GEHA Benefit Plan

www.geha.com

800-821-6136

GEHA®

2020

A Fee-for-Service (High and Standard Options) health plan 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.

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

IMPORTANT
- Rates: Back Cover
- Changes for 2020: Page 14
- Summary of Benefits: Page 125

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

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

Membership dues: There are no membership dues for the Year 2020.

Enrollment codes for this Plan:

311 High Option - Self Only
313 High Option - Self Plus One
312 High Option - Self and Family
314 Standard Option - Self Only
316 Standard Option - Self Plus One
315 Standard Option - Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Government Employees Health Association, Inc. About

Our Prescription Drug Coverage and Medicare

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 choose to enroll in Medicare Part D, 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's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent 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.

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

Visit www.medicare.gov for personalized help, call 800-MEDICARE 800-633-4227, TTY: 877-486-2048.

Table of Contents

Introduction 3
Plain Language 3
Stop Health Care Fraud! 3
Discrimination is Against the Law 4
Preventing Medical Mistakes 5
FEHB Facts 7
Coverage information 7
- No pre-existing condition limitation 7
- Minimum essential coverage (MEC) 7
- Minimum value standard (MVS) 7
- Where you can get information about enrolling in the FEHB Program 7
- Types of coverage available for you and your family 7
- Family member coverage 8
- Children's Equity Act 9
- When benefits and premiums start 9
- When you retire 10

When you lose benefits 10
- When FEHB coverage ends 10
- Upon divorce 10
- Temporary Continuation of Coverage (TCC) 10
- Finding Replacement Coverage 10
- Health Insurance Marketplace 11

Section 1. How This Plan Works 12
General features of our High and Standard Options 12
How we pay providers 13
Your rights and responsibilities 13
Your medical and claims records are confidential 13
Section 2. Changes for 2020 14
Changes to High and Standard Options 14
Section 3. How You Get Care 16
Identification cards 16
Where you get covered care 16
- Covered providers 16
- Covered facilities 16
- Transitional care 18
- If you are hospitalized when your enrollment begins 18

You need prior Plan approval for certain services 19
- Inpatient hospital admission (including Residential Treatment Centers, Skilled Nursing Facility, Long Term Acute Care or Rehab Facility) 19
- Non-urgent care claims 20
- Urgent care claims 20
- Concurrent care claims 20
- Emergency inpatient admission 21
- Maternity care 21
- NICU cases 21
- If your hospital stay needs to be extended 21
- Other services that require preauthorization 22

- Radiology/Imaging procedures preauthorization 23
- If your treatment needs to be extended 24

If you disagree with our pre-service claims decision 24
- To reconsider a non-urgent care claim 24
- To reconsider an urgent care claim 24
- To file an appeal with OPM 25

Overseas claims 25

Section 4. Your Costs for Covered Services 26
- Coinsurance 26
- Copayments 26
- Cost-sharing 26
- Deductible 26
- If your provider routinely waives your cost 26
- Waivers 27
- Differences between our allowance and the bill 27
- Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments 28
- Carryover 28
- If we overpay you 29
- When Government facilities bill us 29

Section 5. Benefits 30

High and Standard Option Overview 32

Non-FEHB Benefits Available to Plan Members 96

Section 6. General Exclusions - Services, Drugs and Supplies We Do Not Cover 97

Section 7. Filing a Claim for Covered Services 99

Section 8. The Disputed Claims Process 102

Section 9. Coordinating Benefits with Medicare and Other Coverage 105

When you have other health coverage or auto insurance 105
- TRICARE and CHAMPVA 105
- Workers' Compensation 105
- Medicaid 106

When other Government agencies are responsible for your care 106

When others are responsible for injuries 106

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) 107

Clinical trials 107

When you have Medicare 108
- What is Medicare? 108
- Should I enroll in Medicare? 108
- The Original Medicare Plan (Part A or Part B) 109
- Tell us about your Medicare coverage 111
- Private contract with your physician 111
- Medicare Advantage (Part C) 112
- Medicare prescription drug coverage (Part D) 112

When you are age 65 or over and do not have Medicare 114

When you have the Original Medicare Plan (Part A, Part B, or both) 115

Section 10. Definitions of Terms We Use in This Brochure 116

Index 123

Summary of Benefits for the High Option of the Government Employees Health Association, Inc. 2020 125

Summary of Benefits for the Standard Option of the Government Employees Health Association, Inc. 2020 127

2020 Rate Information for Government Employees Health Association, Inc. (GEHA) Benefit Plan 130

Introduction

This brochure describes the benefits of **Government Employees Health Association, Inc.** under our contract (CS 1063) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by Government Employees Health Association, Inc. Customer service may be reached at 800-821-6136 or through our website at www.geha.com. The address for the Government Employees Health Association, Inc. administrative offices is:

Government Employees Health Association, Inc.
P.O. Box 21542
Eagan, MN 55121

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, 2020, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2020, and changes are summarized on page 14. 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 or 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 Health Care Fraud!

Fraud increases the cost of health care 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 telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care 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 Explanation of Benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 844-510-0048 or go to www.lighthouse-services.com/geha and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE 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 as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 26 (unless he/she was 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 dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain 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

Government Employees Health Association, Inc. complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, Government Employees Health Association, Inc. does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

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

3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
   - Don’t assume the results are fine if you do not get them when expected. Contact your health care 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 health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, “Who will manage my care when I am in the hospital?”
   - Ask your surgeon:
     - “Exactly what will you be doing?”
     - “About how long will it take?”
     - “What will happen after surgery?”
     - “How can I expect to feel during recovery?”

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

Patient Safety Links

For more information on patient safety, please visit

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care 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 health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care 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 health care professionals working to improve patient safety.

Preventable Health Care 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 health care 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 costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct "Never Events", if you use Aetna Signature Administrators, UnitedHealthcare Options PPO, or UnitedHealthcare Choice Plus. "Never Event" is defined by your claims 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 health care 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 (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. 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, and give you brochures for other plans 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 don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

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

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

Your employment or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches 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 a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	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	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	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	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 has implemented 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 this law applies to you, and only one child is involved in the court or administrative order, you may enroll for Self Plus One coverage in a health plan that provides full benefits in the area where your child lives or provide documentation to your employing office that you have obtained other health benefits coverage for the child. 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 paid according to the 2020 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2019 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 hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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 divorced from a Federal employee or annuitant, you may not continue to get benefits 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 choices. You can also visit OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. 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.

- **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). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. 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, if you are a covered dependent 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/healthcare/plan-information/guides. 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 new kind of 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 FEHBP coverage.

- **Finding Replacement Coverage**

When you contact GEHA, we will assist you with obtaining information about health benefits coverage inside or outside the Marketplace if:

- Your coverage under TCC or the spouse equity law ends;
- You decide not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

You must contact us in writing within 31 days after you are no longer eligible for coverage. For assistance in finding coverage, please contact us at 800-821-6136 or visit our website at www.geha.com.

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

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health 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. You can choose your own physicians, hospitals, and other health care providers. We give you a choice of enrollment in a High Option or a Standard Option.

OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. GEHA holds the following accreditations: Health Plan Accreditation with Accreditation Association for Ambulatory Health Care (AAAHC) and Dental Network Accreditation with URAC. To learn more about this plan's accreditations, please visit the following websites: Accreditation Association for Ambulatory Health Care (www.aaahc.org); URAC (www.urac.org).

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 obstetrical or gynecological care do not require a referral.

General features of our High and Standard Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that we designate certain hospitals and other health care providers as "preferred providers." We assign you a "home network" based on the state where you live. Your home network is listed on your GEHA ID card. Please refer to the chart below to determine your home network.

Aetna Signature Administrators
Alaska, Arizona, California, Connecticut, Georgia, Kentucky, Maine, Massachusetts, Michigan, Nevada, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Vermont and Washington
UnitedHealthcare Options PPO
Alabama, Arkansas, Colorado, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, Washington DC, West Virginia, Wisconsin and Wyoming
UnitedHealthcare Choice Plus
Florida and Texas

The PPO organ/tissue transplant network for all members is LifeTrac. The PPO dialysis network for all members is the Preferred Outpatient Dialysis Network.

You have access to PPO providers inside and outside your home network. When you use a PPO provider in your home network, you are only responsible for the deductible, copayment, and coinsurance for covered charges. When you use a PPO provider that is outside your home network (in a GEHA network listed above but not printed on your GEHA ID card), GEHA will pay a PPO benefit based on a contracted rate, negotiated amount or a billed charge. You are still only responsible for the deductible, copayment, and coinsurance for covered charges. If you expect that you or a dependent will be residing outside of your home network for a temporary period of time, please contact GEHA for special assistance.

To find PPO providers, use the provider search tool on the www.geha.com website or call GEHA at 800-296-0776. When you phone for an appointment, please remember to verify that the physician is still a PPO provider. GEHA 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 a PPO provider or a non-PPO provider for medical treatment. When you see a provider not in the GEHA PPO network, GEHA will pay at the non-PPO level and you will pay a higher percentage of the cost.

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

How we pay providers

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

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

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

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

Health education resources

Our website, at www.geha.com, offers access to the Health e-Report® Newsletter and our Healthy Living resources for information on general health topics, health care news, cancer and other specific diseases, drugs/medication interactions, children's health and patient safety information.

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.

- GEHA was founded in 1937 as the Railway Mail Hospital Association. For over 80 years, GEHA has provided health insurance benefits to Federal employees and retirees.
- GEHA is incorporated as a General Not-For-Profit Corporation pursuant to Chapter 355 of the Revised Statutes of the State of Missouri.
- GEHA's provider network includes over 9,300 hospitals and over 2.7 million in-network physician locations throughout the United States. In circumstances where there is limited access to network providers, GEHA may negotiate discounts with some providers, which will reduce your overall out-of-pocket expenses.

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

If you wish to make a suggestion or a formal complaint or if you want more information about us, call 800-821-6136, or write to GEHA, P. O. Box 21542, Eagan, MN 55121. You may also visit our website at www.geha.com.

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

Your medical and claims records are confidential

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

Section 2. Changes for 2020

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

Changes to High and Standard Options

- Your share of the non-postal or postal premium will increase for Self Only, Self Plus One and Self and Family. See back cover.
- If you reside in Florida, your PPO network has been changed to UnitedHealthcare - Choice Plus. Previously, the PPO network for Florida was Aetna Signature Administrators. See page 12.
- The Plan will no longer require preauthorization for physical, occupational, and speech therapy. See Section 5(a), page 42, for details of coverage.
- The telehealth benefit will now include coverage for dermatology care. See Section 5(a) page 34, Section 5(e) page 74, and Section 5(h) page 94 for details of coverage.
- The Plan will now cover only generic contraceptives at 100% under the preventive benefit. Brand preferred and non-preferred contraceptives will be covered at the applicable cost share as shown in Section 5(f) *Preventive care medications*, page 89. If there is no generic equivalent or you are unable to use the generic contraceptive, cost sharing will be waived for the brand option.
- The Starter Fill Program allows members to receive a 14 or 15 day supply of specialty drugs for the first two months of therapy. This applies to certain specialty drug categories for members who are new to therapy and helps to minimize drug waste and unnecessary costs. See Section 5(f), pages 78 and 87, for specific information about this program.
- Optum will coordinate kidney transplants in states where the network is UnitedHealthcare Options PPO or UnitedHealthcare Choice Plus. See member notification instructions for kidney transplants in Section 5(b) *Organ/tissue transplants,* page 57.
- The Plan will provide four pairs of compression stockings per calendar year without a preauthorization requirement.

Changes to our High Option only

- Members enrolled in Medicare Parts A and B are now eligible to be reimbursed up to $600 per calendar year for Medicare Part B premium payments. See Section 5(h) *Wellness and Other Special Features*, page 93.

Changes to our Standard Option only

- The coinsurance maximum will increase for specialty drugs under the pharmacy benefit. For generic and brand preferred specialty drugs, the coinsurance remains 50%, but the maximum member responsibility will increase from $200 to $250. For brand non-preferred specialty drugs, the coinsurance remains 50%, but the maximum member responsibility will increase from $300 to $400. See Section 5(f) *Specialty drug benefits*, page 87.

We have clarified the following:

- We have updated language that cognitive rehabilitative therapy will be covered when medically necessary following brain injury or traumatic brain injury. See Section 5(a), page 44.
- We have provided additional resources through Lighthouse Services for reporting fraud, waste and abuse under *Stop Health Care Fraud!*, page 3.
- We provided clarification that the Health Advice Line is available 24 hours a day. References updated throughout the brochure.
- We have added clarifying language to the definition for Intensive Outpatient Treatment (IOP) in Section 10. *Definitions*, page 119.
- We have added language regarding the Plan's role in assisting enrollees to find non-group insurance coverage under *FEHB Facts*, page 10.

- We have added language in Section 3 and Section 7 under *Overseas Claims* to clarify that precertification is not required for procedures or hospitalizations outside the United States, but claims for these services will be reviewed for benefit eligibility and medical necessity. See pages 25 and 100.
- We have revised Section 5(f) *Non-covered medications and supplies* to clarify that the exclusions apply specifically to the pharmacy benefit. See page 90.
- We have added language at the beginning of Sections 5(a), 5(b), 5(c) and 5(d) clarifying that we provide benefits at the PPO level of coverage if you are admitted to a non-PPO hospital due to a medical emergency. See pages 33, 51, 63, 70.
- We have updated references to precertification and preauthorization throughout the brochure and added definitions for these terms in Section 10 to provide better consistency and clarity. See page 121.
- We have revised Section 3, *How to precertify a radiology/imaging procedure* to show that US Imaging will no longer be providing assistance with scheduling procedures. See page 23.
- We have provided additional language regarding recurring oral specialty and non-specialty medications that they must be obtained through the pharmacy benefit and outlining when they will not be covered. See Section 5(f) *Specialty drug benefits*, page 87.
- We have added language to further clarify Residential Treatment Center benefits. See pages 66, 76.
- We have added language under the You Pay column in Section 5(e). *Mental Health and Substance Use Disorders* to indicate the out of pocket responsibility when a member goes to non-PPO providers for services. See page 75.
- We have updated the list of *Not Covered* services in Section 5(e). *Mental Health and Substance Use Disorders*. The changes are to clarify existing exclusions, not new additions. See page 76.
- We have updated the specialty drug categories list that appears in Section 5(f) under *CVS Caremark Formulary*. See page 81.
- We have added a note to all instances of the telehealth benefit specifying that practitioners must be licensed in the state where the patient is physically located at the time services are rendered. See pages 34, 74, 94.
- We have updated Section 3 *Other services that require preauthorization* and Section 5(a) *Treatment therapies* to reflect coverage for total parenteral nutrition (TPN) and to indicate preauthorization is required. See pages 22 and 41.
- We have updated Section 3 *Other services that require preauthorization* to remove over-the-counter products from the list of treatments for advanced wound therapy. See page 22.
- We have reformatted the *Maternity* segments in Sections 5(a) and 5(c) to more clearly and accurately reflect the benefit and cost share. See pages 38 and 64.
- We clarified in Section 9 under *Medicare Advantage* that if you go outside the Medicare Advantage plan's network and/or service area, we will not waive our deductibles, coinsurance or copayments. See page 112.

