complete list of preventive care benefits for women go to the Health Resources and Service Administration (HRSA) website at https://hrsa.gov/womens-guidelines. - Note: Screenings subject to appropriate requirements, see additional online references below: • To build your personalized list of preventive services go to https://health.gov/myhealthfinder. Notes: • For Preventive Care medications and anti-obesity medications, see Section 5(f) for cost share requirements *or* visit geha.com/Prescriptions-Summary. • See Section 5(a), *Educational classes and programs,* for coverage of tobacco cessation treatment. • Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination that is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing Out-of-network: Covered under *Traditional medical coverage subject to deductible*

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**HDHP**
• Routine mammogram—covered, including 3D mammograms. - This coverage will include breast ultrasound performed after inconclusive breast cancer screening exam.	In-network: Nothing Out-of-network: Covered under *Traditional medical coverage subject to deductible*
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/m^2). • 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, for education and support of a family member with obesity. Notes: • Nutritional counseling, see Section 5(a), *Educational classes and programs*. • When anti-obesity medication is prescribed see Section 5(f). • For Bariatric or Metabolic surgical treatment or intervention see Section 5(b). • Also see Section 5(g), *Weight Management* program details.	In-network: Nothing after deductible Out-of-network: Covered under *Traditional medical coverage subject to deductible*
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.* • *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*
Preventive care, children	**HDHP**
The **following** preventive services are covered at the time interval recommended at each of the links below. Please consult with your healthcare provider to determine if the services below are appropriate for you. • 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. • Immunizations such as 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. • Routine hearing screening performed during a child's preventive care visit.	In-network: Nothing Out-of-network: Nothing, except any difference between our Plan allowance and the billed amount

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**HDHP**
• 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. • To build your personalized list of preventive services, go to https://health.gov/myhealthfinder. Notes: • For no patient copay preventive medications for appropriate age and dosage limits, see Section 5(f), Preventive care medications, or visit geha.com/Prescriptions-Summary. • See Section 5(a), *Educational classes and programs,* for coverage of tobacco cessation treatment. • Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination that is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing Out-of-network: Nothing, except any difference between our Plan 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. Notes: • Nutritional counseling, see Section 5(a), *Educational classes and programs.* • When anti-obesity medication is prescribed see Section 5(f). • For Bariatric or Metabolic surgical treatment or intervention see Section 5(b). • Also see Section 5(g), *Weight Management* program details.	In-network: Nothing Out-of-network: Nothing, except any difference between our Plan 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, or travel related to judicial or administrative proceedings or orders, or required to obtain or maintain a license of any type.* • *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*

Dental services and benefits		
Benefit description		
Dental services	**(Scheduled Allowance) We Pay**	**You Pay**
Diagnostic and preventive services, including examination, prophylaxis (cleaning), x-rays of all types and fluoride treatment	We will pay 100% of the Plan allowance for preventive dental as follows: • Two examinations per person per year • Two prophylaxis (cleanings) per person per year • Two fluoride treatments per person per year • $150 in allowed x-ray charges per person per year	All charges in excess of the scheduled amounts listed to the left
Amalgam Restorations **Resin - Based Composite Restorations** **Gold Foil Restorations** **Inlay/Onlay Restorations**	$21 One surface $28 Two or more surfaces	All charges in excess of the scheduled amounts listed to the left
Simple extractions	$21 Simple extraction	All charges in excess of the scheduled amount listed to the left
Not covered: *Oral implants and transplants are not covered, including for the treatment of accidental injury*	*You pay all charges*	*All charges*

Supplemental vision care

Connection Vision® - Member Services: 877-808-8538

Website: geha.com/HDHP-Vision.

- You will receive a separate vision ID card to use for these services.
- Members will only be responsible for copays and amounts over allowance at the time of service.
- Out-of-network services will be paid in full at the time of service, and the member will submit an out-of-network claim form for reimbursement.

The following supplemental vision services are covered outside of the HDHP and are not subject to the Plan deductible. Benefits are based on a calendar year. The Plan allows the member to receive either contacts and frame, or frame and lens services. Any unused portion of the funded benefit cannot be applied to offset the cost of additional services.

Vision Benefit			
Vision benefits	**Examination**	**Eyeglass or Contact Lenses**	**Frames**
Reimbursement Frequency	12 months	12 months	24 months

Eye Examination Benefit	**In-network**	**Out-of-network**
Eye exam including dilation as necessary	Covered in full after a $5 exam copay	Reimbursed up to $45
Exam Options:	**In-network**	**Out-of-network**
Standard contact lens fit and follow-up	You pay no more than $55	You pay full retail price
Premium contact lens fit and follow-up	You pay no more than 90% of retail price	You pay full retail price
Frames:	**In-network**	**Out-of-network**
Any available frame at provider location	Covered in full if retail price of the frame selected is $100 or less. For frames costing more than $100, you pay 80% of retail price over $100	Reimbursed up to $45
Eyeglass Lenses (pair):	**In-network**	**Out-of-network**
Standard plastic single vision	$10 materials copay	Reimbursed up to $25
Standard plastic bifocal	$10 materials copay	Reimbursed up to $40
Standard plastic trifocal	$10 materials copay	Reimbursed up to $50
Standard plastic lenticular	$10 materials copay	Reimbursed up to $80
Standard progressive lens	You pay no more than $75	Reimbursed up to $40
Premium progressive lens	Schedule 1: $95 Schedule 2: $105 Schedule 3: $120 Schedule 4: $75 copay + (80% of Retail charge) less $120 allowance	Reimbursed up to $40

Lens Options:	In-network	Out-of-network
UV treatment	You pay $15	You pay full retail price
Tint (solid and gradient)	You pay $15	You pay full retail price
Standard plastic scratch coating	You pay $15	You pay full retail price
Standard polycarbonate	You pay $40	You pay full retail price
Standard anti-reflective coating	You pay $45	You pay full retail price
Polarized	You pay 80% of the retail price	You pay full retail price
Photochromatic/Transitions plastic	You pay $75	You pay full retail price
Premium anti-reflective	Price, based on manufacturer	You pay full retail price
Other add-ons	You pay 80% of the retail price	You pay full retail price
Contact Lenses: (In lieu of frame and eyeglass lenses)	**In-network**	**Out-of-network**
Conventional	You pay the $10 material copay for lenses costing $110 or less plus 85% on the retail price over $110	Reimbursed up to $110
Disposable	You pay the $10 material copay for lenses costing $110 or less plus the retail price over $110	Reimbursed up to $110
Medically necessary	$10 copay, paid in full, requires pre-approval by EyeMed	Reimbursed up to $250
Laser Vision Correction:	**In-network**	**Out-of-network**
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	You pay full retail price
Additional Pairs of Glasses or Contacts:	**In-network**	**Out-of-network**
Additional pairs of glasses or contacts	40% off the retail price for complete pair of eyeglasses and 15% off the retail price for conventional contact lenses after the funded benefit has been used	You pay full retail price

Standard/Premium progressive lenses not covered - fund as a Bifocal lens. Members receive a 20% discount on items not covered by the plan at network providers that cannot be combined with any other discounts or promotional offers. Discount does not apply to network providers' professional services or contact lenses. Limitations and exclusions apply. There are certain brand name Vision Materials in which the manufacturer imposes a no-discount practice. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency. Underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York.

Section 5. Traditional Medical Coverage Subject to the Deductible

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 any applicable medical or payment policies. Policies may be found on our website geha.com/Provider-Policies. In some instances, additional services may be rendered, and additional cost shares may apply.
- Preventive care is covered at 100% (see Section 5, Preventive care) if rendered by preferred providers and is not subject to the calendar year deductible. Preventive care from non-preferred providers is covered under Traditional medical coverage subject to the deductible.
- Benefits are applied based on how your provider bills Us. You must reference all Sections in this Brochure depending on where your care is obtained. For example, but not limited to, any procedure, injection, diagnostic service, laboratory, or x-ray service done in a hospital in conjunction with a physician office examination may apply separate cost share depending on where you obtain your care.
- The calendar year deductible is $1,800 for Self Only enrollment and $3,600 for a Self Plus One enrollment or Self and Family enrollment each calendar year when you use in-network providers. The deductible is $4,500 for Self Only enrollment and $9,000 for Self Plus One or Self and Family enrollment when you use out-of-network providers. Only plan allowance paid for services or supplies from out-of-network providers counts towards this amount. The Self Plus One or the Self and Family deductible can be satisfied by one or more family members. Applicable coinsurance applies after you met your Deductible until you've reached your Out-of-Pocket Maximum.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance and deductibles total $6,000 per person or $12,000 per family for a Self Plus One enrollment or a Self and Family enrollment in any calendar year when you use an in-network provider, you do not have to pay any more for covered services. If you use an out-of-network provider, your maximum out-of-pocket expenses are $8,500 per person or $17,000 per family for a Self Plus One or a Self and Family enrollment in any calendar year. Only out-of-pocket expenses from out-of-network providers count towards those limits. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Be sure to read Section 4, Your Costs for Covered Services, for valuable information about how cost-sharing works. Also, read Section 9, Coordinating Benefits with Medicare and Other Coverage, for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PREAUTHORIZATION FOR SOME SERVICES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization.
- Medications may be available under the Prescription drug benefit and may require prior authorization.
- Benefits for certain prescription medications and supplies (e.g., self-injectable or self-administered) are only eligible for coverage when dispensed by a pharmacy under the pharmacy benefit even if you obtain these medications from your provider.

Benefits Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins	**HDHP**
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "no deductible" when it does not apply. When you receive covered services, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $1,800 for Self Only enrollment or $3,600 for a Self Plus One enrollment or a Self and Family enrollment when you use in-network providers. 100% of allowable charges until you meet the deductible of $4,500 for Self Only enrollment or $9,000 for a Self Plus One enrollment or a Self and Family enrollment when you use out-of-network providers. Only plan allowance paid for services or supplies from out-of-network providers counts towards this amount.
After you meet the deductible, we pay the allowable charge (less your coinsurance) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance for covered services. You may choose to pay the coinsurance from your HSA or HRA, or you can pay for them out-of-pocket. If you have an HRA, we will withdraw the amount from your HRA if funds are available. Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.

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 any applicable medical or payment policies. Policies may be found on our website geha.com/Provider-Policies. In some instances, additional services may be rendered, and additional cost shares may apply.
- Benefits are applied based on how your provider bills Us. You must reference all Sections in this Brochure depending on where your care is obtained. For example, but not limited to, any procedure, injection, diagnostic service, laboratory, or x-ray service done in a hospital in conjunction with a physician office examination may apply separate cost share depending on where you obtain your care.
- The calendar year deductible is $1,800 for Self Only and $3,600 for Self Plus One or Self and Family when you use in-network providers. The deductible is $4,500 for Self Only and $9,000 for Self Plus One or Self and Family when you use out-of-network providers. The Self Plus One or the Self and Family deductible can be satisfied by one or more family members. Applicable coinsurance applies after you met your Deductible until you've reached your Out-of-Pocket Maximum.
- The out-of-network benefits are the standard benefits of this 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.
- When you visit an in-network facility, the professionals who provide services to you may not all be in-network providers. If you receive out-of-network services at an in-network facility, we will pay up to the plan allowance according to the No Surprises Act.
- Medications may be available under the Prescription drug benefit and may require prior authorization.
- Benefits for certain prescription medications and supplies (e.g., self-injectable or self-administered) are only eligible for coverage when dispensed by a pharmacy under the pharmacy benefit even if you obtain these medications from your provider.
- **YOU MUST GET PREAUTHORIZATION FOR SOME SERVICES.** Please refer to preauthorization information shown in Section 3 to be sure which procedures 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, *Coordinating Benefits with Medicare and Other Coverage,* 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.).
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- Preventive services from non-preferred providers will be applied to your deductible and payable under Traditional medical coverage benefits. Non-covered charges and charges in excess of the Plan allowable do not count toward the deductible.