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 GEHA, P. O. Box 21542, Eagan, MN 55121. You may also request replacement cards through our website: www.geha.com.

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.

- **Covered providers**

We provide benefits for the services of covered providers as required by 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.

Under the Plan, we consider covered providers to be medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law.

These covered providers may include: a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.); chiropractor; nurse midwife; nurse anesthetist; audiologist; dentist; optometrist; licensed clinical social worker; licensed clinical psychologist; licensed professional counselor; licensed marriage and family therapist; podiatrist; speech, physical and occupational therapist; nurse practitioner/clinical specialist; nursing school administered clinic; physician assistant; registered nurse first assistants; certified surgical assistants; board certified behavior analyst; board certified assistant behavior analyst; registered behavior technician; Christian Science practitioner, and a dietitian as long as they are providing covered services which fall within the scope of their state licensure or statutory certification.

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

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

- **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).

• Christian Science nursing organization/facilities that are accredited by The Commission for Accreditation of Christian Science Nursing Organization/ Facilities Inc.

• 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 on page 68.

• Hospital
- An institution which is accredited as a hospital under the Hospital Accreditation Program of The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitative Facilities (CARF) or is certified by Medicare; or
- A medical institution which is operated pursuant to law, under the supervision of a staff of doctors, and with 24-hour-a-day nursing service, and which is primarily engaged in providing general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which must be provided on its premises or have such arrangements by contract or agreement; or
- An institution which is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing service and which provides services on the premises for the diagnosis, treatment, and care of persons with mental/ substance use disorders and has, for each patient, a written treatment plan, which must include diagnostic assessment of the patient and a description of the treatment to be rendered, and provides for follow-up assessments by, or under, the direction of the supervising doctor.

• The term hospital does not include a convalescent home or skilled nursing facility, or any institution or part thereof which: a) is used principally as a convalescent facility, nursing facility, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operating as a school.

- Residential Treatment Centers (RTCs) must be accredited by a nationally recognized organization (e.g. CARF, Council on Accreditation (COA) or The Joint Commission (formerly JCAHO)) and licensed by the state, district or territory (if applicable) to provide residential treatment for medical conditions, mental health conditions and/or substance use disorder. If the RTC is not accredited nationally, or if state licensure is available but not obtained, the facility must be Medicare certified. Accredited health care facilities (see page 76 for exclusions) provide 24-hour residential evaluation, treatment, and comprehensive specialized services relating to the individual's medical, physical, mental health, and/or substance use disorder therapy needs.
- Partial Hospital Program or Intensive Outpatient Treatment Facility
  - Is licensed by the state, district or territory (if applicable) as a Day Treatment Program Facility;
  - **And** is accredited for behavioral health services by a nationally recognized organization.

- **Transitional care**

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

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than for cause,

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

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-821-6136. For members residing in Florida and Texas, call UnitedHealthcare Clinical Services at 877-585-9643. 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 hospital 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 or preauthorization and (2) will result in a reduction of benefits if you do not obtain precertification or preauthorization.

- **Inpatient hospital admission (including Residential Treatment Centers, Skilled Nursing Facility, Long Term Acute Care or Rehab Facility)**

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

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

How to precertify an admission to a Hospital, Residential Treatment Centers,Skilled Nursing Facility, Long Term Acute Care or Rehab Facility

First, you, your representative, your physician or your hospital must call Conifer Health Solutions (Medical Management Service – IMMS) before a hospital admission, Residential Treatment Center admission, or services requiring precertification are rendered. The toll-free number is 800-242-1025. For members residing in Florida and Texas, call UnitedHealthcare Clinical Services at 877-585-9643.

For admissions to Skilled Nursing Facilities, Long Term Acute Care Facilities, or Rehabilitation Facilities please call OrthoNet to precertify at 877-304-4419.

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 hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Warning:

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

- We will reduce our benefits for the Inpatient Hospital stay, Long Term Acute Care stay or Rehabilitation Facility stay by $500 if no one contacts us for precertification. 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.
- We will reduce our benefits for the Skilled Nursing Facility stay if no one contacts us for precertification. If the stay is not medically necessary we will not pay any benefits.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States;
- You have another group health insurance policy that is the primary payor for the hospital stay; or

- Medicare Part A is the primary payor for the hospital stay.

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

- **Non-urgent care claims**

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

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

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

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether 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 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at 800-821-6136. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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.

- **The Federal Flexible Spending Account Program - FSAFEDS**
  - Health Care FSA (HCFSA) – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
  - 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.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admission* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

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

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

- **NICU cases**

  Confinements of infants in the neonatal care unit at any level must be reported to GEHA. GEHA, in collaboration with Alere, will review NICU cases, and assign a level of care based on the infant's acuity and consistent with TIOP (March of Dimes report Toward Improving the Outcome of Pregnancy), the 2004 AAP (American Academy of Pediatrics) statement regarding hospital levels of care and NUBC (National Uniform Billing Committee). The facility is notified of the assigned level of care at the time the case is first reviewed and when a change occurs. If the facility bills for a higher level of care than is approved, you will be responsible for the difference between the higher level of care charge and the lower approved level of care charge.

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

  If your hospital stay - including for maternity care - needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then:
  - for the part of the admission that was medically necessary, we will pay inpatient benefits, but,
  - for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

- **Other services that require preauthorization**

Some surgeries and procedures, services and equipment require precertification or preauthorization.

For members residing in Florida and Texas, your provider must call UnitedHealthcare Clinical Services at 877-585-9643 for any services listed below, with the exception of those marked with an asterisk.

For the asterisked (*) services, and for all other members, you or your provider need to call us at 800-821-6136 or visit www.geha.com for preauthorization information:

- ACI (Autologous Cultured Chrondrocytes), also called Genzyme tissue repair (or Carticel) for knee cartilage damage;
- Abdominoplasty/panniculectomy/lipectomy;
- Ablative and surgical treatment of venous insufficiency including sclerotherapy and microphlebectomy;
- Advanced wound therapy provided in an outpatient setting such as skin substitutes, negative pressure wound therapy (wound vac systems), hyperbaric oxygen therapy (HBO);
- *Applied behavioral therapy;
- Attended full-channel nocturnal polysomnography laboratory sleep test performed in a healthcare facility;
- Back/spine surgeries;
- Bariatric procedures;
- Blepharoplasty or any other type of eyelid surgery or brow lift;
- Botox injections;
- Breast reconstruction except immediate reconstruction for diagnosis of cancer;
- Certain prescription drugs including Total Parenteral Nutrition;
- Chronic dialysis provided at a dialysis unit, outpatient hospital facility or in the home;
- Coma stimulation;
- Durable medical equipment (DME);
- ECT (electroconvulsive therapy);
- Epidural injections;
- Experimental/investigational surgery or treatment;
- Facet injections;
- *Genetic testing;
- Growth hormone therapy (GHT);
- Gynecomastia-cosmetic (see mammoplasty);
- *High tech outpatient radiology/imaging;
- Home health services provided by a qualified medical social worker (M.S.W.);
- Injectable drugs for arthritis, psoriasis or hepatitis;
- Injectable hematopoietic drugs (drugs for anemia, low white blood count);
- Inpatient hospital mental health and substance use disorder benefits, inpatient care at residential treatment centers and intensive day treatment;
- Intrathecal pump insertion for pain management (morphine pump, baclofen pump);
- Low-dose computed tomography (LDCT);
- Mammoplasty, reduction (unilateral/bilateral);

- Mastectomy performed prophylactically;
- Morbid obesity surgeries;
- *Non-surgical outpatient cancer treatment, including chemotherapy and radiation, online preauthorization through www.eviti.com;
- *Organ and tissue transplant procedures;
- Orthognathic surgery (jaw), including TMJ;
- *Other selected therapy services including cardiac and pulmonary rehabilitation;
- Prosthetic devices;
- Psychological testing;
- Rhinoplasty and septoplasty;
- Scar revisions;
- Skilled Nursing: Outpatient - Includes Home Skilled Nursing Care, intravenous (IV) therapy and TPN;
- *Speech generating devices;
- Surgical correction of congenital anomalies;
- Surgical treatment of gender dysphoria;
- Surgical treatment of hyperhidrosis (benefits will not be approved unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful);
- Sympathectomy by thoracoscopy or laparoscopy;
- TMS (Transcranial Magnetic Stimulation);
- *Transplants, except cornea (for kidney transplant notification instructions, refer to Section 5(b), page 57, under Organ/Tissue Transplants);
- UPPP Uvulopalatopharyngoplasty;
- *Ventricular assistive device (VAD) including post-hospital device supplies;
- Vision therapy; and
- Other surgeries, as identified by the Plan.

- **Radiology/Imaging procedures preauthorization**

Radiology preauthorization is the process by which prior to scheduling specific imaging procedures we evaluate the medical necessity of your proposed procedure to ensure the appropriate procedure is being requested for your condition. In most cases your physician will take care of preauthorization. Because you are still responsible for ensuring that we are asked to preauthorize your procedure, you should ask your doctor to contact us.

The following outpatient radiology/imaging services need to be preauthorized:

- CT - Computerized Axial Tomography;
- MRI - Magnetic Resonance Imaging;
- MRA - Magnetic Resonance Angiography;
- NC - Nuclear Cardiac Imaging Studies; and
- PET - Positron Emission Tomography.

How to preauthorize a radiology/imaging procedure:

For outpatient CT, MRI, MRA, NC and PET studies, you, your representative or your doctor must call eviCore Healthcare before scheduling the procedure. The toll-free number is 866-879-8317. Provide the following information: patient's name, plan identification number, birth date, requested procedure, clinical support for request, name and telephone number of ordering provider. Once you have received preauthorization approval, see below for scheduling services.

After you obtain preauthorization from eviCore Healthcare, you may be contacted for optional assistance in scheduling your radiology/imaging procedure.

You will not be contacted for this service if you have other primary coverage, Medicare A & B primary or Medicare Part B only.

Warning: You must get preauthorization for certain services. Failure to do so will result in a reduction of our benefits for these procedures by $100 if no one contacts us for preauthorization. If the procedure is not medically necessary, we will not pay any benefits.

Exceptions: You do not need preauthorization in these cases:

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

- **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 claims 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 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 health care 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 telephone, 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: GEHA, Foreign Claims Department, P.O. Box 21542, Eagan, MN 55121. Obtain Overseas Claim Forms from www.geha.com.

Precertification is not required when procedures are performed or you are admitted to a hospital outside of the United States. However, the procedure/service to be performed, the number of days required to treat your condition, and any other applicable benefit criteria, will be reviewed for benefit eligibility and/or medical necessity.

If you have questions about the processing of overseas claims, contact us at 877-320-9469 or by email overseas@geha.com. If possible, include a receipt showing the exchange rate on the date the claimed services were performed. Covered providers outside the United States will be paid at the PPO level of benefits, subject to deductible and coinsurance.

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

Coinsurance

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

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

Copayments

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

Example: When you see your PPO physician, under the High Option, you pay a copayment of $20 per visit.

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

Cost-sharing

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

Deductible

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

- The calendar year deductible is $350 per person under High and Standard Option. 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 $350. Under the Self Plus One and the Self and Family enrollments, once the calendar year deductible amount of $350 is satisfied for an individual, covered benefits are payable for that individual. Additionally, all individual deductible amounts will apply toward the Self Plus One or Family calendar year deductible of $700 for the High and Standard Options; once that amount is reached, benefits become payable for all family members.

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

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your 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 ($350 per person under High and Standard Option) 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 old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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

If your provider routinely waives your cost

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

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

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver please be aware that if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 800-821-6136 or write to GEHA, P. O. Box 21542, Eagan, MN 55121.

Differences between our allowance and the bill

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

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

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, with High Option, you pay just – 10% of our $100 allowance ($10). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his/her bill.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance - plus any difference between our allowance and charges on the bill. Here is an example. You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so with High Option you pay 25% of our $100 allowance ($25). Plus, because there is no agreement between the non-PPO physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.

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

EXAMPLE	**PPO Physician**	**Non-PPO physician**
Physician’s charge	$150	$150
Our allowance	We set it at: $100	We set it at: $100
We pay	90% of our allowance: $90	75% of our allowance: $75
You owe: Coinsurance	10% of our allowance: $10	25% of our allowance: $25
+Difference up to charge?	No: $0	Yes: $50
TOTAL YOU PAY	$10	$75

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

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

PPO

- For High Option, the out-of-pocket maximum is $5,000 for Self Only enrollment; $10,000 when enrollment is Self Plus One or Self and Family when you use PPO providers. For Standard Option the out-of-pocket maximum is $6,500 for self only enrollment; $13,000 when enrollment is Self Plus One or Self and Family if you use PPO providers. Only out-of-pocket expenses from PPO providers count toward these limits.
  - An individual under Self Plus One and Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum under a Self only enrollment.

Non-PPO

- For High Option the out-of-pocket maximum is $7,000 for Self Only enrollment; $14,000 when enrollment is Self Plus One or Self and Family. For Standard Option, the out-of-pocket maximum is $8,500 for Self Only enrollment; $17,000 when enrollment is Self Plus One or Self and Family if you use non-PPO providers. Any of the above expenses for PPO providers also count toward this limit. Non-PPO coinsurance will not accumulate to the PPO maximum. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use PPO Providers.
  - An individual under Self Plus One and Self and Family enrollment will never have to satisfy more than what is required for the out-of-pocket maximum under a Self only enrollment.

Out-of-pocket expenses for PPO and non-PPO 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;
- Expenses in excess of plan limits, for dental and manipulative therapy;
- The cost for non-approved medication and drugs that we exclude;
- Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements (see Section 3); and
- The difference (Standard and High Option) between the cost of the 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 old 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 old 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 old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old 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 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.

Section 5. Benefits

See Section 2 for how our benefits changed this year. Page 125 has a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

High and Standard Option Overview 32
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals 33
- Diagnostic and treatment services 33
- Urgent care facility 34
- Lab, X-ray and other diagnostic tests 34
- Lab Card, service of Quest Diagnostics 35
- Preventive care, adult 35
- Preventive care, children 38
- Maternity care 38
- Family planning 40
- Infertility services 40
- Allergy care 41
- Treatment therapies 41
- Physical, occupational, and speech therapy 42
- Hearing services (testing, treatment and supplies) 44
- Vision services (testing, treatment and supplies) 44
- Foot care 45
- Orthopedic and prosthetic devices 45
- Durable medical equipment (DME) 46
- Home health services 47
- Manipulative therapy 49
- Alternative treatments 49
- Educational classes and programs 49

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals 51
- Surgical procedures 51
- Reconstructive surgery 55
- Oral and maxillofacial surgery 56
- Organ/tissue transplants 57
- Anesthesia 62

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services 63
- Inpatient hospital 64
- Inpatient residential treatment centers (RTC) 66
- Outpatient hospital, clinic or ambulatory surgical center 67
- Extended care benefits/Skilled nursing care facility benefits 68
- Hospice care 68
- Ambulance - accidental injury 69
- Ambulance - non-accidental injury 69

Section 5(d). Emergency Services/Accidents 70
- Accidental injury 70
- Medical emergency 71
- Ambulance - accidental injury 72
- Ambulance - non-accidental injury 72

Section 5(e). Mental Health and Substance Use Disorder Benefits 73
- Professional services 73

Diagnostics....75
Lab Card, service of Quest Diagnostics....75
Inpatient hospital....75
Inpatient residential treatment centers (RTC)....76
Outpatient hospital....76
Emergency room - non-accidental injury....76
Section 5(f). Prescription Drug Benefits....78
Covered medications and supplies – when GEHA is primary....84
Covered medications and supplies – Medicare A & B primary....85
Specialty drug benefits....87
Preventive care medications....89
Section 5(g). Dental Benefits....91
Dental Services....91
Section 5(h). Wellness and Other Special Features....93
Flexible benefits option....93
Services for deaf and hearing impaired....93
Medicare Premium Reimbursement for High Option members enrolled in both Medicare Parts A and B....93
Health Rewards/Health Assessment....93
Lab Card, service of Quest Diagnostics....94
High risk pregnancies....94
24-hour Health Advice Line....94
Telehealth....94
Obesity screening and management....94
Personal Health Record....95
Value Added Programs and Services....95
Summary of Benefits for the High Option of the Government Employees Health Association, Inc. 2020....125
Summary of Benefits for the Standard Option of the Government Employees Health Association, Inc. 2020....127

High and Standard Option Overview

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

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

Each option offers unique features.

- **High Option**
  - Extensive provider network.
  - No requirement to choose a single doctor as your primary physician.
  - No referral needed to see a specialist. However, you might need preauthorization for certain services.
  - Generic drugs: $10 copay at a retail pharmacy; $20 for non-Medicare mail order; $15 for Medicare at the mail order pharmacy.
  - Urgent Care copay of $35 when you use an in-network facility.
  - Within the provider network, 90% coverage for room and board and for other hospital charges after the $100 per admission copay. Precertification is required.
  - Freedom to choose any doctor with extra savings when you see a preferred provider.
- **Standard Option**
  - Affordable premiums.
  - Low $15 copay for office visits to any primary care physician including family or general practitioners, pediatricians, OB/GYN and medical internists.
  - Urgent Care copay of $35 when you use an in-network facility.
  - No requirement to choose a single doctor as your primary physician.
  - No referral needed to see a specialist. However, you might need preauthorization for certain services.
  - Generic drugs: $10 copay at a retail pharmacy; $20 at the mail order pharmacy.
  - Freedom to choose any doctor with extra savings when you see a preferred provider.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 if enrollment is Self Plus One or Self and Family) under the High and Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(no deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians, hospitalists, neonatologists and pathologists who are not preferred providers at the preferred provider rate.
- We will provide PPO benefits if you are admitted to a non-PPO hospital due to a medical emergency. We will also provide PPO benefits if you receive care from professionals who provide services in a non-PPO hospital, when admitted due to a medical emergency. You will be responsible for the difference between the plan allowance and the billed amount.
- **YOU MUST GET PREAUTHORIZATION FOR CERTAIN OUTPATIENT IMAGING PROCEDURES. FAILURE TO DO SO WILL RESULT IN A MINIMUM OF $100 PENALTY**. Please refer to preauthorization information in Section 3 to be sure which procedures require preauthorization.

Benefits Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(no deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • Routine physical examinations • Office medical consultations • Second surgical opinions Note: See page 49 for coverage of Christian Science practitioners.	PPO: $20 copayment (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $15 copayment for office visits to primary care physicians; $30 copayment for office visits to specialists (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
• Emergency room physician care (non-accidental injury) • During a hospital stay • At home	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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 cvs.com/minuteclinic/clinic-locator or call 866-389-2727.	$10 copayment (no deductible)	$10 copayment (no deductible)
Telehealth with MDLIVE Telemedicine professional services for: • Minor acute conditions (see Section 10 for definition) • Dermatology conditions (see Section 10 for definition) Note: For more information on telehealth benefits, please see Section 5(h) *Wellness and Other Special Features*. Note: Practitioners must be licensed in the state where the patient is physically located at the time services are rendered.	Nothing (no deductible)	Nothing (no deductible)
Urgent care facility	**High Option**	**Standard Option**
Outpatient medical services and supplies billed by an urgent care facility	PPO: $35 (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: $35 (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
• CT, MRI, MRA, Nuclear Cardiology and PET studies (outpatient requires preauthorization) • Double contrast barium enemas • Ultrasound • Electrocardiogram and EEG • Non-routine colonoscopy • Prostate-Specific Antigen (PSA) tests • Specialized diagnostic genetic testing (preauthorization required) Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's existing medical condition. 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.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab, imaging facility or radiologist, we will pay non-PPO benefits for lab and radiology charges.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab, imaging center or radiologist, we will pay non-PPO benefits for lab and radiology charges.
Not covered: • *Professional fees for automated lab tests* • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Lab Card, service of Quest Diagnostics	**High Option**	**Standard Option**
You may use this voluntary program for covered outpatient lab tests. You show your Lab Card Program identification card and tell your physician you would like to use the Lab Card benefit. If the physician draws the specimen, he/she can call 800-646-7788 for pick up or you can go to an approved collection site and show your Lab Card along with the test requisition from your physician and have the specimen drawn there. Please Note: You must show your Lab Card each time you obtain lab work whether in the physician's office or collection site. To find an approved collection site near you, call 800-646-7788 or visit www.labcard.com.	Nothing (no deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance.	Nothing (no deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance.
Preventive care, adult	**High Option**	**Standard Option**
We provide benefits for a comprehensive range of preventive care and professional services for adults age 22 and over, including the preventive services recommended under the Patient Protection and Affordable Care Act, such as: • Age and gender appropriate annual preventive medical examination, which may include certain biometric screening measures (Body Mass Index (BMI), blood pressure, cholesterol tests, colorectal cancer screening, glucose and Hemoglobin A1c tests) performed or ordered by your doctor as part of that annual preventive medical examination.	PPO: Nothing (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
We provide Annual A and B rated routine screenings as recommended by the U.S. Preventive Services Task Force (USPSTF), which includes: Routine physical every year and screenings, such as: • Total blood cholesterol • Colorectal cancer screening, including: - Annual coverage of one fecal occult blood test, - Colonoscopy (surgeon and facility charges) every 10 years, ages 50-75 - Sigmoidoscopy (surgeon and facility charges) every 5 years, ages 50-75 - FIT-DNA Screening every 3 years, ages 50-75 • Depression • Diabetes screening in adults who are overweight, obese, or have high blood pressure, ages 40-70 • Hepatitis C virus infection screening for members at high risk for infection. • High Blood Pressure • HIV • Lung cancer screening - Annual low-dose computed tomography (LDCT) in adults ages 55 to 80, who have a 30 pack per year smoking history and currently smoke or have quit within the past 15 years (pre-authorization required, see page 22) Individual counseling on prevention and reducing health risks Well woman care based on current recommendations such as: • Breast cancer screening • Cervical cancer screening (Pap smear) • Chlamydia/gonorrhea screening • Contraceptive methods and counseling • Human papillomavirus (HPV) testing • Routine mammogram, covered for women, including 3D mammograms • Osteoporosis screening - For women age 65 or older or women age 60 or older who are at increased risk, as recommended by specialty organizations such as the USPSTF or the National Osteoporosis Foundation • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Screening and counseling for interpersonal and domestic violence • Gonorrhea prophylactic medication to protect newborns	PPO: Nothing (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Perinatal depression: counseling and interventions Note: Aspirin, fluoride, bowel prep, generic raloxifene, generic tamoxifen, folic acid and generic statins with physician prescription are covered as preventive with the appropriate age/gender or dosage limits with no patient copay. For more specific details visit www.geha.com/prescriptions. Note: Counseling for tobacco/e-cigarette cessation for adult males, pregnant and non-pregnant females, children and adolescents is covered as preventive. See Section 5(a) under Educational classes and programs, page 49. Note: You must see your doctor for the specific purpose of preventive care in order to have the visit considered under this preventive care benefit. If you have a screening or blood test done during a visit to your doctor that is for medical reasons other than prevention, you will likely have to share in some of the cost. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	PPO: Nothing (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule.	PPO: Nothing (no deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)	PPO: Nothing (no deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: USPSTF: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/ For additional information: www.healthfinder.gov/myhealthfinder/default.aspx		
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Preventive care, children	**High Option**	**Standard Option**
• Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics Note: Counseling for tobacco/e-cigarette cessation for adult males, pregnant and non-pregnant females, children and adolescents is covered as preventive. See Section 5(a) under Educational classes and programs, page 49. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended are under the U.S. Preventive Services Task Force (USPSTF) is available online at: USPSTF: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations HHS: www.healthcare.gov/preventive-care-children/ CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: www.healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to: www.brightfutures.aap.org/Pages/default.aspx	PPO: Nothing (no deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)	PPO: Nothing (no deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)
Not covered: • *Professional fees for automated lab tests* • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes for pregnant women • Prenatal care • Delivery • Postnatal care • Sonograms Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 21 for other circumstances, such as extended stays for you or your baby.	PPO: Nothing (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (no deductible) Non-PPO: 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.)	**High Option**	**Standard Option**
• 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. • Hospital services are covered under the Section 5(c) and Surgical benefits Section 5(b) • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)). • 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. Surgical benefits, not maternity benefits, apply to circumcision. • Skilled nursing services, intravenous/infusion therapy, and injections (such as Rhogam) are covered the same as other medical benefits for diagnostic and treatment services. Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.	PPO: Nothing (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• Breastfeeding support and counseling for each birth. Note: Refer to Section 5(a) under *Durable medical equipment (DME)* for obtaining breast pump and supplies. You must obtain the breast pump and supplies from our contracted provider.	PPO: Nothing (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount for support and counseling.	PPO: Nothing (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount for support and counseling.
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* • *Childbirth education classes, services for birth coaching or labor support*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Contraceptive methods and counseling • Voluntary sterilizations (vasectomy and tubal ligation) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover other contraceptives under the *Prescription drug benefits* in Section 5(f).	PPO: Nothing (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilizations* • *Genetic counseling and genetic screening* • *Preimplantation genetic diagnosis (PGD)* • *Expenses for sperm collection and storage*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
• Diagnosis and treatment of infertility except as shown in *Not covered*	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilizations* • *Fertility drugs* • *Genetic counseling and genetic screening* • *Preimplantation genetic diagnosis (PGD)* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (AI)* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment, including materials (such as allergy serum) • 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. • Allergy injections	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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* • *Non-FDA approved sublingual allergy desensitization drugs*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Antibiotic therapy - Intravenous (IV)/Infusion (preauthorization required) • Total Parenteral Nutrition (TPN) (preauthorization required) • Outpatient cardiac rehabilitation following qualifying event/ condition • Chemotherapy and radiation therapy (preauthorization required) Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 57. Specialty benefits may apply, see page 87. • Intravenous (IV)/Infusion Therapy (preauthorization required) • Respiratory and inhalation therapies • Growth hormone therapy (GHT) Note: GHT is covered under the prescription drug benefit. We only cover GHT when we preauthorize the treatment. Call 800-821-6136 for preauthorization. We will ask you to submit information that establishes GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Other services that require preauthorization* in Section 3. Note: Some medications required for treatment therapies may be available through CVS Caremark Mail Service Pharmacy or a CVS Caremark participating network pharmacy. Medications obtained from these sources are covered under the *Prescription drug benefits* in Section 5(f). Applied Behavioral Therapy Benefit • Required Diagnosis of ASD (Autism Spectrum Disorder) by a provider qualified to make the diagnosis: Board Certified Behavior Analyst (BCBA), psychiatrist, pediatrician.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Treatment therapies (cont.)	**High Option**	**Standard Option**
• Initiation of treatment and on-going treatment and intensity of treatment must be medically necessary and appropriate for the child. • Available to children, ages 12 months through age 17. • 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). • Ages 12 months through age 17 qualify for a total of 680 hours per year, which is inclusive of the services of the Board Certified Behavior Analyst, Board Certified Assistant Behavior Analyst, and Registered Behavior Technician. • Approval of on-going services requires demonstrated involvement by family. • Services provided by the school are not reimbursable by the health plan.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Dialysis - • Dialysis - hemodialysis and peritoneal dialysis (preauthorization required) • GEHA has a Preferred Outpatient Dialysis Network • We bundle charges for dialysis; labs drawn during the week of dialysis treatments, and drugs and supplies provided on the day of dialysis, are part of the bundled out-of-network dialysis payment. • Up to three outpatient dialysis treatments are covered each week (any combination of hemodialysis and peritoneal dialysis). • Home dialysis training for the member and a helper are covered outside of the bundled out-of-network payment	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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* • *Maintenance cardiac rehabilitation* • *Topical hyperbaric oxygen therapy* • *Prolotherapy*	*All charges*	*All charges*
Physical, occupational, and speech therapy	**High Option**	**Standard Option**
• Up to 60 outpatient therapy visits per person per calendar year for the combined services of the following: - Qualified physical therapists - Qualified occupational therapists - Qualified speech therapists Inpatient therapy services do not require precertification and are not applied to the 60 visit benefit.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