Benefits Description	You pay After the calendar year deductible…
Diagnostic and treatment services	**HDHP**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinions • Advance care planning • At home • During a hospital stay (services not related to your inpatient stay, may apply separate cost share.) • Telehealth services provided by your physician. Notes: • If you have a screening or blood test done during a preventive visit to your doctor that is for medical reasons other than prevention, you will be responsible for copays and coinsurance for additional services. • If additional services (e.g., lab, x-ray) are provided during your office visit, separate cost shares may apply.	In-network: 5% of the Plan Allowance Out-of-network: 35% of the Plan allowance 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 http://cvs.com/minuteclinic/clinic-locator or call 866-389-2727.	5% of the Plan Allowance
Telehealth services Telehealth professional services through the Plan's administrative partner for: • Minor acute conditions, see Section 10, *Definitions of Terms*. • Dermatology conditions, see Section 10, *Definitions of Terms*. Note: • For more information on telehealth benefits, please see Section 5(g), *Wellness and Other Special Features,* or visit geha.com/Telehealth-Visit.	Nothing Note: HDHP members who have met their deductible will be charged by the provider, but we will then reimburse the member 100% of the Plan Allowance.
Lab, X-ray and other diagnostic tests	**HDHP**
Tests, such as but not limited to: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Prostate-Specific Antigen (PSA) tests • X-rays and other minor diagnostic tests	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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 After the calendar year deductible…
Lab, X-ray and other diagnostic tests (cont.)	**HDHP**
• Non-routine mammograms • CT, MRI, MRA, Nuclear Cardiology and PET studies (**requires preauthorization**) • Double contrast barium enemas • Ultrasound • Electrocardiogram and EEG • Neurological testing • Bone density tests • Specialized diagnostic genetic testing and screening **preauthorization required** - 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 tests included in the panel are experimental or investigational or are not medically necessary. Notes: • See Section 5(b), Surgical Benefits, and 5(c), Outpatient Facility fees, for applicable charges for non-routine colonoscopy procedures. • See Section 5(c) for any applicable outpatient facility charges. • If your in-network provider uses an out-of-network lab, imaging facility, or radiologist, we will pay out-of-network benefits for lab charges.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Sleep Study (Polysomnography) • Home • In-Lab - **requires preauthorization**, see Section 3, *Other services that need prior authorization* Note: Refer to Section 5(c) for outpatient facility fees associated with in-lab sleep studies.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Deductible will be waived in-network for these tests and diagnoses: • Hemoglobin A1C testing with a diagnosis of diabetes • Low-density Lipoprotein LDL testing with a diagnosis of heart disease • International Normalized Ratio (INR) testing with a diagnosis of liver disease and/or bleeding disorders Note: If your in-network provider uses an out-of-network lab, we will pay out-of-network benefits for lab charges.	In-network: 5% of the Plan allowance (no deductible) Out-of-network: 35% of the Plan allowance 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.*	*All charges*

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

Benefits Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests (cont.)	**HDHP**
• *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*
Maternity care	**HDHP**
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) or call SAMHSA's National Helpline 800-662-4357 or go to www. findtreatment.gov. • Breastfeeding and lactation support and counseling for each birth. Here are some things to keep in mind: • *Hospital services* are covered under Section 5(c) and Section 5(b), *Surgical benefits.* • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • As part of your coverage, you will have access to in-network certified nurse midwives and board-certified lactation specialists 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/Maternity 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, but you must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under 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. We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Any maternity services considered preventive will be covered by the Plan at 100% (no deductible). See Section 5, *Preventive care,* for additional information.	In-network: Nothing Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible…
Maternity care (cont.)	**HDHP**
Notes: • 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. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits. • Refer to Section 5(a), *Educational classes and programs,* for information on Childbirth Education classes. • See Section 5(g), for information on G.E.H.A's *Family Planning Care* Program. For more information, visit geha.com/Healthy-Pregnancy.	In-network: Nothing Out-of-network: 35% of the Plan allowance 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 of Terms,* 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	All charges in excess of $1,000, in- and out-of-network combined
Not covered: • *Home uterine monitoring devices.* • *Charges related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest.* • *Charges for services and supplies incurred after termination of coverage.* • *Services for birth coaching or labor support, except when provided by a certified doula. See Section 10, Definitions of Terms.*	*All charges*
Family planning	**HDHP**
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 in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms	In-network: Nothing (no deductible) Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Family planning - continued on next page

Benefits Description	You pay After the calendar year deductible…
Family planning (cont.)	**HDHP**
Notes: • For contraceptive drugs and devices, see Section 5(f), *Prescription drug coverage/ Contraceptive drugs and devices.* • Your plan offers some types of voluntary female sterilization surgery coverage at no cost to members. 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. Any contraceptive procedure that is not already available may be requested through the contraceptive exceptions process described on Our website at geha.com/Family-Planning-Options or by calling Customer Care. 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: 35% of the Plan allowance and any difference between our allowance and the billed amount
Voluntary male sterilization	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilizations* • *Genetic testing and counseling*	*All charges*
Infertility services	**HDHP**
Infertility and related services within this section, **Preauthorization is required**. See Section 3, Refer to *Other services that require preauthorization.* Infertility definition can be found in Section 10, *Definition of Terms.* Diagnosis and treatment of infertility is covered and is specific to: • Artificial Insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Fertility preservation for iatrogenic infertility: • Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval; • Cryopreservation of sperm and mature oocytes; and • Cryopreservation storage costs for 12 months. • **Preauthorization is required**, see Section 3, *Other services that require preauthorization.* Notes: • See Section 5(a), *Lab, x-ray and other diagnostic tests,* for cost share associated with diagnostic testing.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Infertility services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Infertility services (cont.)	**HDHP**
• See Section 5(b), *Surgical procedures,* for cost share associated with covered surgical services. • Fertility drugs, up to 3 cycles (See Section 5(f), *Prescription Drug Benefits*). • See Section 5(g) for information on G.E.H.A's*Family Planning Care Program.*	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Assisted reproductive technology (ART), See Section 10, Definitions of Terms, including:* - *In vitro fertilization (IVF), See Section 10, Definitions of Terms* - *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 egg* • *Cost of donor sperm* • *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 benefits, 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.* • *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 of Terms.*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Allergy care	**HDHP**
• Testing and treatment, including materials (such as allergy serum) • Allergy injections • Allergy testing is limited to 100 tests per person per calendar year Note: Each individual test performed as part of a group or panel is counted individually against the 100-test limit.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Clinical ecology and environmental medicine* • *Provocative food testing* • *Sublingual allergy desensitization drugs*	*All charges*
Treatment therapies	**HDHP**
• Total Parenteral Nutrition (TPN) • Enteral/Tube feeding Nutrition, including Medical Foods for Inborn Errors of Metabolism (IEM). See Section 10 for definition. • Intravenous (IV)/ Infusion Therapy - Home IV/Infusion and antibiotic therapy • Intrathecal pump refills • Chemotherapy and radiation therapy - **Preauthorization is required.** See Section 3, *Other services that require preauthorization.* - 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.* • Respiratory and inhalation therapies • Growth hormone therapy (GHT) - **Preauthorization is required.** See Section 3, *Other services that require preauthorization.* - GHT is covered under the prescription drug benefit. 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. Notes: • Medications required for treatment therapies are available in Section 5(f), *Specialty drug benefits.* • Applied Behavioral Analysis Therapy is available under the *Mental Health and Substance Use Disorder Benefits* in Section 5(e). • Outpatient therapy (including cardiac and pulmonary rehabilitation), Section 5(c), *Outpatient Hospital services* for applicable outpatient facility charges.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Dialysis • Dialysis – hemodialysis and peritoneal dialysis • Initial home dialysis training for the member and a helper is covered	In-network: 5% of the Plan allowance

Treatment therapies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	**HDHP**
• G.E.H.A needs to be notified of the first date of your dialysis, even when an extension is required for coordination of benefits. Refer to G.E.H.A's dialysis notification form located at geha.com/Dialysis-Notification. • See Section 5(f), *Prescription drug benefits,* for available medications required for treatment therapies.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Chelation therapy except for acute arsenic, gold or lead poisoning* • *"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* • *Ongoing licensed/unlicensed dialysis assistance in the home after initial dialysis training*	*All charges*
Physical, occupational, speech, habilitative, and rehabilitative therapy	**HDHP**
We cover up to 60 outpatient therapy visits per person per calendar year for the combined services when a physician: • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Notes: • Inpatient therapy services are not applied to the visit limits, see Section 5(c), *Inpatient hospital* • Rehabilitation and Habilitative therapy, see Section 10, *Definitions of Terms*	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Exercise programs* • *Long-term rehabilitative therapy* • *Maintenance therapy—measurable improvement is not expected, or progress is no longer demonstrated* • *Hot and cold packs* • *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*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Cognitive Rehabilitation	**HDHP**
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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	**HDHP**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing services that are not shown as covered* • *Over-the-counter hearing aids, enhancement devices, accessories or supplies*	*All charges*
Vision services (testing, treatment, and supplies)	**HDHP**
• First pair of contact lenses or standard ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury. • 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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Deductible will be waived in-network for this screening and diagnosis: • Retinopathy screening with a diagnosis of diabetes	In-network: 5% of the Plan allowance (no deductible) Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them, except for the supplemental vision plan* • *Radial keratotomy and other refractive surgeries* • *Special multifocal ocular implant lenses* • *Vision therapy except as noted above* • *Eye exercises and orthoptics*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Foot care	**HDHP**
• Routine foot care only when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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	All charges in excess of $150 (no deductible), in- and out-of-network combined
Not covered: • *Cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and 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 (except for surgical treatment)*	*All charges*
Orthopedic and prosthetic devices	**HDHP**
• 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 • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy • Bioelectric, computer programmed prosthetic devices • Implanted hearing-related devices, such as bone anchored hearing aids Notes: • 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.* • We will pay only for the cost of the standard item. Coverage for specialty items is limited to the cost of the standard item. • **Preauthorization is required,** see Section 3, *Other services that require preauthorization,* for orthopedic and prosthetic devices with a retail price of $1,000 or more.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Over-the-counter hearing aids, enhancement devices accessories or supplies*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Durable medical equipment (DME)	**HDHP**
Durable medical equipment (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 • Are designed for prolonged use • Serve a specific therapeutic purpose in the treatment of an illness or injury We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Rental of Dialysis equipment • Hospital beds • 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 Notes: • **Preauthorization is required,** see Section 3, *Other services that require preauthorization,* for Durable Medical Equipment that has a cumulative rental and/or retail price of $1,000 or more. • See Section 10, *Definitions of Terms,* for Medical Necessity. • Refer to Section 5(f), *Covered medications and supplies,* to obtain glucose meter and diabetic supplies.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Deductible will be waived for in-network for this equipment and diagnosis: • Blood pressure monitor with a diagnosis of hypertension	In-network: 5% of the Plan allowance (no deductible) Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Breast pump and supplies: • One personal use, double channel electric breast pump with double suction capability is purchased for pregnant or nursing members every 12-months with birth/delivery. A prescription is required when requesting a pump.	In-network: Nothing (no deductible) Out-of-network: You pay all charges