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

Benefits Description	You pay After the calendar year deductible...	
Physical, occupational, and speech therapy (cont.)	**High Option**	**Standard Option**
Services must be ordered by a physician. Orders must include the specific professional skills the patient needs, the medical necessity for the therapy, and an anticipated length of time the services are needed. Therapy must be therapeutic, consistent with medically-accepted standards of care, and not experimental, investigational, or solely educational in nature. Combined therapy visits may be used for rehabilitative therapy or habilitative therapy. • Rehabilitative: Therapy is initiated to restore bodily function when there has been a total or partial loss of bodily function due to illness, surgery, or injury. • Habilitative: Therapy is initiated to address a genetic, congenital, or early acquired disorder resulting in significant deficit of Activities of Daily Living (ADL), fine motor, or gross motor skills. Therapy services are provided to enhance functional status and is focused on developing skills that were never present. Note: When you receive therapy from a qualified therapist in the outpatient setting which is medically necessary and meets the criteria for rehabilitative or habilitative therapy, your therapy is covered up to the Plan limits.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Exercise programs* • *Long-term rehabilitation therapy* • *Maintenance therapy-measurable improvement is not expected or progress is no longer demonstrated* • *Hot and cold packs* • *Computers, tablets, computer programs/games used in association with communication aides, internet or phone services used in conjunction with communication devices* • *Hippotherapy* • *Rehabilitative services intended to teach or enhance Instrumental Activities of Daily Living (therapy to promote skills associated with independent living, such as shopping, using a phone, cleaning, laundry, preparing meals, managing medications, driving, or managing money/finances)* • *Sensory Therapy, Auditory Therapy, or Sensory Integration Therapy*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Cognitive Rehabilitation	**High Option**	**Standard Option**
Provided when medically necessary following brain injury or traumatic brain injury. Services will only be covered when provided by: • Speech, occupational and/or physical therapists • Psychologists • Physicians while practicing within their scope of care.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care children.* • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• External hearing aids Note: Benefit is payable per person every three years for adults and annually for children up to age 22.	PPO: All charges in excess of $2,500 (no deductible) Non-PPO: All charges in excess of $2,500 (no deductible)	PPO: All charges in excess of $2,500 (no deductible) Non-PPO: All charges in excess of $2,500 (no deductible)
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment and supplies)	**High Option**	**Standard Option**
• First pair of contact lenses or standard ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury • Outpatient Vision therapy visits by an ophthalmologist or optometrist require preauthorization.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Computer programs of any type, including but not limited to those to assist with vision therapy* • *Eyeglasses or contact lenses and examinations for them except as shown above* • *Radial keratotomy and other refractive surgery* • *Special multifocal ocular implant lenses*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Foot care	**High Option**	**Standard Option**
• Routine foot care only when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: $20 copayment for the office visit (no deductible); plus 10% of the Plan allowance for other services performed during the visit Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $15 copayment for the office visit to primary care physicians; $30 copayment for office visits to specialists (no deductible); plus 15% of the Plan allowance for other services performed during the visit Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• Diabetic shoes and shoe inserts individually designed and fitted to offload pressure points on the diabetic foot are limited to $150 per person per calendar year	PPO: All charges in excess of $150 (no deductible) Non-PPO: All charges in excess of $150 (no deductible)	PPO: All charges in excess of $150 (no deductible) Non-PPO: All charges in excess of $150 (no deductible)
Not covered: • *Cutting, trimming of toenails or removal of corns, calluses, or similar routine treatment of conditions of the foot, except as stated above*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers and surgically implanted breast implant following mastectomy • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical procedures.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.* Note: We will pay only for the cost of the standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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* • *Bioelectric, computer programmed prosthetic devices*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Durable medical equipment (DME)	**High Option**	**Standard Option**
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 Note: Call us at 800-821-6136 to obtain a contract provider or PPO provider in your area. Your chosen provider should call for preauthorization. We may contact you to recommend a provider in your area to decrease your out-of-pocket expense. Note: Coverage for specialty equipment such as specialty wheelchairs and beds is limited to the cost of the standard care and is subject to a home evaluation. Note: Please see the definition for Medical Necessity, page 118. Note: Refer to Section 5(f) for glucose meter and diabetic supplies, page 80.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Breast pump and supplies: • One double channel electric breast pump with double suction capability is purchased for breast-feeding patients with a physician's prescription every two years. A new prescription is required when requesting a new/replacement pump. Additional pumps may be obtained from the GEHA breast pump contracted provider at the member's expense. - There is no cost to the member when the designated pump is obtained through GEHA's breast pump contracted provider. You must obtain the breast pump and supplies from our contracted provider.	Plan's Contracted DME Provider: Nothing (no deductible) Non Contracted DME Provider: All Charges	Plan's Contracted DME Provider: Nothing (no deductible) Non Contracted DME Provider: All Charges

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
- An initial all-inclusive supply kit is provided with a new pump order. Two supplemental supply kits are allowed in a 12 month period. Supplemental supply kits contain new tubing and canisters. All other requested supplies can be obtained from the GEHA contracted provider at the member's expense. Call 800-482-1993 anytime in the last 2 months of pregnancy and submit your physician's order. The pump and supplies will be delivered within 1-5 business days.	Plan's Contracted DME Provider: Nothing (no deductible) Non Contracted DME Provider: All Charges	Plan's Contracted DME Provider: Nothing (no deductible) Non Contracted DME Provider: All Charges
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) 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. Must be preauthorized.	PPO: All charges in excess of $1,250 per calendar year (no deductible) Non-PPO: All charges in excess of $1,250 per calendar year (no deductible)	PPO: All charges in excess of $1,250 per calendar year (no deductible) Non-PPO: All charges in excess of $1,250 per calendar year (no deductible)
Not covered: • *Computers, tablets, computer programs/games used in association with communication aides, internet or phone services used in conjunction with communication devices* • *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 page 117)* • *Lifts, such as seat, chair or van lifts* • *Wigs* • *Bone stimulators except for established non-union fractures* • *Devices or programs to eliminate bed wetting* • *If a member is a patient in a facility other than the member's primary residence, or in a distinct part of a facility that provides services such as skilled nursing, rehabilitation services, or provides medical or nursing, DME will not be covered separately for rental or purchase.*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
50 in-home intermittent visits per person, per calendar year, not to exceed one visit up to two hours per day when: • A registered nurse (R.N.), a licensed practical nurse (L.P.N.) under the supervision of a registered nurse, or qualified* medical social worker (M.S.W.) provides the services • The attending physician orders the care • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services • The physician indicates the length of time the services are needed	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
• Medical social services provided by a qualified* medical social worker may be covered under the home health service benefit when the member meets the following criteria: - Member must be in need of home health services on an intermittent basis; home health skilled nursing, physical therapy, speech-language, or occupational therapy. - Member must be under the care of a physician who signs the plan of care. - The plan of care indicates how the services which are required necessitate the skills of a qualified* medical social worker to be performed safely and effectively. - In-home assessment services from a qualified* medical social worker are required to support accurate diagnosis and amelioration of social determinants of health identified as an impediment to the effective treatment of the patient's medical condition or rate of recovery. *Services performed by a qualified medical social worker are only eligible for reimbursement when furnished through a licensed home health agency or under the supervision of an eligible physician actively involved in the member's care. Note: Covered services are based on our review for medical necessity. Note: Please refer to the *Specialty drug benefits* beginning on page 87 for information on benefits for home infusion therapies.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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* • *Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption* • *Hourly nursing where there is no skilled need or the need is beyond a two hour visit per day (otherwise known as private duty nursing) provided in the acute care facility, post-acute facilities (skilled nursing facilities), rehabilitation facilities, long-term acute care facilities, long-term care facilities, in the home.* • *On-going licensed/unlicensed dialysis assistance in the home after initial dialysis training*	*All charges*	*All charges*

Benefits Description	You pay After the calendar year deductible...	
Manipulative therapy	**High Option**	**Standard Option**
Manipulative therapy services limited to: • 20 visits per person per calendar year for manipulation of the spine • 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 ($25 per person per calendar year)	PPO and Non-PPO: All charges in excess of $20 per visit (no deductible) All charges in excess of $25 for X-rays of the spine (no deductible)	PPO and Non-PPO: All charges in excess of $20 per visit (no deductible) All charges in excess of $25 for X-rays of the spine (no deductible)
Not covered: • *Any treatment not specifically listed as covered* • *Maintenance therapy - measurable improvement is not expected or progress is no longer demonstrated*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Acupuncture: • Benefits are limited to 20 procedures per person per calendar year for medically necessary acupuncture treatments for: - Anesthesia - Pain relief Christian Science Practitioners: • Benefits are limited to 50 sessions per person per calendar year Christian Science Facilities: • Nursing care and room and board in a facility accredited by the Commission for Accreditation of Christian Science Nursing Organizations up to 30 days per person per calendar year	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *All other alternative treatments, including clinical ecology and environmental medicine* • *Any treatment not specifically listed as covered* • *Naturopathic services*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is limited to: • Tobacco Cessation/E-cigarettes – We cover counseling sessions including proactive telephone counseling, group counseling and individual counseling for adult males, pregnant and non-pregnant females, children and adolescents. Benefits are payable for up to two attempts per person per calendar year, with up to four counseling sessions per attempt.	PPO: Nothing (no deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount (no deductible)	PPO: Nothing (no deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount (no deductible)

Educational classes and programs - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• In addition, we cover over-the-counter (with a physician's prescription) and prescription smoking cessation drugs approved by the FDA. The quantity of drugs reimbursed will be subject to recommended courses of treatment. You may obtain smoking cessation drugs with your plan identification card, through CVS Caremark Mail Service Pharmacy or a non-Network Retail pharmacy. (See page 84 for filing instructions in Section 5(f) *Prescription drug benefits*.)	PPO: Nothing (no deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount (no deductible)	PPO: Nothing (no deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount (no deductible)
• Diabetes Education – Provided by Certified Diabetes Educators or physician through a program certified by the American Diabetes Association. 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; and - Ordered by the physician treating the member's diabetes that includes a statement signed by the physician that the service is needed. - Up to 10 hours of instruction allowed per year.	PPO: Nothing up to the Plan allowance (up to 10 hours of instruction, no deductible) Non-PPO: Nothing up to the Plan allowance and any difference between our allowance and the billed amount (up to 10 hours of instruction, no deductible)	PPO: Nothing up to the Plan allowance (up to 10 hours of instruction, no deductible) Non-PPO: Nothing up to the Plan allowance and any difference between our allowance and the billed amount (up to 10 hours of instruction, no deductible)
• Nutritional Counseling – Provided by a dietitian with a state license or statutory certification. Nutritional counseling must be ordered by a physician	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 if enrollment is Self Plus one or Self and Family) under the High and Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(no deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- When using a PPO hospital, the professionals who provide services may not all be PPO providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if services are performed by non-PPO radiologists, anesthesiologists, emergency room physicians, hospitalists, neonatologists or pathologists at a PPO hospital, we will pay up to the Plan allowable at the preferred provider rate.
- We will provide PPO benefits if you are admitted to a non-PPO hospital due to a medical emergency. We will also provide PPO benefits if you receive care from professionals who provide services in a non-PPO hospital, when admitted due to a medical emergency. You will be responsible for the difference between the plan allowance and the billed amount.
- **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.

Benefits Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(no deductible)" when it does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • 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*)	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
• Surgical treatment of obesity is covered for adults aged 18 years or older, with presence of persistent severe obesity, documented in contemporaneous clinical records, defined as any of the following: - Body mass index (BMI) (see appendix) exceeding 40; or - BMI greater than 35 in conjunction with any of the following severe co-morbidities: • Clinically significant obstructive sleep apnea; or • Coronary heart disease, with objective documentation (by exercise stress test, radionuclide stress test, pharmacologic stress test, stress echocardiography, CT angiography, coronary angiography, heart failure or prior myocardial infarction); or • Hemodynamically significant cardiomyopathy; or • Refractory Hyperlipidemia defined as failure to achieve acceptable levels of lipids despite maximal diet and pharmacological therapy; or • Severe arthropathy of the spine or weight bearing joints when obesity prohibits appropriate surgical management; or • Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic) despite concurrent use of 3 anti-hypertensive agents of different classes. • Type 2 Diabetes • For adolescents (under age 18) who have documented completed bone growth and presence of obesity with specified co-morbidities defined as: - BMI exceeding 40 with one or more of the following serious co-morbidities: • Clinically significant obstructive sleep apnea; or • Type 2 diabetes mellitus; or • Pseudo tumor comorbidities; or • Medically refractory hypertension. OR - BMI exceeding 50 with one or more of the following less serious co-morbidities: • Dyslipidemias; or • Nonalcoholic steatohepatitis; or • Venous stasis disease; or • Significant impairment in activities of daily living; or • Intertriginous soft-tissue infections; or • Stress urinary incontinence; or • Gastroesophageal reflux disease; or • Weight-related arthropathies that impair physical activity.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
For eligibility of coverage for surgical treatment for obesity, there must also be demonstration of each of the following: • Documentation of failure to lower the body mass index within the last twelve months through a medically supervised program of diet and exercise of at least six months duration. • Psychological clearance of the member's ability to understand and adhere to the pre-and post-operative program, based on a psychological assessment performed by a licensed professional mental health practitioner. • Member has not smoked in the six months prior to surgery. • Member has not been treated for substance use for one year prior to surgery and there is no evidence of substance use during the one-year period prior to surgery. Benefits for subsequent surgery for morbid obesity, performed on an inpatient or outpatient basis, are subject to each of the following additional pre-surgical requirements: • All criteria listed above for the initial procedure must be met again, except when performed to treat a documented, clinically significant complication from the prior morbid obesity surgery. • Previous surgery for morbid obesity was at least two years prior to repeat procedure. • Weight loss from the initial procedure was less than 50% of the member's excess body weight at the time of the initial procedure. • Documented evidence demonstrating that the member complied with previously prescribed post-operative nutrition and exercise program. Note: Benefits are payable only for bariatric surgery which meets the above criteria. Bariatric surgery must be preauthorized. • Insertion of internal prosthetic devices (see Section 5 (a) *Orthopedic and prosthetic devices* for device coverage information) • Treatment of burns • Assistant surgeons are covered up to 20% of our allowance for the surgeon's charge for procedures when it is medically necessary to have an assistant surgeon. 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. • Surgical treatment of gender dysphoria such as surgical change of sex characteristics (bilateral mastectomy), genital reconstructive surgeries (vaginectomy, urethroplasty, scrotoplasty, penectomy, vaginoplasty, labiaplasty and clitoroplasty) and augmentation mammoplasty - Requirements	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
• Must be 18 years of age or older • Must have documented evidence of persistent gender dysphoria • Must have evidence of well-controlled physical and mental health conditions • Must have letter from qualified mental health professional supporting decision for procedure (two letters if requesting genital reconstructive surgery) - Additional information to above based on specific surgical requests: • Genital reconstructive surgeries require 1) an additional letter of support from a qualified mental health provider, 2) 12 months of hormone therapy as appropriate for member's gender goal, and 3) greater than 12 months living a gender role congruent with gender identity. • Augmentation mammoplasty requires 1) 18 months of hormone therapy as appropriate for member's gender goal, and 2) documentation that size is not sufficient for comfort in social role. Note: Post-operative care is considered to be included in the fee charged for a surgical procedure by a doctor. Any additional fees charged by a doctor are not covered unless such charge is for an unrelated condition. Note: Voluntary sterilizations, surgically implanted contraceptives, injectable contraceptive drugs (such as Depo-Provera), intrauterine devices (IUDs), and diaphragms are listed as covered under Section 5(a) *Family planning*.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure based on: - Full Plan allowance • For the secondary and subsequent procedures based on: - One-half of the Plan allowance Note: Multiple or bilateral surgical procedures performed through the same incision are “incidental” to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician or surgeon* • *Routine treatment of conditions of the foot (see Foot care)* • *Surgical treatment of hyperhidrosis unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm – limited to children under the age of 18 unless there is a functional deficit. Examples of congenital anomalies are: cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance 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) Note: We pay for internal breast prostheses as hospital benefits if billed by a hospital. If included with the surgeon's bill, surgery benefits will apply. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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 if repair is initiated promptly or as soon as the member's condition permits* • *Surgeries related to sexual dysfunction* • *Surgeries to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit* • *Charges for photographs to document physical conditions*	*All charges*	*All charges*

Reconstructive surgery - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• *Transgender procedures not specifically listed above, such as: rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing or other procedures used for feminization, chin or nose implants or lip reductions or other procedures used for masculization, transgender reversal unless secondary to surgical complications.*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate • Excision of cysts and incision of abscesses unrelated to tooth structure • Extraction of impacted (unerupted or partially erupted) teeth • Alveoloplasty, partial or radical removal of the lower jaw with bone graft • Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues • Open reduction of dislocations and excision, manipulation, aspiration or injection of temporomandibular joints • Removal of foreign body, skin, subcutaneous areolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones and incision/excision of salivary glands and ducts • Repair of traumatic wounds • Incision of the sinus and repair of oral fistulas • Surgical treatment of trigeminal neuralgia • 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. Masticating (biting or chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at 100% for charges incurred within 72 hours of an accident (see page 70). • Orthognathic surgery for the following conditions: - severe sleep apnea only after conservative treatment of sleep apnea has failed - cleft palate and Pierre Robin Syndrome - Orthognathic surgery for any other condition is not covered • Other oral surgery procedures that do not involve the teeth or their supporting structures	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
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)* • *Orthodontic treatment* • *Any oral or maxillofacial surgery not specifically listed as covered* • *Orthognathic surgery, except as outlined above for severe sleep apnea, cleft palate and Pierre Robin Syndrome (even if necessary because of TMJ dysfunction or disorder)*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for preauthorization procedures. Solid organ transplants limited to: • 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 - Notify the Plan of a pending kidney transplant. If you are a member, or if you are an Aetna provider, call GEHA at 800-821-6136. If you are a UnitedHealthcare Options PPO or UnitedHealthcare Choice Plus provider, please call UHC Provider Services for benefit verification at 877-343-1887. • Kidney/Pancreas • Liver • Lung single/bilateral/lobar • Pancreas	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Refer to *Other services* in Section 3 for preauthorization procedures. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. 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 non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e., Fanconi's, Paroxysmal Noctural Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia • 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 - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Neuroblastoma	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
Blood or Marrow Stem Cell Transplants: Plan's denial is limited to indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, staging or the diagnosis. • Allogeneic transplants for: - Advanced neuroblastoma - Infantile malignant osteopetrosis - Mucopolysaccharidoses/Mucolipidoses - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Childhood rhabdomyosarcoma - Mantle Cell (Non-Hodgkin lymphoma) - Multiple myeloma - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, - Waldenstrom's macroglobulinemia	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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. Refer to *Other services* in Section 3 for preauthorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Noctural Hemoglobinuria, Pure Red Cell Aplasia) - Multiple Myeloma	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
- Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia • 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	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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. Refer to Other services in Section 3 for preauthorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Donor expenses • We will cover donor screening tests and donor search expenses for up to four potential donors of organ/tissue transplants. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated below. This benefit applies only if the recipient is covered by the Plan and if the donor's expenses are not otherwise covered.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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 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 GEHA is the primary payor. • Transportation benefits are payable for follow-up care up to one year following the transplant. The transportation benefit is not available for cornea or kidney transplants. You must contact Customer Service at 800-821-6136 for what are considered reasonable temporary living expenses.	PPO: Nothing (no deductible) Non-PPO: Nothing (no deductible)	PPO: Nothing (no deductible) Non-PPO: Nothing (no deductible)

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Limited Benefits • The process for preauthorizing organ 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 GEHA's Care 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. (Cornea and kidney transplants do not require preauthorization.)		
• We will pay for a second transplant evaluation recommended by a physician qualified to perform the transplant, if: the transplant diagnosis is covered and the physician is not associated or in practice with the physician who recommended and will perform the organ transplant. A third transplant evaluation is covered only if the second evaluation does not confirm the initial evaluation. • The transplant must be performed at a Plan-designated organ transplant facility to receive maximum benefits. GEHA uses a defined transplantation 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. 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.	PPO: $20 copayment (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount If precertification is not obtained or a Plan-designated organ 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.	PPO: $15 copayment for office visits to primary care physicians; $30 copayment for office visits to specialists (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount If precertification is not obtained or a Plan-designated organ 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.
• Chemotherapy and procedures related to bone marrow transplantation must be performed only at a Plan-designated organ transplant facility to receive maximum benefits. • Simultaneous transplants such as kidney/pancreas, heart/lung, heart/liver are considered as one transplant procedure and are limited to $100,000 when not performed at a Plan-designated organ transplant facility.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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.)	**High Option**	**Standard Option**
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* • *Expenses for sperm collection and storage*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional fees for the administration of anesthesia in: • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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*	*All Charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)". The calendar year deductible is $350 per person ($700 if enrollment is in Self Plus One or in Self and Family).
- A High Option per admission copayment applies of $100 (PPO) and $300 (non-PPO) for inpatient hospital services.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The 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). See page 49 for coverage of a Christian Science facility.
- When using a PPO hospital, the professionals who provide services may not all be PPO providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if services are performed by non-PPO radiologists, anesthesiologists, emergency room physicians, hospitalists, neonatologists or pathologists at a PPO hospital, we will pay up to the Plan allowable at the preferred provider rate.
- We will provide PPO benefits if you are admitted to a non-PPO hospital due to a medical emergency. We will also provide PPO benefits if you receive care from professionals who provide services in a non-PPO hospital, when admitted due to a medical emergency. You will be responsible for the difference between the plan allowance and the billed amount.
- Charges billed by a facility for implantable devices, surgical hardware, etc., are subject to the Plan allowance, which is based on the provider's cost plus 20% with submitted invoice, or two times the Medicare allowance without an invoice. Providers are encouraged to notify us on admission to determine benefits payable.
- When you receive hospital observation services, we apply outpatient benefits to covered services up to 48 hours. Inpatient benefits will apply only when your physician formally admits you to the hospital as an inpatient. It is your responsibility to ensure that we are contacted for precertification if you are admitted as an inpatient.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS, INCLUDING OBSERVATION CARE EXCEEDING 48 HOURS. FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification. Confinements which are considered not medically necessary will not be covered. Penalties are not subject to the catastrophic limit.

Benefits Description	You pay	
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodation • General nursing care • Meals and special diets Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate. Note: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges. 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 (Note: Calendar year deductible applies.) Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay hospital benefits and when the anesthesiologist bills, we pay surgery benefits.	PPO: $100 per admission copayment and 10% of the Plan allowance Non-PPO: $300 per admission copayment and 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount for other hospital services	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)
Maternity care – Inpatient hospital Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 21 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.	PPO: Nothing Non-PPO: $300 per admission copayment and 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount for other hospital services	PPO: Nothing Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)

Inpatient hospital - continued on next page

Benefits Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Other hospital services and supplies, such as: • Delivery room, 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 and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: Calendar year deductible applies.) Note: We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. Note: 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. Note: For facility care related to maternity, including care at birthing facilities, we will waive the per admission copayment and pay for covered services in full when you use PPO providers. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.	PPO: Nothing Non-PPO: $300 per admission copayment and 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount for other hospital services	PPO: Nothing Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)
Not covered: • *Any part of a hospital admission that is not medically necessary (see Section 10), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting.* • *Any part of a hospital admission that is related to a non-covered surgery or procedure* • *Custodial care (see Section 10)* • *Non-covered facilities such as nursing homes or schools* • *Personal comfort items such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*

Benefits Description	You pay	
Inpatient residential treatment centers (RTC)	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodation • General nursing care • Meals and special diets • Ancillary charges, and • Covered therapy services when billed by the facility (see page16 for services billed by professional providers.) Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate. Note: 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. Note: We limit covered facilities for medically necessary substance use disorder treatment to a hospital and/or RTC.	PPO: $100 per admission copayment and 10% of the Plan allowance Non-PPO: $300 per admission copayment and 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount for other hospital services	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)
Benefits are not available for non-covered services, including: • *Pastoral, marital, educational counseling or training services* • *Therapy for sexual dysfunction or inadequacy* • *Services performed by a non-covered provider* • *Treatment for learning disabilities and mental retardation* • *Travel time to the member's home to conduct therapy* • *Services rendered or billed by schools, halfway houses, sober homes, group homes, similar types of facilities or billed by their staff* • *Marriage counseling* • *Services that are not medically necessary* • *The following services are not covered as a part of any inpatient or outpatient mental health or substance use disorder treatment services: respite care; outdoor residential programs; recreational therapy; educational therapy or classes; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services; custodial or long term care provided because home care is not available or is unsuitable.* *Note: We cover professional services as described on page 73 when they are provided and billed by a covered professional provider acting within the scope of his or her license.*	*All charges*	*All charges*

Benefits Description	You pay	
Outpatient hospital, clinic or ambulatory surgical center	**High Option**	**Standard Option**
• 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, splints, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Cardiac rehabilitation following qualifying event/condition • Observation care is covered up to a maximum of 48 hours as an outpatient hospital service, see Section 10. Note: Please refer to page 87 for information on benefits for *Specialty drug* medications dispensed by hospitals. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)
Not covered: • *Maintenance cardiac rehabilitation* • *Services that are related to a non-covered surgery or procedure*	*All charges*	*All charges*
Maternity care – Outpatient hospital • Delivery room, recovery, observation, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and 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 and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia services Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.	PPO: Nothing Non-PPO: 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)	PPO: Nothing Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)

Benefits Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
• Inpatient confinement at a Skilled Nursing Facility for the first 21 days following transfer from an authorized acute inpatient confinement when skilled care is still required. Benefits limited to $700 per day. No other benefits are payable for inpatient skilled nursing facility charges. Note: When Medicare Part A is primary, Medicare pays the initial 20 days in full for confinement in a qualified skilled nursing facility, for each Medicare defined benefit period; this plan covers copayments or coinsurance incurred during the 21st day of confinement during the benefit period.	PPO: Charges in excess of $700 per day for the first 21 days not to exceed the Plan allowance All charges after 21 days not to exceed the Plan allowance Non PPO: Charges in excess of $700 per day for the first 21 days All charges after 21 days	PPO: Charges in excess of $700 per day for the first 21 days not to exceed the Plan allowance All charges after 21 days not to exceed the Plan allowance Non PPO: Charges in excess of $700 per day for the first 21 days All charges after 21 days
Hospice care	**High Option**	**Standard Option**
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team, under the direction of a Plan-approved independent hospice administration. • We pay up to $15,000 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 $15,000. 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.	PPO: Nothing up to the Plan limits (calendar year deductible applies) Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)	PPO: Nothing up to the Plan limits (calendar year deductible applies) Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)
Not covered: • *Charges incurred during a period of remission, charges incurred for treatment of a sickness or injury of a family member that are covered under another plan provision, charges incurred for services rendered by a close relative, bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services*	*All charges*	*All charges*

Benefits Description	You pay	
Ambulance - accidental injury	**High Option**	**Standard Option**
Ambulance service within 72 hours of an accident is covered as follows: • Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary) *Member is responsible for all charges for 100 miles or greater when medically necessary treatment is available within 100 miles.	PPO: Nothing up to the Plan allowance within 100 miles* Non-PPO: Only the difference between our allowance and the billed amount within 100 miles*	PPO: Nothing up to the Plan allowance within 100 miles* Non-PPO: Only the difference between our allowance and the billed amount within 100 miles*
• Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.	PPO: Nothing up to the Plan allowance Non-PPO: Only the difference between our allowance and the billed amount	PPO: Nothing up to the Plan allowance Non-PPO: Only the difference between our allowance and the billed amount
Ambulance - non-accidental injury	**High Option**	**Standard Option**
• Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary) *Member is responsible for all charges for 100 miles or greater when medically necessary treatment is available within 100 miles.	PPO: 10% of the Plan allowance within 100 miles* (calendar year deductible applies) Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount within 100 miles* (calendar year deductible applies)	PPO: 15% of the Plan allowance within 100 miles* (calendar year deductible applies) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount within 100 miles* (calendar year deductible applies)
• Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
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*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 if enrollment is Self Plus one or Self and Family) under the High and Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(no deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians, hospitalists, neonatologists and pathologists who are not preferred providers at the preferred provider rate.
- We will provide PPO benefits if you are admitted to a non-PPO hospital due to a medical emergency. We will also provide PPO benefits if you receive care from professionals who provide services in a non-PPO hospital, when admitted due to a medical emergency. You will be responsible for the difference between the plan allowance and the billed amount.