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	**HDHP**
- 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 geha.com/Healthy-Pregnancy. Note: Refer to Section 5(a), *Maternity Care,* for information on Breastfeeding support and counseling.	In-network: Nothing (no deductible) Out-of-network: You pay all charges
Speech Generating Devices, see Section 10, *Definitions of Terms* • **Preauthorization is required,** see Section 3, *Other services that require preauthorization* • 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	All charges in excess of $1,250 per calendar year, in- and out-of-network combined
Wigs/cranial hair prosthesis used for hair loss due to the treatment of cancer. Note: One wig/cranial hair prosthesis per lifetime.	All charges in excess of $350, in- and out-of-network combined
Not covered: • *Motorized wheelchairs and other power operated vehicles unless meeting ACA requirements and medical necessity* • *Deluxe or upgraded equipment and supplies* • *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 (*see Section 10, *Definitions of Terms)* • *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*
Home health services	**HDHP**
Medically necessary part-time or intermittent skilled nursing care by a licensed Home Health agency, when ordered by an appropriate medical professional, for services such as: • Wound care for pressure sores or a surgical wound • Patient and caregiver education • Intravenous or nutrition therapy • Injections	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Home health services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Home health services (cont.)	**HDHP**
• Monitoring serious illness and unstable health status Services may include, but are not limited to, therapies, DME or Medical Supplies and are not payable separately. Services are limited to 50 visits per calendar year as defined by service type billed by the home health agency. Notes: • Please refer to the Specialty drug benefits in Section 5(f), *Prescription Drug Benefits,* for information on benefits for home infusion therapy medications. • See *Durable medical equipment (DME)* above for coverage of DME benefit services received in the home.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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, Definitions of Terms)* • *Long-term care (see Section 10, Definitions of Terms)* • *Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption* • *Private duty nurse*	*All charges*
Chiropractic services	**HDHP**
Benefit for Chiropractic services is limited to 20 visits per person per calendar year. Services are 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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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, cold pack application, naturopathic services and rolfing* • *Maintenance therapy - measurable improvement is not expected or progress is no longer demonstrated*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Alternative treatments	**HDHP**
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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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*
Educational classes and programs	**HDHP**
Coverage is limited to: • Tobacco Cessation programs - We cover counseling sessions including proactive phone counseling, group counseling and individual counseling. Benefits are payable for up to two attempts per person per calendar year, with up to four counseling sessions per attempt. • 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 CVS Caremark Mail Service Pharmacy or a non-Network Retail pharmacy. (See filing instructions in Section 5(f), *Prescription drug benefits.*)	In-network: Nothing (no deductible) Out-of-network: Nothing, except any difference between our Plan allowance and the billed amount (no deductible)
• Diabetes self-management – 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: Nothing up to the Plan allowance and any difference between our allowance and the billed amount (no deductible)
• Nutritional Counseling – Provided by a dietitian with a state license or statutory certification. Nutritional counseling must be ordered by a physician.	In-network: Nothing up to the Plan allowance Out-of-network: 35% of the Plan allowance 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.* For more information visit geha.com/Healthy-Pregnancy.	All charges in excess of $150, in- and out-of-network combined
Not covered: • *Weight loss programs, except as specified by the brochure*	*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 any applicable medical or payment policies. Policies may be found on our website geha.com/Provider-Policies. In some instances, additional services may be rendered, and additional cost shares may apply.
- Benefits are applied based on how your provider bills Us. You must reference all Sections in this Brochure depending on where your care is obtained. For example, but not limited to, any procedure, injection, diagnostic service, laboratory, or x-ray service done in a hospital in conjunction with a physician office examination may apply separate cost share depending on where you obtain your care.
- The calendar year deductible is $1,800 for Self Only and $3,600 for Self Plus One or Self and Family when you use in-network providers. The deductible is $4,500 for Self Only and $9,000 for Self Plus One or Self and Family when you use out-of-network providers. The Self Plus One or the Self and Family deductible can be satisfied by one or more family members. Coinsurance applies after you meet your deductible and continues until you reach your out-of-pocket maximum.
- The out-of-network benefits are the standard benefits of this 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.
- When you visit an in-network facility, the professionals who provide services to you may not all be in-network providers. If you receive out-of-network services at an in-network facility, we will pay up to the Plan allowance according to the No Surprises Act.
- Medications may be available under the Prescription drug benefit and may require prior authorization.
- Benefits for certain prescription medications and supplies (e.g., self-injectable or self-administered) are only eligible for coverage when dispensed by a pharmacy under the pharmacy benefit even if you obtain these medications from your provider.
- **YOU MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 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, *Coordinating Benefits with Medicare and Other Coverage*, 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 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.).
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.

Benefits Description	You pay After the calendar year deductible…
Surgical procedures	**HDHP**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine 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 a functional deficit (see *Reconstructive surgery* below) • Insertion of internal prosthetic devices (see Section 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. - **Preauthorization is required,** see Section 3, *Other services that require preauthorization.* Notes: • 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. • For female and male surgical family planning procedures, see Section 5(a), *Family Planning.* • Assistant surgeons are covered up to 20% of our allowance for the surgeon's charge for procedures when it is medically necessary to have an assistant surgeon. Registered nurse first assistants and certified surgical assistants are covered up to 15% of our allowance for the surgeon's charge for the procedure if medically necessary to have an assistant surgeon.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefits Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**HDHP**
When multiple 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 procedure(s) based on: - One-half of the Plan allowance Note: Multiple 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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician or surgeon* • *Routine treatment of conditions of the foot (see Section 5(a), Foot care)* • *Surgical treatment of hyperhidrosis unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful* • *Removal of excess skin covered only if medically necessary*	*All charges*
Reconstructive surgery	**HDHP**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm - limited to children under the age of 18 unless there is a functional defect. Examples of congenital anomalies are cleft lip, cleft palate, birth marks, and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy or lumpectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses; and surgical bras and replacements (see Section 5(a), *Orthopedic and prosthetic devices* for coverage) Notes: • 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.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefits Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	**HDHP**
• 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. • **Preauthorization is required**, see Section 3, *Other services that require preauthorization.*	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury (See Section 5(d) Accidental injury)* • *Surgery for Sex-Trait Modification to treat gender dysphoria* • *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* *For Sex-Trait Modification: If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. Ongoing sex-trait modification hormone treatment is not a covered benefit under this plan as of 1/1/2026. Our exception process is as follows: To initiate the exception process, contact Customer Care at 800-821-6136, Monday-Friday between 8 a.m. - 8 p.m. E.T. If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process.* *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*
Oral and maxillofacial surgery	**HDHP**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate, and severe functional malocclusion • Excision of cysts and incision of abscesses unrelated to tooth structure • Extraction of impacted (unerupted or partially erupted) teeth • Partial or radical removal of the lower jaw with bone graft • Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues when unrelated to teeth and supporting structures • 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	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Oral and maxillofacial surgery - continued on next page

Benefits Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	**HDHP**
• Repair of traumatic wounds • Incision of the sinus and repair of oral fistulas • Surgical treatment of trigeminal neuralgia • Repair of accidental injury to sound natural teeth such as expenses for x-rays, drugs, crowns, bridgework, inlays and dentures. We may review x-rays and/or treatment records in order to determine benefit coverage. • Accidental dental injury is covered. - Note: Services are paid at regular medical Plan benefits. See Sections 5(a) through 5(f) for applicable services and benefits. • Orthognathic surgery for the following conditions **requires preauthorization** and is not covered for any other condition, see Section 3, *Other services that require preauthorization:* - 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	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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 surgery not specifically listed as covered* • *Orthognathic surgery, except as outlined above for moderate or severe sleep apnea, craniofacial congenital anomalies, severe malocclusion, or used as reconstructive procedure (even if necessary, because of TMJ dysfunction or disorder)* • *Masticating (biting or chewing) incidents that are not considered to be accidental injuries* • *Apicoectomy, Alveolectomy, root canal therapy*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants	**HDHP**
All transplants and related services within this section, **Preauthorization is required**. See Section 3, *Other services that require preauthorization*.	Services are paid at regular medical Plan benefits.
These **solid organ and tissue transplants** are subject to medical necessity and experimental/investigational review by the Plan. Solid organ and tissue transplants are covered and 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 • 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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants: The Plan extends coverage for the diagnoses as indicated below. 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	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
- Beta Thalassemia Major - Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Hemoglobinopathy - Immune deficiency diseases other than Severe Combined Immunodeficiency (SCID, e.g., Wiskott-Aldrich syndrome, Kostmann's syndrome, Leukocyte Adhesion Deficiencies) not amenable to more conservative treatments - 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) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g. Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Multiple myeloma - Multiple sclerosis - 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 - 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 lymphoma and aggressive Dendritic Cell neoplasms)	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
- Amyloidosis - Breast Cancer - Childhood rhabdomyosarcoma - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Ependymoblastoma - Epithelial ovarian cancer - Mantle Cell (non-Hodgkin lymphoma) - Medulloblastoma - Multiple myeloma - Multiple sclerosis - Neuroblastoma - Pineoblastoma - Scleroderma - Scleroderma-SS (severe, progressive) - Systemic sclerosis - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Waldenström's macroglobulinemia	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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. • 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 - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic syndromes	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
- 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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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 that 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 • 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	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
- 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 - Systemic sclerosis	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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. • Transportation benefits are only payable when G.E.H.A is the primary payor.	All charges in excess of $10,000

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
• Transportation benefits are payable for follow-up care up to one year following the transplant. • You must contact Customer Care at 800-821-6136 for what are considered reasonable temporary living expenses.	All charges in excess of $10,000
National Transplant Program (NTP) We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. Notes: • If you are a participant in a clinical trial, please see Section 9, *Clinical Trials*, for coverage details. • The process for preauthorizing transplants is more extensive than the normal process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact G.E.H.A's Medical Management Department so we can arrange to review the clinical results of the evaluation and determine if the proposed procedure meets our definition of "medically necessary" and is on the list of covered transplants. Coverage for the transplant must be authorized in advance, in writing. • The transplant must be performed at a Plan-designated transplant facility to receive maximum benefits. G.E.H.A uses a defined transplant network, which may be different than the Preferred Provider Network. • 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. • 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.	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*