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 or surgical care. 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, or sudden inability to breathe. 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…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(no deductible)" when it does not apply.		
Accidental injury	**High Option**	**Standard Option**
If you receive care for your accidental injury within 72 hours, we cover: • Treatment outside a hospital or in the outpatient/emergency room department of a hospital or urgent care facility • Related outpatient physician care	PPO: Nothing (no deductible) Non-PPO: Only the difference between our allowance and the billed amount (no deductible)	PPO: Nothing (no deductible) Non-PPO: Only the difference between our allowance and the billed amount (no deductible)

Accidental injury - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Accidental injury (cont.)	**High Option**	**Standard Option**
Note: Emergency room charges associated directly with an inpatient admission are considered "Other charges" under *Inpatient hospital benefits* (see page 64) and are not part of this benefit, even though an accidental injury may be involved. Expenses incurred after 72 hours, even if related to the accident, are subject to regular benefits and are not paid at 100%. This provision also applies to dental care required as a result of accidental injury to sound natural teeth. Masticating (chewing) incidents are not considered to be accidental injuries.	PPO: Nothing (no deductible) Non-PPO: Only the difference between our allowance and the billed amount (no deductible)	PPO: Nothing (no deductible) Non-PPO: Only the difference between our allowance and the billed amount (no deductible)
If you receive care for your accidental injury after 72 hours, we cover: • Non-surgical physician services and supplies • Surgical care Note: We pay hospital benefits if you are admitted.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 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*	*All charges.*	*All charges.*
Medical emergency	**High Option**	**Standard Option**
• Outpatient medical or surgical services and supplies billed by a hospital for emergency room treatment. Note: We will provide PPO benefits if you are admitted to a non-PPO hospital due to a medical emergency. You will be responsible for the difference between the plan allowance and the billed amount.	PPO: 10% of the Plan allowance Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
Urgent Care Facility	**High Option**	**Standard Option**
Outpatient medical services and supplies billed by an urgent care facility	PPO: $35 (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: $35 (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Benefits Description	You pay After the calendar year deductible…	
Ambulance - accidental injury	**High Option**	**Standard Option**
Ambulance service within 72 hours of an accident is covered as follows: • Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary) *Member is responsible for all charges for 100 miles or greater when medically necessary treatment is available within 100 miles.	PPO: Nothing up to the Plan allowance within 100 miles* (no deductible) Non-PPO: Nothing up to the Plan allowance within 100 miles* (no deductible)	PPO: Nothing up to the Plan allowance within 100 miles* (no deductible) Non-PPO: Nothing up to the Plan allowance within 100 miles* (no deductible)
• Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.	PPO: Nothing (no deductible) Non-PPO: Nothing up to the Plan allowance (no deductible)	PPO: Nothing (no deductible) Non-PPO: Nothing up to the Plan allowance (no deductible)
Ambulance - non-accidental injury	**High Option**	**Standard Option**
• Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary) *Member is responsible for all charges for 100 miles or greater when medically necessary treatment is available within 100 miles.	PPO: 10% of the Plan allowance within 100 miles* (calendar year deductible applies) Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount, within 100 miles* (calendar year deductible applies)	PPO: 15% of the Plan allowance within 100 miles* (calendar year deductible applies) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount, within 100 miles* (calendar year deductible applies)
• Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
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*	*All charges*	*All charges*

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

You may choose to get care In-Network or Out-of-Network.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 if enrollment is in Self Plus one or in Self and Family) under the High and Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(no deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- A High Option per admission copayment applies of $100 (PPO) and $300 (non-PPO) for inpatient hospital services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- When you receive hospital observation services, we apply outpatient benefits to covered services for up to 48 hours. Inpatient benefits will apply only when your physician formally admits you to the hospital as an inpatient. It is your responsibility to ensure that we are contacted for precertification if you are admitted as an inpatient.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS INCLUDING OBSERVATION CARE EXCEEDING 48 HOURS, INPATIENT RESIDENTIAL TREATMENT CENTERS AND INTENSIVE DAY TREATMENT. FAILURE TO PRECERTIFY INPATIENT SERVICES WILL RESULT IN A MINIMUM $500 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 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 ECT, TMS, and psychological testing. See Section 10 *Definitions*.
- Note: Avoid paying providers for services prior to precertification. It is important to assure services are authorized and provided by a covered provider or facility.

Benefits Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(no deductible)" when it does not apply.		
Professional services	**High Option**	**Standard Option**
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, marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional services - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Professional services (cont.)	**High Option**	**Standard Option**
Diagnosis and treatment of psychiatric conditions, mental illness, or mental 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 alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive day treatment in a provider's office or other professional setting (requires preauthorization)	PPO: $20 copayment per office visit (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $15 copayment per office visit (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
• Electroconvulsive therapy • Inpatient professional fees	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
First primary care or specialist visit for the management of a mental health condition as a follow up within 30 days of a mental health inpatient confinement.	PPO: Nothing (no deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Telehealth with MDLIVE Telemental health professional services for: • Behavioral health counseling • Substance use disorder counseling Note: For more information on telehealth benefits, please see Section 5(h) *Wellness and Other Special Features*. Note: Practitioners must be licensed in the state where the patient is physically located at the time services are rendered.	Nothing (no deductible)	Nothing (no deductible)

Benefits Description	You pay After the calendar year deductible…	
Diagnostics	**High Option**	**Standard Option**
• 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)	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Lab Card, service of Quest Diagnostics	**High Option**	**Standard Option**
You may use this voluntary program for covered outpatient lab tests. You show your Lab Card Program identification card and tell your physician you would like to use the Lab Card benefit. If the physician draws the specimen, he/she can call 800-646-7788 for pick up, or you can go to an approved collection site and show your Lab Card along with the test requisition from your physician, and have the specimen drawn there. Please Note: You must show your Lab Card each time you obtain lab work whether in the physician's office or collection site. To find an approved collection site near you, call 800-646-7788 or visit www.labcard.com.	Nothing (no deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance.	Nothing (no deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance.
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets • Ancillary charges Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate. Note: When the facility bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges. Note: We limit covered facilities for medically necessary substance use disorder treatment to a hospital and/or RTC.	PPO: 10% of the Plan allowance, no deductible ($100 per admission copayment applies) Non-PPO: 25% of the Plan allowance, no deductible ($300 per admission copayment applies) and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount

Benefits Description	You pay After the calendar year deductible…	
Inpatient residential treatment centers (RTC)	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets • Ancillary charges • Covered therapy services when billed by the facility (see page 73 for services billed by professional providers.) Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate. Note: We limit covered facilities for medically necessary substance use disorder treatment to a hospital and/or RTC.	PPO: 10% of the Plan allowance, no deductible ($100 per admission copayment applies) Non-PPO: 25% of the Plan allowance, no deductible ($300 per admission copayment applies) and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital	**High Option**	**Standard Option**
• Services such as partial hospitalization or intensive day treatment programs	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Emergency room - non-accidental injury	**High Option**	**Standard Option**
• Outpatient services and supplies billed by a hospital for emergency room treatment Note: We pay hospital benefits if you are admitted.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
Services we do not cover	**High Option**	**Standard Option**
Benefits are not available for non-covered services, including: • *Pastoral, marital, educational counseling or training services* • *Therapy for sexual dysfunction or inadequacy* • *Services performed by a non-covered provider* • *Treatment for learning disabilities and mental retardation*	*All charges*	*All charges*

Services we do not cover - continued on next page

Benefits Description	You pay After the calendar year deductible…	
Services we do not cover (cont.)	**High Option**	**Standard Option**
• *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* • *Services that are not medically necessary* • *The following services are not covered as a part of any inpatient or outpatient mental health or substance use disorder treatment services: respite care; outdoor residential programs; recreational therapy; educational therapy or classes; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services; custodial or long term care provided because home care is not available or is unsuitable.* *Note: We cover professional services as described on page 73 when they are provided and billed by a covered professional provider acting within the scope of his or her license.*	*All charges*	*All charges*

Precertification

To be eligible to receive full benefits for mental health and substance use disorder treatment, you must follow the authorization process:

- For members residing in Florida and Texas, call UnitedHealthcare Clinical Services at 877-585-9643.
- For all other members, you must call Conifer Health Solutions at 800-242-1025 to receive authorization for inpatient care and outpatient intensive day treatment. They will authorize any covered treatment.
- You should call our Care Management Department 800-821-6136 to precertify benefits for psychological testing. Psychological testing claims will be denied if we determine the testing is not medically necessary.

If you do not obtain precertification for inpatient care and outpatient intensive day treatment, we will decide whether the stay was medically necessary. If we determine the stay was medically necessary, we will pay the services less the $500 penalty. If we determine that it was not medically necessary, we will only pay for any covered services that are otherwise payable on an outpatient basis. If you remain in the hospital beyond the days we approved and did not get the additional days precertified, we will pay inpatient benefits for the part of the admission that was medically necessary. See Section 3 for details.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about catastrophic protection for these benefits; and
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

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 www.geha.com for a list of drugs that require preauthorization for medical necessity.
- Your benefit includes the Advanced Control Specialty Formulary (ACSF); please see page 81 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.
- Some medications must be approved by GEHA and/or CVS Caremark, our Pharmacy Benefit Manager, before they are a covered benefit. Members must make sure their prescribers obtain preauthorizations for certain prescription drugs and supplies before coverage applies. Medication may be limited as to its quantity, total dose, duration of therapy, age, gender or specific diagnosis. GEHA's preauthorization process may include step therapy which requires you to use a generic/preferred medication(s) before a non-preferred medication is covered. Preauthorizations must be renewed periodically.
- There is no calendar year deductible for prescription drugs processed under the prescription benefit. Copayments and coinsurance for prescription drugs go toward the annual PPO out-of-pocket limit except for the difference between the cost of the generic and brand name medication.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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 thirty days, arrangements can be made for an additional 60 days to be dispensed through CVS Caremark Mail Service Pharmacy. Call GEHA Customer Service 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, a mail order form, and a reply envelope.
- 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 Caremark 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. Refills for maintenance medications are not considered new prescriptions except when the doctor changes the strength or the prescription has expired. As part of the administration of the prescription drug program, we reserve the right to maximize your quality of care as it relates to the utilization of pharmacies. Some medications may require preauthorization by CVS Caremark or GEHA.
- 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.

Prescription drug benefits

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

- **Drug coupon/copay cards:** We do not honor or coordinate benefits with drug coupon/copay cards. You are responsible for your copay or coinsurance as indicated in this brochure.
- **Who can write your prescription:** A licensed physician or dentist, and in states allowing it, licensed or certified physician assistant, nurse practitioner or psychologist must prescribe your medication. In addition, your mailing address must be within the United States or include an APO address.
- **Where you can obtain them:** You may fill the prescription at a participating network retail pharmacy, CVS Caremark Mail Service Pharmacy, or through a non-network pharmacy. We pay a higher level of benefits when you use a network pharmacy.
- **How to obtain preauthorization:** If you are filling a medication requiring a preauthorization for medical necessity please call 855-240-0536. At Mail, CVS Caremark will conduct the preauthorization for medical necessity review.
- **Your benefit includes the Advanced Control Specialty Formulary (ACSF)**; please see page 81 for additional information.
- **Our prescription benefit may include step therapy.** GEHA's preauthorization process may include step therapy which requires you to use a generic/preferred medication(s) before a non-preferred medication is covered. If you are filling a non-preferred medication and have already tried the generic/preferred medication(s), the non-preferred medication will be dispensed for the applicable plan copayment. When you try to fill a 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 copayment. If the physician does not approve, a preauthorization review will be initiated to determine the medical necessity of the non-preferred drug. Unless there are documented clinical reasons why you cannot take the generic/preferred drug, you may still obtain the non-preferred drug but you will be responsible for 100% of the cost, which will not apply to your annual out-of-pocket maximum. If the preauthorization for the non-preferred medication is approved, you will be responsible for the applicable plan copayment.
- **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.

  CVS Caremark Mail Service Pharmacy can compound some medications. When a claim is submitted for online processing or direct reimbursement of a compound medication, the 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 as part of the claim for both online claims and paper claim submissions. At least one of the ingredients in the compound prescription claim must require a physician's prescription in order to be covered by the Plan. You are responsible for the appropriate brand name or generic copay or coinsurance based on the compound ingredients. Preauthorization may be required. Experimental or investigational drugs are not FDA approved and are not covered by GEHA. If the compound includes an experimental or investigational drug, the compound will not be covered.

  If the mail order pharmacy cannot accommodate your prescription, please consult a participating retail pharmacy. 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 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. Compound medications are limited to a 30-day supply. The only exceptions for filling greater than a 30-day supply are through CVS Caremark Mail Service Pharmacy, CVS Pharmacy or Standard Option members may use a CVS Caremark Extended Day Supply (EDS) network pharmacy. Please confirm your compounding pharmacy meets this requirement or contact CVS Caremark at 844-443-4279 prior to filling the prescription. Mail the claim to CVS Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136. Claim calculations, copayments, and reimbursement for direct claims is performed using an industry standard reimbursement method for compounds.

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;*
- FDA approved contraceptive drugs and devices for women;
- Diabetic medications and supplies, such as:
  - Insulin;
  - Needles and syringes for the administration of covered medications;
  - Blood glucose meter - provided at no charge by the manufacturer, through the CVS Caremark Mail Service Pharmacy, call toll free: 877-418-4746;
- Prenatal vitamins for pregnant women;
- Ostomy supplies (please include the manufacturer's product number to ensure accurate fill of the product).

High Option and Standard Option Prescription Drug Tiers

Under the **High Option and Standard Option**, 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 preferred or non-preferred applicable plan coinsurance. If an approved generic equivalent is available, but you or your physician specifies that the prescription must be dispensed as written with the brand name medication, you will pay the generic copayment plus the difference between the cost of the generic drug and the brand name drug dispensed. Your physician may request the brand name drug be approved through a medical necessity review. If your brand name drug is approved as medically necessary, your coinsurance will be the applicable brand name coinsurance.

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

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. Selection criteria sources include but are not limited to: peer-reviewed literature; recognized compendia; consensus documents; nationally sanctioned guidelines and other publications of the National Institutes of Health, Agency for Healthcare Research and Quality, and other organizations or government agencies; drug labeling approved by the FDA; and input from medical specialty practitioners.

Non-Preferred drugs are FDA approved prescription medications that are covered by GEHA, however they are not included on the CVS Caremark Preferred Drug List. Most commonly utilized medications have generic or preferred medications available.

High Option Maintenance Choice

Maintenance Choice® lets you choose how to get 90-day supplies of your maintenance medications: through mail service or at a retail CVS Pharmacy. Either way, you pay mail service prices for 90-day supplies. After two retail 30-day prescription fills, members are required to use their mail service benefit. With the Maintenance Choice program, members can continue to use retail CVS Pharmacy locations to gain access to a 90-day supply while accessing the mail order coinsurance under your plan. Maintenance Choice also allows members the ability to have their prescription transferred from the mail order service, to a retail CVS Pharmacy location if the member wants the experience of talking with pharmacy staff in person. If a member would like to get started with mail service for the first time, they can call the CVS Caremark Fast Start program and CVS Caremark will work with their physician to acquire a 90-day supply prescription to be filled through either the CVS Caremark Mail Service Pharmacy or their local retail CVS Pharmacy. The CVS Caremark Fast Start program can be reached at 800-875-0867 or members can sign in or register at www.caremark.com/faststart once their plan year begins.

CVS Caremark formulary

Your prescription drug program includes use of the CVS Caremark formulary which is developed by an independent panel of doctors and pharmacists who ensure the medications are clinically appropriate and cost-effective. In an effort to continue to help promote affordable and clinically appropriate products, there are a select number of drugs that are excluded from the formulary and not covered by the Plan. For these drugs, generics and/or 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. Please refer to our website at www.geha.com or call CVS Caremark at 844-4-GEHARX or 844-443-4279 for a list of excluded medications and/or formulary alternatives covered by the Plan.

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 non-preferred medication. The ACSF is reviewed quarterly and medications may change formulary status including preferred to non-preferred and non-preferred to preferred. Impacted members will be notified of the change at least 90 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 www.geha.com to view the most current list of specialty drugs. You may also call CVS Specialty at 800-237-2767. Specialty category examples include:

- Acromegaly
- Alcohol/Opioid Dependency
- Allergic Asthma
- Alpha-1 Antitrypsin Deficiency
- Anemia
- Cardiac Disorders
- Central Precocious Puberty (CPP)
- Cryopyrin-Associated Periodic Syndromes
- Cushing's Syndrome
- Cystic Fibrosis
- Dupuytren's Contracture
- Electrolyte Disorder
- Gastrointestinal Disorders-Other
- Gout
- Growth Hormone and Related Disorders
- Hematopoietics
- Hemophilia, Von Willebrand Disease and Related Bleeding Disorders
- Hepatitis
- Hereditary Angioedema
- HIV Medications
- Hormonal Therapies
- Immune Deficiencies and Related Disorders
- Immune (Idiopathic) Thrombocytopenic Purpura
- Infectious Disease
- Inflammatory Bowel Disease
- Iron Overload
- Lipid Disorders
- Lysosomal Storage Disorders
- Movement Disorders
- Multiple Sclerosis
- Muscular Dystrophy
- Neuromuscular Disorders
- Neutropenia
- Oncology—Injectable
- Oncology—Oral/Topical
- Osteoporosis
- Paroxysmal Nocturnal Hemoglobinuria
- Phenylketonuria
- Pre-Term Birth
- Psoriasis
- Pulmonary Arterial Hypertension
- Renal Disease
- Respiratory Syncytial Virus
- Retinal Disorders
- Rheumatoid Arthritis
- Seizure Disorders
- Systemic Lupus Erythematosus
- Transplant
- Urea Cycle Disorders

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. Changes to the formulary are not considered benefit changes.

Coordinating with other drug coverage

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

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

1. Present prescription ID cards from both your primary insurance plan and GEHA.
2. If able, the pharmacy will electronically process both your primary and secondary claims and the pharmacist will tell you if you have any remaining copay/coinsurance to pay.
3. If the pharmacy cannot electronically process the secondary claim, purchase your prescription using the prescription ID card issued by your primary insurance carrier and pay any copay/coinsurance required by the primary insurance. Then, mail your pharmacy receipt and primary Explanation of Benefits (EOB) to CVS Caremark for consideration of possible reimbursement through your GEHA, secondary benefit. Submit these claims to CVS Caremark, PO Box 52136, Phoenix, AZ 85072-2136.

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

1. Purchase your prescription using the prescription ID card issued by your primary insurance carrier and pay any copay/coinsurance required by the primary insurance.
2. Then, mail your pharmacy receipt and primary EOB to CVS Caremark for consideration of possible reimbursement through your GEHA, secondary benefit. Submit these claims to CVS Caremark, PO Box 52136, Phoenix, AZ 85072-2136.

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.

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

When coordination of benefits apply, reimbursement is based on GEHA's retail Plan allowable benefit. Our benefit payment will be based on the lesser of:

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

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. Please note, the CVS Caremark Mail Service Pharmacy is not a Medicare Part B provider for diabetic supplies. You must use a retail pharmacy willing to bill Medicare as primary.

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

Patient Safety

GEHA 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 – GEHA reserves the right to maximize your quality of care as it relates to the utilization of pharmacies.

GEHA 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 844-4-GEHARX or 844-443-4279 or visit www.caremark.com. 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 for drugs which require a prescription, ostomy supplies, diabetic supplies and insulin, syringes and needles for covered injectable medications, and oral contraceptives. Some medications may not be available in a 90-day supply from 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.

Some medications may require approval by CVS Caremark or GEHA. 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; enclose your prescription and the correct copayment.

Under regular circumstances, you should receive your medication within approximately 14 days from the date you mail your prescription. You will also receive reorder instructions. If you have any questions or need an emergency consultation with a registered pharmacist, you may call CVS Caremark toll-free at 844-4-GEHARX or 844-443-4279 available 24 hours a day, 7 days a week. Forms necessary for refills will be provided each time you receive a supply of medication.

Mail to:
CVS Caremark
PO Box 94467
Palatine, IL 60094-4467

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

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

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

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

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

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

Benefits Description	You pay	
Covered medications and supplies – when GEHA is primary	**High Option**	**Standard Option**
Network Retail Pharmacy All copayments are for up to a 30-day supply per prescription. A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when a Federally-approved generic drug is available. If there is no generic equivalent available, you pay the applicable plan coinsurance. If you choose 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. Your physician may call 855-240-0536, if he/she determines there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance. Note: Medications to treat some complex and chronic medical conditions are only available through CVS Specialty. See page 81 for the categories of drugs in this program.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug, whichever is less Preferred: 25% of Plan allowance up to a maximum of $150, for up to a 30-day supply Non-Preferred: 40% of Plan allowance up to a maximum of $200, for up to a 30-day supply For the third and all subsequent refills of a maintenance medication, you pay the greater of 50% of Plan allowance or the amount described above (except for Maintenance Choice).	Generic: $10 or the retail pharmacy's usual and customary cost of the drug, whichever is less Preferred: 50% of Plan allowance up to a maximum of $200, for up to a 30-day supply Non-Preferred: 50% of Plan allowance up to a maximum of $300, for up to a 30-day supply Retail fills eligible for a greater than a 30-day supply will be subject to 50% of Plan allowance up to the maximum of $500 for preferred and $600 for non-preferred.
Non-Network Retail Pharmacy If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to: CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 Your claim will be calculated on the coinsurance or the appropriate copayments. Reimbursement will be based on GEHA's costs had you used a participating pharmacy. You must submit original drug receipts. All copayments are for up to a 30-day supply per prescription. If you choose 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. Your physician may call 855-240-0536, if he/she determines there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Preferred: 25% of Plan allowance up to a maximum of $150, for up to a 30-day supply Non-Preferred: 40% of Plan allowance up to a maximum of $200, for up to a 30-day supply For the third and all subsequent refills of a maintenance medication, you pay the greater of 50% of Plan allowance or the amount described above. You pay the difference between our allowance and the cost of the drug.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug whichever is less Preferred: 50% of Plan allowance up to a maximum of $200, for up to a 30-day supply Non-Preferred: 50% of Plan allowance up to a maximum of $300, for up to a 30-day supply Retail fills eligible for a greater than a 30-day supply will be subject to 50% of Plan allowance up to the maximum of $500 for preferred and $600 for non-preferred You pay the difference between our allowance and the cost of the drug.

Covered medications and supplies – when GEHA is primary - continued on next page

Benefits Description	You pay	
Covered medications and supplies – when GEHA is primary (cont.)	**High Option**	**Standard Option**
CVS Caremark Mail Service Pharmacy All copayments are for up to a 90-day supply per prescription. A generic equivalent will be dispensed unless you or your physician specifies the prescription be dispensed as written (DAW), when a generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance. If you choose 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. Your physician may call 855-240-0536, if he/she determines there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.	Generic: $20 or the cost of the drug, whichever is less Preferred: 25% of Plan allowance up to a maximum of $350, for up to a 90-day supply Non-Preferred: 40% of Plan allowance up to a maximum of $500, for up to a 90-day supply Maintenance Choice lets you choose how to get a 90-day supply of your maintenance medications through mail service or at a CVS Pharmacy.	Generic: $20 or the cost of the drug, whichever is less Preferred: 50% of Plan allowance up to a maximum of $500, for up to a 90-day supply Non-Preferred: 50% of Plan allowance up to a maximum of $600, for up to a 90-day supply
Covered medications and supplies – Medicare A & B primary	**High Option**	**Standard Option**
Network Retail Pharmacy All copayments are for up to a 30-day supply per prescription. A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written, (DAW) when a generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance. If you choose 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. Your physician may call 855-240-0536, if he/she determines there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance. Note: Medications to treat some complex and chronic medical conditions are only available through CVS Specialty. See page 81.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug, whichever is less Preferred: 20% of Plan allowance up to a maximum of $150, for up to a 30-day supply Non-Preferred: 35% of Plan allowance up to a maximum of $200, for up to a 30-day supply For the third and all subsequent refills of a maintenance medication, you pay the greater of 50% of Plan allowance or the amount described above.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug, whichever is less Preferred: 50% of Plan allowance up to a maximum of $200, for up to a 30-day supply Non-Preferred: 50% of Plan allowance up to a maximum of $300, for up to a 30-day supply Retail fills eligible for a greater than a 30-day supply will be subject to the 50% of Plan allowance up to the maximum of $500 for preferred and $600 for non-preferred

Covered medications and supplies – Medicare A & B primary - continued on next page

Benefits Description	You pay	
Covered medications and supplies – Medicare A & B primary (cont.)	**High Option**	**Standard Option**
Non-Network Retail If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to: CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 Your claim will be calculated on the coinsurance or the appropriate copayments. Reimbursement will be based on GEHA's costs had you used a participating pharmacy. You must submit original drug receipts. All copayments are for up to a 30-day supply per prescription. If you choose 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. Your physician may call 855-240-0536, if he/she determines there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug, whichever is less Preferred: 20% of Plan allowance up to a maximum of $150, for up to a 30-day supply Non-Preferred: 35% of Plan allowance up to a maximum of $200, for up to a 30-day supply You pay the difference between our allowance and the cost of the drug.	Generic: $10 or the retail pharmacy's usual and customary cost of the drug, whichever is less Preferred: 50% of Plan allowance up to a maximum of $200, for up to a 30-day supply Non-Preferred: 50% of Plan allowance up to a maximum of $300, for up to a 30-day supply Retail fills eligible for a greater than a 30-day supply will be subject to 50% of Plan allowance up to the maximum of $500 for preferred and $600 for non-preferred You pay the difference between our allowance and the cost of the drug.
CVS Caremark Mail Service Pharmacy All copayments are for up to a 90-day supply per prescription. A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when a Federally-approved generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance. If you choose 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. Your physician may call 855-240-0536, if he/she determines there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.	Generic: $15 or the cost of the drug, whichever is less Preferred: 15% of Plan allowance up to a maximum of $350, for up to a 90-day supply Non-Preferred: 30% of Plan allowance up to a maximum of $500, for up to a 90-day supply Maintenance Choice lets you choose how to get 90-day supplies of your maintenance medications through mail service or at a retail CVS Pharmacy.	Generic: $20 or the cost of the drug, whichever is less Preferred: 50% of Plan allowance up to a maximum of $500, for up to a 90-day supply Non-Preferred: 50% of Plan allowance up to a maximum of $600, for up to a 90-day supply

Benefits Description	You pay	
Specialty drug benefits	**High Option**	**Standard Option**
Specialty medications are certain pharmaceuticals which may be biotech or biological drugs. Specialty medications are oral, injectable or infused, and/or may require special handling. To maximize patient safety, most specialty medications require preauthorization. These drugs are used in the treatment of complex, chronic medical conditions which include but are not limited to hemophilia, multiple sclerosis, hepatitis, cancer, rheumatoid arthritis, pulmonary hypertension, transplant, HIV, osteoarthritis, and immune deficiency. If you are new to select specialty therapies (i.e.: oral oncology, hepatitis B, Parkinson's disease psychosis and hematological disorders), you will receive a 14 or 15 day supply for the first 2 months of therapy. Your coinsurance will be prorated. If you continue on this therapy, you may receive up to a 30 day supply of the medication. Some specialty medications may not be available in a 30-day supply, your coinsurance will be based on days of therapy. For certain specialty therapies, you are required to use the generic unless your physician demonstrates medical necessity for the brand. If you choose 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 he/she determines there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance. CVS Specialty Pharmacy provides not only your specialty medications, but also personalized pharmacy care management services. If you have questions, visit www.CVSCaremarkSpecialtyRx.com or call Specialty Customer Care toll-free at 800-237-2767. Outpatient, non-surgical cancer treatments require preauthorization through eviti at www.eviti.com or call eviti at 888-678-0990. Specialty drugs require preauthorization. See "How to obtain preauthorization" on page 79. Your benefit includes the Advanced Control Specialty Formulary (ACSF); please see page 81 for additional information. A separate copayment applies per prescription fill up to a 30-day supply. This copayment does apply to the out-of-pocket maximum. When other coverage is primary and the primary coverage does not pay benefits, the $300 (High Option) or $500 (Standard Option) copayment for specialty pharmacy medications not dispensed by the CVS Specialty Pharmacy does apply. If Medicare denies benefit, GEHA does not waive the coinsurance. Recurring oral 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.	**Medications dispensed by CVS Specialty Pharmacy:** **When GEHA is primary:** • Generic and Preferred: 25% of Plan allowance up to a maximum of $150, for up to a 30-day supply • Non-Preferred: 40% of Plan allowance up to a maximum of $200, for up to a 30-day supply **When Medicare is primary:** • Generic and Preferred: 15% of Plan allowance up to a maximum of $150, for up to a 30-day supply • Non-Preferred: 30% of Plan allowance up to a maximum of $200, for up to a 30-day supply **Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals may be paid under the medical benefit. Recurring oral medications must be obtained through the pharmacy benefit.** **When GEHA is Primary or when other coverage is primary and denies claim, you pay after the calendar year deductible:** • Generic and Preferred: $300 copayment applies per prescription fill and 25% of the Plan allowance, up to a 30-day supply • Non-Preferred: $300 copayment applies per prescription fill and 40% of the Plan allowance, up to a 30-day supply	**Medications dispensed by CVS Specialty Pharmacy:** **When GEHA is primary:** • Generic and Preferred: 50% of Plan allowance up to a maximum of $250, for up to a 30-day supply • Non-Preferred: 50% of Plan allowance up to a maximum of $400, for up to a 30-day supply **When Medicare is primary:** • Generic and Preferred: 50% of Plan allowance up to a maximum of $250, for up to a 30-day supply • Non-Preferred: 50% of Plan allowance up to a maximum of $400, for up to a 30-day supply **Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals may be paid under the medical benefit. Recurring oral medications must be obtained through the pharmacy benefit.** **When GEHA is Primary or when other coverage is primary and denies claim, you pay after the calendar year deductible:** • Generic and Preferred: $500 copayment per 30-day supply applies per prescription fill and 50% of the Plan allowance, up to a 30-day supply • Non-Preferred: $500 copayment per 30-day supply applies per prescription fill and 50% of the Plan allowance, up to a 30-day supply

Specialty drug benefits - continued on next page

Benefits Description	You pay	
Specialty drug benefits (cont.)	**High Option**	**Standard Option**
	When Medicare is Primary and denies claim: • Generic and Preferred: $300 copayment applies per prescription fill and 15% of the Plan allowance, up to a 30-day supply • Non-Preferred: $300 copayment applies per prescription fill and 30% of the Plan allowance, up to a 30-day supply	**When Medicare is Primary and denies claim**: • Generic and Preferred: $500 copayment per 30-day supply applies per prescription fill and 50% of the Plan allowance, up to a 30-day supply • Non-Preferred: $500 copayment per 30-day supply applies per prescription fill and 50% of the Plan allowance, up to a 30-day supply
Non-Specialty Pharmacy retail purchase If CVS Specialty Pharmacy is not used and you purchase a specialty medication through a retail pharmacy, you must submit your claim to: Government Employees Health Association, Inc. Attention: RX Program PO Box 21542 Eagan, MN 55121 Reimbursement will be based on GEHA's costs had you used the specialty pharmacies. You must submit original drug receipts. If you choose 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 he/she determines there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance. A separate copayment applies per prescription fill up to a 30-day supply. This copayment does apply to the out-of-pocket maximum. When other coverage is primary and the primary coverage does not pay benefits, the $300 (High Option) or $500 (Standard Option) copayment for specialty pharmacy medications not dispensed by the CVS Specialty Pharmacy does apply. If Medicare denies benefit, GEHA does not waive the coinsurance.	**When GEHA is primary:** • $300 copayment per prescription fill and: Generic and Preferred: 25% of Plan allowance Non-Preferred: 40% of Plan allowance You pay the difference between our allowance and the cost of the drug. **When Medicare is primary:** • Generic and Preferred: 15% of Plan allowance Non-Preferred: 30% of Plan allowance You pay the difference between our allowance and the cost of the drug.	**When GEHA is primary:** • $500 copayment per prescription fill and 50% of the Plan allowance You pay the difference between our allowance and the cost of the drug.