Benefits Description	You pay After the calendar year deductible…
Anesthesia	**HDHP**
Professional fees for the administration of anesthesia in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Notes: • 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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered • *Anesthesia related to non-covered surgeries or procedures*	*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 any applicable medical or payment policies. Policies may be found on our website geha.com/Provider-Policies. In some instances, additional services may be rendered, and additional cost shares may apply.
- Benefits are applied based on how your provider bills Us. You must reference all Sections in this Brochure depending on where your care is obtained. For example, but not limited to, any procedure, injection, diagnostic service, laboratory, or x-ray service done in a hospital in conjunction with a physician office examination may apply separate cost share depending on where you obtain your care.
- The calendar year deductible is $1,800 for Self Only and $3,600 for Self Plus One or Self and Family when you use in-network providers. The deductible is $4,500 for Self Only and $9,000 for Self Plus One or Self and Family when you use out-of-network providers. Only plan allowance paid for services or supplies from out-of-network providers counts towards this amount. The Self Plus One or the Self and Family deductible can be satisfied by one or more family members. Applicable coinsurance applies after you met your Deductible until you've reached your Out-of-Pocket Maximum.
- The out-of-network benefits are the standard benefits of this 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.
- When you visit an in-network facility, the professionals who provide services to you may not all be in-network providers. If you receive out-of-network services at an in-network facility, we will pay up to the Plan allowance according to the No Surprises Act.
- Medications may be available under the Prescription drug benefit and may require prior authorization.
- Benefits for certain prescription medications and supplies (e.g., self-injectable or self-administered) are only eligible for coverage when dispensed by a pharmacy, under the pharmacy benefit even if you obtain these medications from your provider.
- **YOU MUST GET PRECERTIFICATION FOR INPATIENT STAYS UNLESS DUE TO A MEDICAL EMERGENCY. FAILURE TO DO SO WILL RESULT IN A FINANCIAL PENALTY**. 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.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating Benefits with Medicare and Other Coverage,* for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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).
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital	**HDHP**
Precertification is required in advance of admission. Inpatient services provided and billed by a hospital or other covered facility such as surgery, intensive care or other treatments billed by the hospital or facility while you are staying there.	Services are paid at regular medical Plan benefits.
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Notes: • 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. • When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges. Other hospital services and supplies, such as: • Operating, recovery, 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 - See Section 5(a) for any applicable *Durable Medical Equipment (DME)* cost share. 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.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount
Maternity care – Inpatient hospital Here are some things to keep in mind: • You do not need to precertify your normal delivery; see Section 3, *Maternity care* for other circumstances, such as extended stays for you or your baby.	In-network: Nothing (deductible applies) Out-of-network: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	**HDHP**
• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but **you must precertify**. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. • We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family or Self Plus One enrollment. • Surgical benefits, not maternity benefits, apply to circumcision.	In-network: Nothing (deductible applies) Out-of-network: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount
Not covered: • *Any part of a hospital admission that is not medically necessary, see Section 10, Definitions of Terms, 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, Definitions of Terms)* • *Long-term care (see Section 10, Definitions of Terms)* • *Non-covered facilities such as nursing homes, schools* • *Personal comfort items such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient facility (hospital or ambulatory surgical center)	**HDHP**
• Operating, recovery, observation, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood or blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Outpatient cardiac and pulmonary rehabilitation, 36 visits maximum each per year • Respiratory and inhalation therapies 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.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Outpatient facility (hospital or ambulatory surgical center) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Outpatient facility (hospital or ambulatory surgical center) (cont.)	**HDHP**
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, Prostate-Specific Antigen (PSA) tests) and pathology services • CT, MRI, MRA, Nuclear Cardiology and PET studies - Note: **Preauthorization is required for these tests.** • In Lab Attended Polysomnography (sleep study) - **Requires preauthorization.** • Non-routine colonoscopy - Note: See Section 5(a), *professional fees,* and 5(b), *surgical fees,* for applicable charges for non-routine colonoscopy Note: 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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance 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*
Maternity care – Outpatient hospital or birth center Here are some things to keep in mind: • You do not need to precertify your normal delivery; see Section 3, *Maternity 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 regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. • We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family or Self Plus One enrollment. • Surgical benefits, not maternity benefits, apply to circumcision.	In-network: Nothing (deductible applies) Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Treatment Therapies - **Preauthorization is required**, see Section 3, *Other services that require preauthorization.* • Intravenous (IV)/Infusion Therapy - Outpatient IV/infusion and antibiotic therapy • 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.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Outpatient facility (hospital or ambulatory surgical center) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Outpatient facility (hospital or ambulatory surgical center) (cont.)	**HDHP**
• 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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Extended care benefits/Skilled nursing care facility benefits	**HDHP**
Inpatient confinement at a skilled nursing facility when the following criteria is met: • **Precertification is required** prior to admission • Benefits are limited to 50 days per calendar year. 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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount
Hospice/ End of life care	**HDHP**
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 • 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: 5% up to the Plan limits Out-of-network: 35% up to the Plan limits

Hospice/ End of life care - continued on next page

Benefit Description	You pay After the calendar year deductible...
Hospice/ End of life care (cont.)	**HDHP**
Not covered: • *Charges incurred during a period of remission, charges incurred for treatment of a sickness or injury of a family member that are covered under another plan provision, charges incurred for services rendered by a close relative* • *Bereavement counseling, pastoral counseling, financial or legal counseling* • *Funeral arrangements* • *Homemaker or caretaker services*	*All charges*
Ambulance	**HDHP**
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: 5% of the Plan allowance Out-of-network: 5% of the Plan allowance and any difference between our allowance and the billed amount
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. **Note: Medical Necessity review is required for all air ambulance transportation.**	In-network: 5% of the Plan allowance Out-of-network: 5% of the Plan allowance
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 ground 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*

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 any applicable medical or payment policies. Policies may be found on our website geha.com/Provider-Policies. In some instances, additional services may be rendered, and additional cost shares may apply.
- Benefits are applied based on how your provider bills Us. You must reference all Sections in this Brochure depending on where your care is obtained. For example, but not limited to, any procedure, injection, diagnostic service, laboratory, or x-ray service done in a hospital in conjunction with a physician office examination may apply separate cost share depending on where you obtain your care.
- The calendar year deductible is $1,800 for Self Only and $3,600 for Self Plus One or Self and Family when you use in-network providers. The deductible is $4,500 for Self Only and $9,000 for Self Plus One or Self and Family when you use out-of-network providers. The Self Plus One or the Self and Family deductible can be satisfied by one or more family members. Applicable coinsurance applies after you met your Deductible until you've reached your Out-of-Pocket Maximum.
- 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 if you receive care from professionals who provide services in an out-of-network hospital, when admitted due to a medical emergency.
- 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.
- When you visit an in-network facility, the professionals who provide services to you in a facility may not all be in-network providers. If you receive out-of-network services at an in-network facility, we will pay up to the Plan allowance according to the No Surprises Act.
- Medications may be available under the Prescription drug benefit and may require prior authorization.
- Benefits for certain prescription medications and supplies (e.g., self-injectable or self-administered) are only eligible for coverage when dispensed by a pharmacy under the pharmacy benefit even if you obtain these medications from your provider.
- **YOU MUST GET PREAUTHORIZATION FOR SOME SERVICES**. Please refer to the preauthorization information shown in Section 3 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, *Coordinating Benefits with Medicare and Other Coverage,* for information about how we pay if you have other coverage or if you are age 65 or over.

What is an Accidental Injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings.

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, the 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 After the calendar year deductible…
Accidental injury	**HDHP**
If you receive care for your accidental injury within 72 hours, we cover: • Treatment in an outpatient facility or in the outpatient/emergency room department of a hospital • Related outpatient physician care • Related diagnostic services Note: Emergency room charges associated directly with an inpatient admission are considered "Other charges" under *Inpatient hospital b*enefits in Section 5(c) and are not part of this benefit, even though an accidental injury may be involved. This provision also applies to dental care required as a result of accidental injury to sound natural teeth.	In-network: 5% of the Plan allowance Out-of-network: 5% of the Plan allowance, plus the difference between the billed amount and the Plan allowance
Not covered: • *Oral implants and transplants; including for the treatment of accidental injury* • *Masticating (chewing) incidents are not considered to be accidental injuries.*	*All charges*
Medical emergency	**HDHP**
Outpatient medical or surgical services and supplies billed by a hospital for emergency room treatment. Notes: • 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.	In-network: 5% of the Plan allowance Out-of-network: 5% of the Plan allowance
Urgent care facility	**HDHP**
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: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
MinuteClinic	**HDHP**
For MinuteClinic®: Please see Section 5(a), *MinuteClinic®*, for complete benefits and coverage information.	Services are paid at regular medical Plan benefits.
Ambulance - Accidental injury	**HDHP**
Ambulance (Local and Air): Please see Section 5(c), *Ambulance,* for complete ambulance benefit coverage information. Note: **Medical Necessity review is required for all air ambulance transportation**.	Services are paid at regular medical Plan benefits.

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 any applicable medical or payment policies. Policies may be found on our website geha.com/Provider-Policies. In some instances, additional services may be rendered, and additional cost shares may apply.
- Benefits are applied based on how your provider bills Us. You must reference all Sections in this Brochure depending on where your care is obtained. For example, but not limited to, any procedure, injection, diagnostic service, laboratory, or x-ray service done in a hospital in conjunction with a physician office examination may apply separate cost share depending on where you obtain your care.
- The calendar year deductible is $1,800 for Self Only and $3,600 for Self Plus One or Self and Family when you use in-network providers. The deductible is $4,500 for Self Only and $9,000 for Self Plus One or Self and Family when you use out-of-network providers. The Self Plus One or the Self and Family deductible can be satisfied by one or more family members. Applicable coinsurance applies after you met your Deductible until you've reached your Out-of-Pocket Maximum.
- The out-of-network benefits are the standard benefits of this 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.
- When you visit an in-network facility, the professionals who provide services to you may not all be in-network providers. If you receive out-of-network services at an in-network facility, we will pay up to the Plan allowance according to the No Surprises Act.
- Medications may be available under the Prescription drug benefit and may require prior authorization.
- Benefits for certain prescription medications and supplies (e.g., self-injectable or self-administered) are only eligible for coverage when dispensed by a pharmacy, under the pharmacy benefit even if you obtain these medications from your provider.
- **YOU MUST GET PRECERTIFICATION FOR ALL INPATIENT STAYS, RESIDENTIAL TREATMENT CENTERS AND INTENSIVE DAY TREATMENT UNLESS DUE TO A MEDICAL EMERGENCY. FAILURE TO PRECERTIFY THESE SERVICES WILL RESULT IN A FINANCIAL PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification. Refer to requirements for covered Facilities shown in Section 3. Penalties are not subject to the catastrophic limit.
- Outpatient mental health and/or substance use disorder treatment services such as Intensive Day Treatment, including Partial Hospital Services and Intensive Outpatient Treatment, must be precertified as well as various outpatient services such as applied behavioral analysis therapy and psychological testing. See Section 10, *Definitions of Terms.*
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating Benefits with Medicare and Other Coverage,* for information about how we pay if you have other coverage, or if you are age 65 or over.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.

Benefits Description	You pay After the calendar year deductible…
Professional services	**HDHP**
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.
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 outpatient treatment in a provider's office or other professional setting - **Preauthorization is required**, see Section 3, *Other services that require preauthorization* • Electroconvulsive therapy (ECT) - facility fees may also apply • Inpatient professional fees	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
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 after deductible for the first 5 visits for treatment of prenatal and postpartum depression; after 5 visits, 5% of the plan allowance. Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount.
Applied Behavioral Analysis Therapy	**HDHP**
Here are some things to keep in mind: • **Preauthorization is required**, see Section 3, *Other services that require preauthorization.* • Required Diagnosis of ASD (Autism Spectrum Disorder) by a provider qualified to make the diagnosis: Board Certified Behavior Analyst (BCBA), psychiatrist, pediatrician. • Initiation of treatment and on-going 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 and services may be provided by Board Certified Assistant Behavior Analysts (BCaBA) or Registered Behavior Technicians (RBTs). • Approval of on-going services requires demonstrated involvement by family.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Applied Behavioral Analysis Therapy - continued on next page

Benefits Description	You pay After the calendar year deductible…
Applied Behavioral Analysis Therapy (cont.)	**HDHP**
• Services provided by the school are not reimbursable by the health plan.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Diagnostics	**HDHP**
• 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 • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment (**requires preauthorization** for testing exceeding 8 hours/calendar year) Note: See Section 5(c), for any applicable outpatient facility charges.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Telehealth Services	**HDHP**
Behavioral health professional services through the Plan's administrative partner for: • Mental health counseling • Substance use disorder counseling Note: • For more information on telehealth benefits, please see Section 5(g), *Wellness and Other Special Features,* or visit geha.com/Telehealth-Visit	Nothing Note: HDHP members who have met their deductible will be charged by the provider, but G.E.H.A will then reimburse the member 100% of the Plan Allowance.
Telehealth services provided by a healthcare provider other than the Plan's telehealth vendor.	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facilities	**HDHP**
Precertification is required in advance of admission. Inpatient services provided and billed by a hospital or other covered facility. Note: We limit covered facilities for medically necessary treatment to a hospital and/or RTC. Room and board, such as, ward, semiprivate, or intensive care accommodations, General nursing care, meals and special diets, and other ancillary charges	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount

Benefits Description	You pay After the calendar year deductible…
Outpatient hospital or other covered facilities	**HDHP**
Preauthorization required, see Section 3, *Other services that require preauthorization.* • Services such as partial hospitalization intensive day treatment programs	In-network: 5% of the Plan allowance Out-of-network: 35% of the Plan allowance and any difference between our allowance and the billed amount
Emergency room	**HDHP**
See Section 5(d), *Medical emergency*	Services are paid at regular medical Plan benefits.
Services we do not cover	**HDHP**
Not covered as part of any professional office, inpatient or outpatient treatment services: • *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* • *Treatment for learning and intellectual disabilities* • *Travel time to the member's home to conduct therapy* • *Services rendered or billed by schools, halfway houses, sober homes, or billed by their staff* • *Marriage counseling* • *Hypnotherapy* • *Services that are not medically necessary* • *Respite care, outdoor residential programs, recreational therapy, educational therapy or classes* • *Outward Bound programs, including equine therapy provided during the approved stay* • *Personal comfort items, such as guest meals and beds, telephone, 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.)* • *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*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We use a formulary drug list that excludes coverage for certain medications unless we determine they are medically necessary. Refer to geha.com/Prescriptions-Summary for a list of drugs that require preauthorization for medical necessity.
- Your benefit includes the Advanced Control Specialty Formulary (ACSF); please see *CVS Caremark Formulary* for additional information.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $1,800 for Self Only and $3,600 for Self Plus One or Self and Family when you use in-network providers. The deductible is $4,500 for Self Only and $9,000 for Self Plus One or Self and Family when you use out of-network providers. Only Plan allowance paid for services or supplies from out-of-network providers counts towards this amount. The Self Plus One or the Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- Some medications must be approved by G.E.H.A and/or CVS Caremark, our Pharmacy Benefit Manager, before they are a covered benefit. Your prescribers must obtain **preauthorization for certain prescription drugs and supplies** before coverage applies. Medication may be limited as to its quantity, total dose, duration of therapy, age, sex or specific diagnosis. **Preauthorizations must be renewed periodically.**
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and eligible prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating Benefits with Medicare and Other Coverage*, for information about how we pay if you have other coverage, or if you are age 65 or over. We will not waive the High Deductible Health Plan deductible and coinsurance for Medicare members.
- 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 or if you received a 90-day supply of a specific medication within the last 30 days, arrangements can be made for an additional 60 days to be dispensed through CVS Caremark Mail Service Pharmacy. Call G.E.H.A Customer Care at 800-821-6136 so we can work with you to find the most cost effective and efficient manner of meeting your emergency prescription needs.
- Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/plan identification card, and a mail order form.
- 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.
- CVS Specialty Pharmacy is the exclusive provider for specialty medications. You may contact the Specialty Pharmacy at 800-237-2767.
- **Federal Law prohibits the return of prescription medications.** Medication cannot be returned to CVS Caremark or retail pharmacies, and you will be responsible for the cost. Be sure to check the cost of your medication before filling the prescription.

- 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.
- 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.
- Select specialty therapies are included in the Starter Fill Program. For these medications, you will receive a 14 or 15-day supply for the first 2 months of therapy. Your coinsurance will be prorated based on the days of therapy.
- Medications may be available under the Prescription drug benefit and may require prior authorization.
- Benefits for certain prescription medications and supplies (e.g., self-injectable or self-administered) are only eligible for coverage when dispensed by a pharmacy, under the pharmacy benefit even if you obtain these medications from your provider.
- Some specialty and non-specialty medications may not be available in a 30-day supply; your coinsurance will be based on days of therapy.
- Coinsurance for prescription drugs goes toward the annual in-network out-of-pocket limit except for the difference between the cost of the generic and brand name medication.
- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals**, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

Prescription Drug Benefits

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

- **Drug coupon/copay cards:** We do not coordinate with drug coupon/copay cards.
- **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. 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, CVS Caremark Mail
  Service Pharmacy, or through a non-network pharmacy. We pay a higher level of benefits when you use a network pharmacy. CVS Specialty Pharmacy is the exclusive provider for specialty medications. You may contact the Specialty Pharmacy at 800-237-2767.
- **We have a managed formulary.** If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost.
  - Please see our online formulary and drug pricing search tools at the following geha.com/Prescriptions-Summary.
- **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 geha.com/Prescriptions-Summary or Caremark mobile app (available for Android and Apple).

    Reimbursement will be based on G.E.H.A's costs had you used a participating pharmacy. Members are responsible for their applicable deductible 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.
- **Your benefit includes the Advanced Control Specialty Formulary (ACSF)**; please see *CVS Caremark Formulary* for additional information.
- **Our prescription benefit includes a step therapy program.** G.E.H.A's preauthorization process may include a 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 the generic/preferred medication(s), the brand and/or non-preferred medication will be dispensed for the applicable plan coinsurance.
  - When you try to fill a brand and/or non-preferred medication and you have not tried the 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 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 coinsurance.
  - Unless there are documented clinical reasons why you cannot take the generic/preferred drug, you may still obtain the brand and/or non-preferred drug, but you will be responsible for 100% of the cost, which will not apply to your annual out-of-pocket maximum.

Prescription Drug Benefits - continued on next page

Prescription Drug Benefits (cont.)

- **Compound Medication:** A compound drug is a medication made by combining, mixing or altering ingredients in response to a prescription, to create a customized drug that is not otherwise commercially available. 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 through the prescription benefit. Coverage for other ingredients commonly found in compound prescriptions may also **require preauthorization** before coverage is allowed.
  - 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 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 or online. If the retail pharmacy is unable to submit the compound medication claim electronically to CVS Caremark, you will pay the full cost of the medication and must submit the claim 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.
  - Mail the claim to CVS Caremark, PO Box 52136, Phoenix, AZ 85072-2136 or submit for reimbursement online via Caremark web portal geha.com/Prescriptions-Summary or Caremark mobile app (available for Android and Apple).
  - Claim calculations, coinsurance, and reimbursement for direct claims are performed using an industry standard reimbursement method for compounds.

Prescription Drug Tiers

- We divide prescription drugs into categories or tiers: generic, preferred, and non-preferred medications. Please note specialty medications can be considered either preferred or non-preferred. 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 applicable plan coinsurance for the medications dispensed. 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 coinsurance 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 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. This list is developed by an independent panel of doctors and pharmacists who ensure the medications are clinically appropriate and cost-effective.
  - **Non-Preferred drugs** are FDA approved prescription medications that are covered by G.E.H.A, 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. Formularies are reviewed quarterly; medications may change formulary status. You will receive notification if your cost share increases due to a formulary change. 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 not covered by the Plan. For these drugs, generics and/or therapeutic alternative medications in the same drug class are readily available. If one of these excluded drugs is medically necessary, a **preauthorization for medical necessity is required**. We do not cover excluded drugs unless we determine the medical necessity to treat a medical condition based on objective clinical data. New drugs and supplies may be added to the list as they are introduced and may require medical necessity review until the formulary status is determined. Please visit our website at geha.com/Prescriptions-Summary to view formulary medications and the most current list of specialty drugs. You may also call CVS Specialty at 800-237-2767.

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 very 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. The ACSF is reviewed quarterly, and medications may change formulary status. Impacted members will be notified of the change at least 60 days in advance. If the formulary change will lower your cost share for the medication(s), you have the option to speak with your doctor about a prescription for the lower cost alternative.

Please visit our website at geha.com/Prescriptions-Summary to view the most current list of specialty drugs. You may also call CVS Caremark at 844-443-4279 or CVS Specialty at 800-237-2767.

Notes:

- **Changes to the formulary are not considered benefit changes.**
- 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.
- **Any rebates or savings received by the Plan on the cost of drugs purchased under this Plan from drug manufacturers are credited to the health plan and are used to reduce health care costs.**

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 G.E.H.A.
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.
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 G.E.H.A, secondary benefit. Submit these claims to CVS Caremark, PO Box 52136, Phoenix, AZ 85072-2136 or submit for reimbursement online via Caremark web portal geha.com/Prescriptions-Summary 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 G.E.H.A reimbursement will be based on the G.E.H.A 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 G.E.H.A, secondary benefit. Submit these claims to CVS Caremark, PO Box 52136, Phoenix, AZ 85072-2136 or submit for reimbursement online via Caremark web portal geha.com/Prescriptions-Summary or Caremark mobile app (available for Android and Apple).

Coordinating with other drug coverage - continued on next page

Coordinating with other drug coverage (cont.)

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 geha.com/Prescriptions-Summary or Caremark mobile app (available for Android and Apple).

In any event, if you use G.E.H.A's plan ID card when another insurance plan is primary, you will be responsible for reimbursing G.E.H.A 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 G.E.H.A's retail Plan allowable benefit. Our secondary and tertiary claim payment is the lesser of:

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

Note: G.E.H.A secondary and tertiary member responsibility could be higher than G.E.H.A'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** - To receive your Medicare Part B-eligible medications by mail, send your mail-order prescriptions to CVS Caremark. 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.
  - 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.

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

Patient Safety

G.E.H.A has several programs to promote patient safety. Through these programs, we work to ensure safe and appropriate quantities of medication are being dispensed. The result is improved care and safety for our members. Patient safety programs include:

- Preauthorization - Approval must be obtained for certain prescription drugs and supplies before providing benefits for them.
- Quantity allowances - Specific allowances are in place for certain medications, based on manufacturer and FDA recommended guidelines.
- Pharmacy utilization - G.E.H.A reserves the right to maximize your quality of care as it relates to the utilization of pharmacies.

G.E.H.A will participate in other approved managed care programs, as deemed necessary, to ensure patient safety.

How to use participating network retail pharmacies

You may fill your prescription at any participating retail pharmacy. To locate participating pharmacies, call CVS Caremark at 844-443-4279 or visit geha.com/Prescriptions-Summary. To receive maximum savings, you must present your plan ID card at the time of each purchase, and your enrollment information must be current and correct. In most cases, you simply present the plan ID card together with the prescription to the pharmacist.

How to use CVS Caremark Mail Service Pharmacy

Through this service, you may receive up to a 90-day supply per prescription of maintenance medications and/or supplies 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 geha.com/Mail-Order-RX; enclose your prescription and the correct coinsurance.

Under regular circumstances, you should receive your medication within approximately 14 days from the date you mail your prescription. If you have any questions or need an emergency consultation with a registered pharmacist, you may call CVS Caremark at 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.

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 844-443-4279. Have your prescription bottle with the prescription information ready.

To order by mail: Simply mail the G.E.H.A Mail Order Form and coinsurance to CVS Caremark, PO Box 659541, San Antonio, TX 78265-9541.

To order online: Go to geha.com/Prescriptions-Summary.

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.

Covered medications and supplies

You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail.

- 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 medications and supplies, such as:
  - Insulin
  - Needles and syringes for the administration of covered medications
  - Blood glucose meter - provided at no charge by the manufacturer, through the CVS Caremark Mail Service Pharmacy, call 800-588-4456.
- Drugs associated with artificial insemination and/or drugs associated with up to three (3) cycles of in vitro fertilization (IVF) treatment. **Prior authorization is required.**
- Medications prescribed to treat obesity. **Prior authorization is required.**
- Prenatal vitamins for pregnant women.
- FDA approved contraceptive drugs and devices for women.
- Covered ostomy supplies (please include the manufacturer's product number to ensure accurate fill of the product).

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies	**HDHP**
Network Retail Pharmacy All coinsurance is for up to a 30-day supply per prescription. Notes: • A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when an FDA approved generic drug is available. If there is no generic equivalent available, you will pay the brand name copay/coinsurance. • If you or your physician choose a brand name medication when a generic is available, you will be charged the generic coinsurance plus the difference in cost between the brand name and the generic. Your physician may call 855-240-0536, if they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance. • Medications to treat some complex and chronic medical conditions are only available through CVS Specialty. See CVS Caremark formulary for the categories of drugs in this program.	Generic/Preferred: 25% of Plan allowance Non-Preferred: 40% of Plan allowance
Preferred Insulin - Network Retail Pharmacy All coinsurance is for up to a 30-day supply per prescription. Notes: • This benefit is not available at non-network retail pharmacies. • For generic or non-preferred medications, please see regular Plan benefits. • If you or your physician chooses a brand name medication when a generic is available, you will be charged the generic copay plus the difference in cost between the brand name and the generic.	Preferred: 15% of the Plan allowance (no deductible)

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**HDHP**
Non-Network Retail Pharmacy All coinsurance is for up to a 30-day supply per prescription. Notes: • Your claim will be calculated on the appropriate coinsurance and deductible. Reimbursement will be based on G.E.H.A's costs had you used a participating pharmacy. You must submit original drug receipts. • If you or your physician chooses a brand name medication when a generic is available, you will be charged the generic coinsurance plus the difference in cost between the brand name and the generic. Your physician may call 855-240-0536, if they determine there is medical necessity for the brand therapy. If approved, your copay/coinsurance will be the applicable brand name copay/coinsurance. • If a participating pharmacy is not available where you reside or you do not use your identification card, you may submit your claim, with original drug receipts to: CVS Caremark PO Box 52136 Phoenix, AZ 85072-2136 You may also submit prescription reimbursement requests online via Caremark web portal geha.com/Prescriptions-Summary or Caremark mobile app (available for Android and Apple.)	Generic/Preferred: 25% of network price and any difference between our allowance and the cost of the drug Non-Preferred: 40% of network price and any difference between our allowance and the cost of the drug
CVS Caremark Mail Service Pharmacy All coinsurance is for up to a 90-day supply per prescription. Notes: • A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when an FDA approved generic drug is available. If there is no generic equivalent available, you pay the applicable plan coinsurance. • If you or your physician chooses a brand name medication when a generic is available, you will be charged the generic coinsurance plus the difference in cost between the brand name and the generic. Your physician may call 855-240-0536, if they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.	Generic/Preferred: 25% of Plan allowance Non-Preferred: 40% of Plan allowance
Preferred Insulin - CVS Caremark Mail Service Pharmacy All coinsurance is for up to a 90-day supply per prescription. Note: • For generic or non-preferred medications, please see regular Plan benefits. • If you or your physician chooses a brand name medication when a generic is available, you will be charged the generic coinsurance plus the difference in cost between the brand name and the generic.	Preferred: 15% of the Plan allowance (no deductible)

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**HDHP**
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 FEHB 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. Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described on G.E.H.A's website at geha.com/Family-Planning-Options or by calling CVS Caremark at 844-443-4279. Exception requests for contraceptive coverage will be processed within 24 hours of receiving complete information. Reimbursement for covered over the counter contraceptives (prescription required) can be submitted by sending in your original prescription receipt obtained from your pharmacy to: CVS Caremark PO Box 52136 Phoenix, AZ 85072-2136 You may also submit prescription reimbursement requests online via Caremark web portal geha.com/Prescriptions-Summary or Caremark mobile app (available for Android and Apple). Notes: • 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 FEHB plan. • Some contraceptives and services are covered under the medical benefit; see Section 5(a), *Family Planning*.	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 geha.com/Prescriptions-Summary 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, growth hormone therapy, 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 coinsurance will be prorated. If you continue on this therapy, you may receive up to a 30-day supply of the medication.

Your benefit includes the Advanced Control Specialty Formulary (ACSF); please see *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**. You or your provider need to call us at 800-821-6136 or visit geha.com/Provider-Partner-Tools.

*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 will be based on days of therapy (length of time medication remains in your system).

Benefits Description	You pay After the calendar year deductible...
Specialty drug benefits	**HDHP**
CVS Specialty Pharmacy All coinsurance is 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. Notes: • If you or your physician chooses a brand name specialty drug for which a generic drug exists, you will pay the applicable coinsurance and the difference between the cost of the brand name drug and the cost of the generic drug. Your physician may call 855-240-0536, if they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance. • Recurring oral medications must be obtained through the pharmacy benefit. • **Specialty medications dispensed by other sources including physician offices, home health agencies, and outpatient hospitals may be paid under the medical benefit**, see Section 5(a), *Treatment Therapies,* or Section 5(c), *Outpatient facility.*	• Generic and Preferred: 25% of Plan allowance, up to a 30-day supply • Non-Preferred: 40% of Plan allowance, up to a 30-day supply

Benefits Description	You pay After the calendar year deductible...
Preventive care medications	**HDHP**
Preventive Care: The following preventive medications are covered as recommended under the Patient Protection and Affordable Care Act (ACA). Preventive medications with USPSTF A and B recommendations are covered with no cost-share 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/ BrowseRec/Index/Browse-recommendations. Age restrictions apply. To receive preventive care benefits, a prescription from a doctor must be presented to the pharmacy. A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written, when an FDA approved generic drug is available unless substitution is prohibited by state law. • Aspirin - All single ingredient generic oral dosage forms less than or equal to 81mg OTC only (requires a prescription) for the prevention of pre-eclampsia after 12 weeks of gestation. Limit of 100 units per fill. • 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. • Fluoride supplements (not toothpaste or rinses) - Single ingredient brand name and generic prescription products in an oral dosage form less than 0.5mg for children five 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 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 G.E.H.A's exclusive Specialty Pharmacy. • Iron supplements - Single ingredient pediatric oral liquids (requires a prescription) for children age 6-12 months. • Opioid rescue agent under this Plan with no cost share when obtained from a network pharmacy with a prescription. Limited to three doses annually (requires a prescription). 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 800-662-4357 or go to https ://www. findtreatment.samhsa.gov/. **Prior authorization may be required on some formulations.** • Statins - Certain statins for individuals age 40-75 years.	Nothing (no deductible)

Preventive care medications - continued on next page

Benefits Description	You pay After the calendar year deductible...
Preventive care medications (cont.)	**HDHP**
• Women's 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.	Nothing (no deductible)
• Immunizations: Vaccines; childhood and adult, RX only - Coverage dependent on vaccine type. - G.E.H.A 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 844-443-4279 to identify a participating vaccine pharmacy or go to geha.com/Prescriptions-Summary. G.E.H.A 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. G.E.H.A members should also ask retail pharmacies if there is an age requirement for vaccines that can be administered at that pharmacy.	Nothing (no deductible) for most vaccines. Please check with CVS Caremark at 844-443-4279 for coverage benefits.
• Tobacco cessation - Gum, lozenge, patch, inhaler, spray and oral therapy, brand name and generic coverage, RX and OTC (requires a prescription). - We will cover over the counter (with a physician's prescription) and prescription tobacco cessation drugs approved by the FDA. The quantity of drugs reimbursed will be subject to recommended courses of treatment. You may obtain tobacco cessation drugs with your G.E.H.A ID card, through a participating network retail pharmacy, CVS Caremark Mail Service Pharmacy, or a non-network retail pharmacy (see previous section *Covered medications and supplies* for filing instructions). Note: For additional information on Tobacco Cessation *Educational Classes and Programs*, see Section 5(a).	Nothing (no deductible), day supply limits apply depending on therapy
Non-covered medications and supplies	**HDHP**
The following medications and supplies are not covered under the G.E.H.A prescription drug benefit: *Not covered:* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at non-Plan pharmacy; except for out-of-area emergencies*	*All charges*

Non-covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible...
Non-covered medications and supplies (cont.)	**HDHP**
• *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 (see Section 5(a), Treatment Therapies, for details)* • *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* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria* *If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. Ongoing sex-trait modification hormone treatment is not a covered benefit under this plan as of 1/1/2026. Our exception process is as follows: To initiate the exception process, contact Customer Care at 800-821-6136, Monday-Friday, 8 a.m.-8 p.m. E.T. If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process.* *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*

Section 5(g). Wellness and Other Special Features

Special features	Description
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to 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).
Impaired Hearing Services	TTY service is available at 800-821-4833 for members who are hearing impaired.
Wellness Incentives	Earn rewards for healthy actions with G.E.H.A's Wellness Incentives program. Total annual rewards are limited to $250 each for the subscriber and covered spouse. Maximum reward amounts are not guaranteed. Rewardable activities include, but may not be limited to, the following: • Health assessment (must complete to be eligible for additional rewards) • Preventive cancer screenings (Cervical, Colorectal, and Breast) • Annual physical • Health and Wellness webinars Members will be issued a rewards account with a reloadable debit card, which can be used for eligible dental and/or vision expenses and, once they have satisfied their deductible, can be used for eligible medical expenses. **For detailed information about eligibility requirements, how to access the health assessment and all available rewards, visit geha.com/Reward-My-Health.**
24-hour Nurse Advice Line	Call the G.E.H.A 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 24-hour Nurse Advice Line allows you to conveniently manage your symptoms and treatment anywhere you have access to a phone.

Telehealth	Telehealth is available at a reduced cost through the Plan's administrative partner. Go to geha.com/Telehealth-Visit 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, *Definitions of Terms*), dermatology conditions (see Section 10, *Definitions of Terms*) and counseling for mental health and substance use disorder. Notes: • This benefit is available at reduced cost only through the Plan's administrative partner. • Practitioners must be licensed in the state where the patient is physically located at the time services are rendered.
Weight Management	G.E.H.A offers a number of services and tools for weight management. • BMI calculation through on-line health risk assessment • Nutrition counseling (see *Educational Classes and Programs*, Section 5(a)) • Behavior change programs with coaching for members who qualify • Discounts for gym memberships and other services through Connection Fitness • Bariatric surgery, when medically necessary. Bariatric surgery must be preauthorized.
G.E.H.A Maternity Program	G.E.H.A makes various maternity resources available to you or your covered dependent. Visit geha.com/Healthy-Pregnancy to order your packet on pregnancy and prenatal care and to learn more about the maternity program.
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	G.E.H.A 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 geha.com/Your-Health-Journey for a list of programs, program criteria, and contact information. Please note that eligibility for these services may vary, and not all members will qualify.
Family Planning Care Program	G.E.H.A Care Management resources and guidance are available to assist members or covered dependents through the infertility process. Visit geha.com/Family-Planning-Support. Note: Infertility coverage is limited. See Section 5(a), *Infertility services,* for covered services.
Preconception Program	G.E.H.A 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 geha.com/Pregnancy-Prep.
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 • Access the Plan's telehealth partner at geha.com/Telehealth-Visit

	• 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 geha.com/My-Member-Portal.
Clinical Assistance Programs	G.E.H.A offers several programs to support and partner with you during your healthcare journey. When you are experiencing a new diagnosis or struggling with managing your health, G.E.H.A is here to support you by offering various programs. You may find out more about our programs at geha.com/Your-Health-Journey. A nurse case manager may contact you to participate in one of these programs and provide assistance with the coordination of your care, education and clinical support. Please note that eligibility for these services may vary, and not all members will qualify.
Health Education Resources	Visit our website at geha.com/Provider-Partner-Tools for information on: • General health topics • Links to healthcare news • Cancer and other specific diseases • Drugs/medication interactions • Kids' health • Patient safety information • Helpful website links
Care Support	• G.E.H.A has a strong patient safety program. Pharmacy initiatives help ensure that members have fewer health complications related to prescription drugs. Disease management programs help our members with specific health conditions such as heart disease and diabetes. Medical case managers assist patients with high-risk pregnancies, durable medical equipment, transplants and other special needs. • Patient safety information is available online at geha.com/Provider-Partner-Tools.
Account Management Tools	If you have an HDHP (with either the HSA or HRA): • Complete claims payment history is available online through geha.com/My-Member-Portal; and • You will also receive an (EOB) after every claim. If you have an HSA under the HDHP: • You will receive a monthly statement from the HSA Bank™ outlining your HSA account balance and activity for the month; • You may also access your HSA account on-line at geha.com/HDHP-HSA. If you have an HRA under the HDHP: • Your HRA account balance will be available on-line through your Member Account at geha.com/My-Member-Portal; and • To request reimbursement from your HRA account for qualified out-of-pocket medical expenses that are not submitted to G.E.H.A by your doctor, hospital, dentist or pharmacy, call G.E.H.A's Customer Care at 800-821-6136 or go to geha.com/My-Member-Portal to obtain our Health Reimbursement Arrangement Claim Form. This form is also used to request reimbursement from your HRA for Medicare premiums.

Special features	Description
Consumer Choice Information	• If you have our HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. You can find network providers online at geha.com/My-Member-Portal. • Pricing information for prescription drugs is available at www.caremark.com. • Link to online pharmacy through CVS Caremark at www.caremark.com. • Educational materials on the topics of HSAs, HRAs and HDHPs are available at geha.com/My-Member-Portal.

Non-FEHB Benefits Available to Plan Members

The benefits in this Section are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or 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 800-821-6136 or visit our website at geha.com/Get-Support.

Connection Hearing® - 844-224-2711 - geha.com/Hearing-Savings
G.E.H.A members and their families, including over-age children, domestic partners, same-sex spouses, parents, and grandparents, can save 30% to 60% off the average retail price of hearing aids through the Plan's hearing partner. Shop from a selection of more than 100 of the latest hearing aids from the top hearing aid manufacturers in the world.

Call to set up an appointment with a provider in your area or go online to learn more.

Connection Fitness® - 800-821-6136 - geha.com/Fit-For-Less
G.E.H.A promotes healthy lifestyles and fitness activities. G.E.H.A 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 - geha.com/Discount-Dental
Free to G.E.H.A 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 G.E.H.A health plan members. To find a participating Connection Dental provider in your area, call or go online.

Connection Dental Plus® - 833-434-2988 - geha.com/More-Dental-Care
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 Federal employees, retirees and annuitants, including those who are not members of the G.E.H.A health plan. Learn more about eligibility and coverage by calling or going online.

Oral Care Program - 855-944-8361 - geha.com/Smile-Savings
G.E.H.A members save up to 70% off a premium electric toothbrush and 20% off of the lowest-published price for professional teeth-whitening when using our preferred partner. Supplies such as custom-fitted trays, teeth whitening gel and desensitizing gel can be ordered online. Call or go online to learn more about the brands and products offered by G.E.H.A.

Emergency Response Services - 800-640-0518 - geha.com/Medical-Alert-System

G.E.H.A members and their extended family (including over-age children, domestic partners, same-sex spouses, parents and grandparents) can receive discounted emergency response services.

To receive this G.E.H.A discount (free activation plus a 10% discount on your monthly billing), call and request a free brochure. A representative will follow up after the brochure arrives to discuss your options.

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, *Other services that require preauthorization*.

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 related to sexual dysfunction or sexual inadequacy.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program or other Federal Programs.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- 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, occupational and speech therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services or supplies for cosmetic purposes.
- Surgery to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit.
- Services or supplies not specifically listed as covered.
- Services or supplies not reasonably necessary for the diagnosis or treatment of an illness or injury, except for routine physical examinations and immunizations.
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges 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 charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare "limiting charge" (see Section 9, *Coordinating Benefits with Medicare and Other Coverage*), services, drugs or supplies related to avoidable complications and medical errors, "Never Event" policies (see *Preventing Medical Mistakes*) or State premium taxes however applied.
- Charges in excess of the "Plan allowance" as defined in Section 10.
- Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital.
- Stand-by physicians and surgeons.
- Clinical ecology and environmental medicine.
- Chelation therapy except for acute arsenic, gold, or lead poisoning.

- Treatment for impotency, even if there is an organic cause for impotency. Exclusion applies to medical/surgical treatment as well as prescription drugs.
- Treatments other than surgery or orthopedic appliances for temporomandibular joint dysfunction and disorders (TMJ).
- Computers, tablets, wearable or digital devices, software or application programs (“apps”, including phone apps), and subscriptions are not covered (even if ordered by a doctor) unless explicitly stated as a covered service or as offered through participation in a clinical program.
- Surgical treatment of hyperhidrosis unless alternative therapies such as Botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful.
- Weight loss programs.
- Home test kits including but not limited to HIV and drug home test kits.
- Services, drugs, or supplies ordered or furnished by a non-covered provider.
- Services provided by school systems to children are not reimbursable by the health plan.
- Services or supplies we are prohibited from covering under the Federal law.
- Any benefits or services required solely for your employment are not covered by this plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include “gender transition” services), other than mid-treatment exceptions, see Section 3, *How You Get Care*.
- Medical and prescription drugs related to Sex-Trait Modification are excluded.

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 prior Plan approval), 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 geha.com/My-Member-Portal.

In most cases, providers and facilities file HIPAA compliant electronic claims for you. In cases where a paper claim must be used, the 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 G.E.H.A ID card, for both in and out-of-network claims.

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

G.E.H.A 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:

G.E.H.A 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 geha.com/UM-Care-Form. 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);
- The charge for each service or supply.

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 any 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.
- If your claim is for the rental or purchase of durable medical equipment, private duty nursing or physical therapy, occupational therapy, or speech therapy, you must provide a written statement from the provider specifying the medical necessity for the service or supply and the length of time needed.

- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing provider's 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 of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. 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 facilities outside the United States and Puerto Rico, send a completed Overseas Claim Form and the itemized bills to: G.E.H.A Medical Claims, PO Box 21172, Eagan, MN 55121. Obtain Overseas Claim Forms from geha.com/Health-Overseas-Access and overseas dental claim forms from geha.com/Dental-Overseas-Access.

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.

If you have questions about the processing of overseas claims, contact us at 800-821-6136 or go to geha.com/My-Member-Portal. Covered providers outside the United States will be paid at the in-network level of benefits, subject to Plan deductible and 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.

You may be required to pay for the services at the time you receive them and then submit a claim to us for reimbursement. Proof of payment is required to be submitted with Overseas Claim Form. Canceled checks, cash register receipts, or balance due statements are not acceptable. All foreign claim payments will be made directly to the enrollee.

When members living abroad are stateside and seeking medical care, contact us at 800-821-6136, or visit geha.com/Locate-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.

Note: It is recommended that any member traveling outside the United States or territories purchase Travel Insurance.

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.

Please follow this Federal Employees 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, referrals, 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 Care Department by writing G.E.H.A Post-Service Appeals, PO Box 21324, Eagan, MN 55121 or calling 800-821-6136.

For additional information on the Claim Dispute Process go to geha.com/My-Member-Portal.

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.

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; b) To do so you may log in at geha.com/My-Member-Portal and complete the online appeal submission form or send your request to us at: Pre-Service Appeals: G.E.H.A, PO Box 400046, San Antonio, TX 78229 or Post-Service Appeals: G.E.H.A, PO Box 21324, Eagan, MN 55121 c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; e) 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: a) Pay the claim, or b) Write to you and maintain our denial, or c) 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, Federal Employees Insurance Operations, FEHB 2, 1900 E Street NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; • 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 so they can quickly review your claim on appeal. You may call OPM's FEHB 2, at 202-606-3818.

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.

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 www.naic.org or geha.com/Multiple-Plans.

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

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, minus any cost share you may owe, up to our regular benefit, or up to the member's responsibility as determined by the primary plan, whichever is less. We will not pay more than what we would have paid if we were primary. When applicable, authorization must be given to Us to obtain information about benefits or services available from the other coverage, or to recover overpayments if this Plan previously paid as primary. All terms and conditions of this Plan, as secondary payor, remain in force.

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 FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage 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 FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage 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 G.E.H.A 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.

Maternity care expenses incurred by a Plan member serving as a surrogate 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 that may be received 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.

All G.E.H.A 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 G.E.H.A'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 G.E.H.A requires to obtain information about any claim(s) for compensation from other sources you may have.

- You must include all benefits paid by G.E.H.A 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 G.E.H.A for up to the amount of the benefits paid.
- When benefits are payable under the Plan in relation to the illness or injury, G.E.H.A 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 G.E.H.A 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 FEHB 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 G.E.H.A 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"). G.E.H.A 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. G.E.H.A's lien consists of the total benefits paid to diagnose or treat the illness or injury. G.E.H.A'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.

G.E.H.A's lien extends to all expenses incurred prior to the settlement or judgment date, even if those expenses were not submitted to G.E.H.A for payment at the time you reimbursed G.E.H.A. The lien remains your obligation until it is satisfied in full. Failure to refund G.E.H.A 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 medical plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your medical 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 877-888-3337, TTY 877-889-5680 you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB plan 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.

When you have Medicare

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

- **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 and you are an annuitant/ retiree, 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 geha.com/Medicare-Options.

We do NOT waive deductibles or coinsurance for Medicare members enrolled in the High Deductible Health Plan.

Services obtained from a non-Medicare provider: We will limit our payment to the cost share amount we would have paid after Original Medicare's payment based on our Plan allowable and the type of service you receive.

You can find more information about how our Plan coordinates benefits with Medicare as outlined in our *Medicare Benefits Guide* at **geha.com/Medicare-Options**.

- **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 800-633-4227, 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 plan's Medicare Advantage plan and also remain enrolled in our FEHB 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, we will not waive any of our 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 Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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 FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal 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 FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*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, 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 FEHB 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 FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount - the "equivalent Medicare amount" - set by Medicare's rules for what Medicare would pay, not on the actual charge.
- You are responsible for your applicable deductibles 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 and coinsurance.

If your physician:
Participates with Medicare and is **not** in our network,
Then you are responsible for: your deductibles, coinsurance, 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, 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, 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.

Although your provider of service **accepts** Medicare assignment, we **do not** waive your deductibles, or 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 a 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 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.

Calendar year deductible

There is an in-network deductible and an out-of-network deductible for the entire Plan year for covered services - medical, prescription, inpatient, outpatient, mental health and manipulative therapy - you must incur for almost all covered services and supplies before we start paying benefits.

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 be covered by the G.E.H.A 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 described in this brochure are effective:

- January 1 for continuing enrollments and for all annuitant enrollments;
- The first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during the open season for the first time; and
- For new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system.

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

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

Experimental or investigational services A medical, surgical, diagnostic, psychiatric, mental health, substance use disorder, or other healthcare service, technology, supply, treatment, procedure, drug, medication, device, or biological product (referred to as "service") is experimental or investigational if the Plan determines any of the following to apply:

1. A service which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given for the proposed use or patient-specific diagnosis or condition at the time it is furnished.
2. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis for the proposed use or patient-specific diagnosis or condition.
3. Reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
4. Reliable evidence shows that the healthcare service does not improve health outcome, is not more beneficial as established alternative(s) for the proposed use or patient specific condition or diagnosis, service does not produce improvement outside of the research setting or is otherwise not consistent with generally accepted standards of medical practice in the United States.
5. Reliable evidence shall mean credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, nationally recognized evidence-based clinical guidelines and criteria from independent sources, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas, and any other relevant factors. Please refer to geha.com/Coverage-Criteria for details on the literature used in medical decision making.

Determination of experimental/investigational status may require review of appropriate government publications such as those of the National Institute of Health, National Cancer Institute, Agency for Healthcare Policy and Research, Food and Drug Administration, National Library of Medicine, the American Hospital Formulary Service, or the United States American Hospital Pharmacopoeia Dispensing Information. We reserve the right to consult expert opinion in determining whether healthcare services are Experimental or Investigational.

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.

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 are focused on developing skills that were never present.

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

Health reimbursement arrangement (HRA)	Tax-free health plan deposits provided by us which allows you to accumulate savings for tax-free withdrawals for qualified medical expenses including your health plan deductible and other qualified out-of-pocket medical expenses.
Health savings account (HSA)	A tax-free account with monthly contributions made by us which earn interest for you to accumulate funds to help cover the deductible and other medical out-of-pocket expenses that roll over from year to year when not used for medical expenses. You have the option to make additional contributions to your account up to the maximum allowed by 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.
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.
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.
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 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).

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. G.E.H.A 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. G.E.H.A will not cover "grocery" food items that can routinely be obtained online or in stores (e.g., gluten-free breads).

Medical necessity

Healthcare services, drugs, supplies or equipment provided by a hospital or covered provider of the healthcare services for the purpose of preventing, evaluating, diagnosing, or treating a Medical or Behavioral Health Condition, that the Plan determines are all of the following:

- Are clinically appropriate to diagnose or treat the patient's condition, illness or injury in terms of type, frequency, extent, site and duration of treatment, and treatment setting are considered effective for your condition;
- Are consistent with generally accepted standards of medical practice in the United States.
- Generally accepted standards of medical practice are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, nationally recognized evidence-based clinical guidelines and criteria from independent sources, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas, and any other relevant factors. Please refer to geha.com/Coverage-Criteria for details on the literature used in medical decision making.
- Are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- Are not a part of or associated with the scholastic education or vocational training of the patient;
- Are not more costly than an alternate drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of your condition;
- In the case of inpatient care, cannot be provided safely as observation or on an outpatient basis;
- Is not custodial or long-term care (see the Plan's definition).

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary. 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. Some 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 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 misuse or dependence upon substances such as alcohol, narcotics, or hallucinogens; may also be collectively referred to as Behavioral Health conditions. Precertification 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 under Covered Facilities.
- Residential Treatment Center (RTC): See Section 3 under Covered 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 G.E.H.A's definition of a covered provider in Section 3. G.E.H.A 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 disorder 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.

The Plan provides outpatient hospital benefits for observation care. If you are in the hospital for more than a few hours, confirm with your physician whether your stay is inpatient or outpatient so that you are aware of how your hospital claim will be processed.

Plan

A Fee-for-Service High Deductible Health Plan with a Preferred Provider Network administered by G.E.H.A as permitted through contract with Office of Personnel Management (OPM).

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.

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.

We determine our Plan allowance as follows:

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: 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 the federal law.

2. The Plan allowance for covered services received from out-of-network providers, including physicians or healthcare facilities, are determined by the ClearHealth CRS program and is 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 at 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.
Premium contribution to HSA/HRA	The portion of your monthly health plan premium that is credited toward our annual HSA deposit to your HSA based on your effective date of enrollment; or the portion of your health plan premium credited to your HRA which is available to you upon your enrollment in this Plan.
Primary care provider	Physician that focuses on a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants who are practicing within the scope of their license and are credentialed and designated by the Plan to be primary care physicians. They often maintain long-term relationships with patients and treat a range of health-related issues. 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.
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.
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 preauthorization. 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.
Speech generating devices	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.

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 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.

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 Care 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.

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

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Summary of Benefits for the HDHP of the Government Employees Health Association, Inc. 2026

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 FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at geha.com/Plan-Summaries. 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.

In 2026, for each month you are eligible for the Health Savings Account (HSA), we'll deposit $83.33 per month for Self Only enrollment or $166.66 per month for Self Plus One or Self and Family enrollment to your HSA. For 2026, a monthly premium pass through that is not a whole number will have any remaining balance included in the final monthly contribution. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), we'll contribute up to $1,000 for Self Only and $2,000 for Self Plus One or Self and Family annually when you are enrolled in the HDHP. The amount of your HRA (prorated for the number of months remaining in the calendar year) will be available to you upon enrollment. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the $1,800 Self Only or $3,600 Self Plus One or Self and Family calendar year deductible when you use in-network providers; or subject to the $4,500 Self Only or $9,000 Self Plus One or Self and Family calendar year deductible when you use out-of-network providers. Only plan allowance paid for services or supplies from out-of-network providers counts towards this amount. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other healthcare professional.

HDHP Benefits	You pay	Page
In-network medical preventive care:	In-network: Nothing Out-of-network: Covered under Traditional medical coverage subject to deductible	42
Medical/surgical services provided by physicians: Diagnostic and treatment services provided in the office	In-network: 5%* for covered office visits and 5%* of other covered professional services including x-ray and lab Out-of-network: 35%* of covered professional services	51
Services provided by a hospital: Inpatient	In-network: 5%* of covered hospital charges Out-of-network: 35%* of covered hospital charges	79
Services provided by a hospital: Outpatient	In-network: 5%* of covered hospital charges Out-of-network: 35%* of covered hospital charges	80
Emergency benefits: Accidental injury	Regular benefits*	85
Emergency benefits: Medical emergency	Regular benefits*	85
Mental health and substance use disorder treatment:	Regular cost-sharing*	87
Prescription drugs: Retail pharmacy (up to a 30-day supply)	Network pharmacy Generic/Preferred: Member pays 25%* Non-Preferred: Member pays 40%* Non-network pharmacy	95

	Generic/Preferred: Member pays 25%* and any difference between our allowance and the cost of the drug Non-Preferred: Member pays 40%* and any difference between our allowance and the cost of the drug	
Prescription drugs: Mail order (up to a 90-day supply)	Generic/Preferred: Member pays 25%* Non-Preferred: Member pays 40%*	98
Dental care:	All charges for diagnostic and preventive services which exceed Plan limits; and charges in excess of the scheduled amounts for restorations and extractions	45
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $6,000/Self Only or $12,000/Self Plus One or Self and Family enrollment per calendar year for in-network providers. Some costs do not count toward this protection. Nothing after $8,500/Self Only or $17,000/Self Plus One or Self and Family enrollment per calendar year for out-of-network providers. Some costs do not count toward this protection. Only out-of-pocket expenses from out-of-network providers count towards those limits.	28

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2026 Rate Information for Government Employees Health Association, Inc. (G.E.H.A) Benefit Plan

To compare your FEHB health plan options, please go to www. opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to **www. opm.gov/FEHBpremiums** or **www. opm.gov/Tribalpremium**.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Nationwide					
HDHP Option Self Only	341	$244.85	$81.62	$530.51	$176.84
HDHP Option Self Plus One	343	$526.41	$175.47	$1,140.56	$380.18
HDHP Option Self and Family	342	$646.88	$215.63	$1,401.58	$467.19