Benefits Description	You pay	
Preventive care medications	**High Option**	**Standard Option**
Preventive Care - The following medications to promote better health will be offered with no cost-sharing at a participating pharmacy as recommended under the Patient Protection and Affordable Care Act (ACA), link to the website www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations. Age restrictions apply. Note: 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 ≤81 mg OTC only (requires a prescription) for prevention of cardiovascular disease (CVD) for age ranges 50-59; and 81mg generic OTC for the prevention of pre-eclampsia after 12 weeks of gestation. Limit of 100 units per fill applies for both populations. • Fluoride supplements (not toothpaste or rinses) - Single ingredient brand name and generic prescription products in an oral dosage form ≤ 0.5mg for children 5 years of age and younger. • Folic acid supplements - Single ingredient generic 0.4mg and 0.8mg tabs. OTC only (requires a prescription) for women 55 years of age and younger. Limit of 100 units per fill. • Generic tamoxifen and raloxifene - with prescription for women ages 35 and over for the prevention of breast cancer. • Colorectal Cancer Prevention - Bowel prep products - brand name and generic, Rx only, age 50-75 years. • 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. • Statins - low to moderate dose of certain generic statins for individuals age 40-75 years.	Nothing (no deductible)	Nothing (no deductible)
• Immunizations: Vaccines; childhood and adult, Rx only, coverage dependent on vaccine type. - GEHA members can go to a participating retail pharmacy to receive certain vaccinations. Influenza vaccine is commonly administered by retail pharmacies. Other vaccines, such as those for pneumococcal pneumonia (Pneumovax), varicella (Zostavax and Shingrix) and hepatitis B (Heptavax) may also be available through retail pharmacies.	Nothing (no deductible) for most vaccines. Please check with CVS Caremark at 844-4-GEHARX or 844-443-4279 for coverage benefits.	Nothing (no deductible) for most vaccines. Please check with CVS Caremark at 844-4-GEHARX or 844-443-4279 for coverage benefits.

Preventive care medications - continued on next page

Benefits Description	You pay	
Preventive care medications (cont.)	**High Option**	**Standard Option**
- Members may call CVS Caremark at 844-4-GEHARX or 844-443-4279 to identify a participating vaccine pharmacy or go to www.caremark.com. GEHA members should check with the retail pharmacy to ensure availability of a pharmacist who can inject vaccines and availability of the vaccine product before going to the pharmacy. GEHA members should also ask retail pharmacies if there is an age requirement for vaccines that can be administered at that pharmacy.	Nothing (no deductible) for most vaccines. Please check with CVS Caremark at 844-4-GEHARX or 844-443-4279 for coverage benefits.	Nothing (no deductible) for most vaccines. Please check with CVS Caremark at 844-4-GEHARX or 844-443-4279 for coverage benefits.
• Smoking Cessation/E-cigarettes - 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 GEHA ID card, through a participating network retail pharmacy, CVS Caremark Mail Service Pharmacy, or a non-network retail pharmacy (see page 84 for filing instructions).	Nothing (no deductible), day supply limits apply depending on therapy	Nothing (no deductible), day supply limits apply depending on therapy
Non-covered medications and supplies	**High Option**	**Standard Option**
The following medications and supplies are not covered under the GEHA prescription drug benefit: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements (alone or in combination) not listed as a covered benefit or that do not require a prescription are not covered, including enteral formula available without a prescription* • *Nonprescription medications not shown as covered* • *Medical supplies such as dressings and antiseptics* • *Drugs which are investigational* • *Drugs prescribed for weight loss* • *Drugs to treat infertility* • *Drugs to treat impotency* • *Certain prescription drugs that have an over-the-counter (OTC) equivalent drug are not covered* • *Certain compounding chemicals including, but not limited to, OTC products, experimental, investigational, bulk powders, bulk chemicals, and certain bases.* • *Drugs to enhance athletic performance* *Note: OTC or prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation/ E-cigarettes benefit, through a participating network retail pharmacy, CVS Caremark Mail Service Pharmacy or a non-network retail pharmacy. See above.*	*All charges*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your 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 other coverage.***
- There is no calendar year deductible for dental benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists, which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5(c) for *Inpatient hospital benefits.*

Accidental injury benefit

We cover restorative services and supplies necessary to promptly repair sound natural teeth. The need for these services must result from an accidental injury. The repair of accidental injury to sound natural teeth includes but is not limited to, expenses for X-rays, drugs, crowns, bridgework, inlays, and dentures. We do not cover oral implants and transplants. Masticating (biting or chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at 100% for charges incurred within 72 hours of an accident. Services incurred after 72 hours are paid at regular Plan benefits.

Dental benefit description				
Dental Services	**High Option Scheduled Allowance We Pay**	**High Option Scheduled Allowance You Pay**	**Standard Option Scheduled Allowance We Pay**	**Standard Option Scheduled Allowance You Pay**
Diagnostic and preventive services, including examination, prophylaxis (cleaning), X-rays of all types and fluoride treatment	$22 per visit (maximum two visits per year)	All charges in excess of the scheduled amount listed to the left	50% up to the Plan allowance for diagnostic and preventive services per year 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 (payable at 50%)	50% up to the Plan allowance and all charges in excess of the Plan allowance for diagnostic and preventive services

Dental Services - continued on next page

Dental benefit description				
Dental Services (cont.)	**High Option Scheduled Allowance We Pay**	**High Option Scheduled Allowance You Pay**	**Standard Option Scheduled Allowance We Pay**	**Standard Option Scheduled Allowance You Pay**
Amalgam Restorations **Resin - Based Composite Restorations** **Gold Foil Restorations** **Inlay/Onlay Restorations**	$21 One surface $28 Two or more surfaces	All charges in excess of the scheduled amounts listed to the left	$21 One surface $28 Two or more surfaces	All charges in excess of the scheduled amounts listed to the left
Simple Extractions	$21 Simple extraction	All charges in excess of the scheduled amount listed to the left	$21 Simple extraction	All charges in excess of the scheduled amount listed to the left
Not covered: • *Oral implants and transplants are not covered, including for the treatment of accidental injury*	*Nothing*	*All charges*	*Nothing*	*All charges*

Section 5(h). 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).
Services for deaf and hearing impaired	TTY service is available at 800-821-4833 for members who are hearing impaired.
Medicare Premium Reimbursement for High Option members enrolled in both Medicare Parts A and B	High Option members enrolled in both Medicare Part A *and* Part B are eligible to be reimbursed up to $600 per calendar year for their Medicare Part B premium payments. For more information on how to get reimbursement for your paid Medicare Part B premiums, please visit www.geha.com or call 800-821-6136.
Health Rewards/Health Assessment	Adults over age 18 in Self Only, Self Plus One and Self and Family enrollments are eligible to take the health risk assessment, which will provide the member with valuable information about health status and steps to consider to improve their health. The GEHA Health Rewards program provides rewards for participation in activities that promote health improvements. The Health Rewards program is limited to two adults, over age 18, in Self Plus One and Self and Family enrollments. Members can earn health rewards up to a total of $250 for the following activities: 1. Completion of the annual health assessment ($75.00); 2. Completion of the annual biometric screening provided by GEHA ($75.00); 3. Completion of wellness portal classes; such as weight management, stress management, smoking cessation; or 4. Participation in a targeted health program (by invitation) (up to $100) Members will be issued a Health Rewards Savings card, which can be used to purchase eligible medical services and medical care items. **For detailed information about how to access the health risk assessment and incentives that may be available through the Health Rewards program, visit:** www.geha.com/rewards**.**

Special features	Description
Lab Card, service of Quest Diagnostics	The Lab Card Program gives you and your covered dependents the option of receiving 100% covered outpatient laboratory testing. Lab Card is an optional program. If you choose not to use Lab Card, you will not be penalized. You will simply pay the deductible, coinsurance or copay portion of your lab work. Lab Card does not replace your current health care benefits; it simply gives you and your dependents the option of receiving 100% coverage for outpatient laboratory testing. Please Note: You must show your Lab Card each time you obtain lab work whether in the physician's office or collection site. This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Card Program) are subject to applicable deductibles and coinsurance. Lab Card covers most outpatient laboratory testing included in your health insurance plan, provided the tests have been ordered by a physician and you have asked for the Lab Card benefit and shown your Lab Card. Outpatient lab work includes: blood testing (e.g., cholesterol, CBC), urine testing (e.g., urinalysis), cytology and pathology (e.g., pap smears, biopsies), and cultures (e.g., throat culture). Lab Card does not cover: Lab work ordered during hospitalization, lab work needed on an emergency (STAT) basis and time sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests, non-laboratory work such as mammography, X-ray, imaging and dental work.
High risk pregnancies	GEHA makes various maternity resources available to you or your covered dependent. Visit www.geha.com/maternity to order your packet on pregnancy and prenatal care.
24-hour Health Advice Line	Call the toll-free GEHA 24-hour Health 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 Health Advice Line allows you to conveniently manage your symptoms and treatment anywhere you have access to a phone.
Telehealth	Telehealth is available through MDLIVE. Go to https://members.mdlive.com/geha-callmd/ or call 888-912-1183 to access on demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions (see Section 10 for definition), dermatology conditions (see Section 10 for definition) and counseling for behavioral health and substance use disorder. Note: This benefit is available only through the MDLIVE contracted telehealth provider network. Note: Practitioners must be licensed in the state where the patient is physically located at the time services are rendered.
Obesity screening and management	GEHA 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 5a*) • 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.

Special features	Description
Personal Health Record	Our Personal Health Record helps you track health conditions, allergies, medications and more. This program is voluntary and confidential. To access this tool, log in through your member dashboard at www.geha.com.
Value Added Programs and Services	GEHA offers a number of programs and services to members to assist with special conditions and needs. Members can work with a nurse or health coach to deal with obesity, chronic conditions, cancer while in active treatment, and others. Visit www.geha.com for a list of programs, program criteria, and contact information.

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 their website at www.geha.com.

Non-Covered Prescription Drugs	844-4-GEHARX or 844-443-4279

Certain erectile dysfunction prescription drugs not covered by GEHA's Prescription Drug Program are available to GEHA health plan members at a discount. If your physician writes a prescription for a non-covered erectile dysfunction drug (excluding Levitra and Viagra) to treat impotency, you may purchase it through the CVS Caremark Mail Service Pharmacy, paying 100% of the discounted amount. To order, complete the form called CVS Caremark Mail Service Pharmacy Order Form, which is available from www.geha.com and mail along with full payment to the address on the order form.

CVS Caremark ExtraCare® Health Card	www.cvs.com

The CVS ExtraCare Health Card provides a 20 percent discount on items purchased for the health care of cardholder, spouse or dependents and applies to regular priced CVS Health Brand health-related items valued at $1 or more.

Connection Hearing® powered by TruHearing	844-224-2711	www.TruHearing.com

GEHA members save 30 percent to 60 percent off the average retail price of hearing aids with TruHearing, making it affordable to address your unique hearing needs. GEHA also offers you a hearing aid allowance of $2,500 (see the Hearing Services section of this brochure). You can apply your allowance to the cost of hearing aids through TruHearing to further minimize your out-of-pocket cost. TruHearing will submit the claim on your behalf, and you will only be responsible for charges in excess of your allowance.

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

Free to all GEHA High or Standard Option Plan members, you receive vision exam coverage for no additional premium. Through Connection Vision powered by EyeMed, you and your covered family members each pay only $5 for an annual routine eye exam when you use a qualified EyeMed participating provider. Or, if you seek services from a non-participating provider, you can be reimbursed up to $45 for your annual eye exam.

Connection Fitness®	800-821-6136	www.geha.com/health-and-wellness/connection-fitness

GEHA promotes healthy lifestyles and fitness activities. All GEHA health plan members can take advantage of our Connection Fitness program including discounts on gym memberships, access to online tools, and activity tracking.

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

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

CONNECTION Dental *Plus*®	800-793-9335	www.geha.com/cdplus

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

Smile Brilliant	855-944-8361	www.smilebrilliant.com/geha

GEHA members save 20% off of the lowest-published price for professional teeth-whitening. Smile Brilliant's custom-fitted trays, teeth whitening gel and desensitizing gel can be ordered online at www.smilebrilliant.com/geha.

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

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sexual dysfunction or sexual inadequacy.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, 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 page 114), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare "limiting charge" (see page 115), services, drugs or supplies related to avoidable complications and medical errors, "Never Event" policies (see page 119) or State premium taxes however applied.
- Charges in excess of the “Plan allowance” as defined beginning on page 119.
- 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 for temporomandibular joint dysfunction and disorders (TMJ).
- 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.
- Hourly nursing where there is no skilled need or the need is beyond a two hour visit per day (otherwise called private duty nursing) provided in the acute care facility, post-acute facilities (skilled nursing facilities), rehabilitation facilities, long-term acute care facilities, long-term care facilities, in the home.
- Computers, tablets, computer programs/games used in association with communication aides, internet or phone services used in conjunction with communication devices.
- Services provided by school systems to children with Autism Spectrum Disorder (ASD) are not reimbursable by the health plan.

Section 7. Filing a Claim for Covered Services

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

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

How to claim benefits

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

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

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

GEHA
P.O. Box 21542
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. 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;
- The charge for each service or supply; and
- Provider signature.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

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 rental or purchase of durable medical equipment; private duty nursing; and 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.
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

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 hospitals outside the United States and Puerto Rico, send a completed Overseas Claim Form and the itemized bills to: GEHA, Foreign Claims Department, P.O. Box 21542, Eagan, MN 55121. Obtain Overseas Claim Forms from www.geha.com.

Precertification is not required when procedures are performed or you are admitted to a hospital outside of the United States. However, the procedure/service to be performed, the number of days required to treat your condition, and any other applicable benefit criteria, will be reviewed for benefit eligibility and/or medical necessity.

If you have questions about the processing of overseas claims, contact us at 877-320-9469 or by email overseas@geha.com. If possible, include a receipt showing the exchange rate on the date the claimed services were performed. Covered providers outside the United States will be paid at the PPO level of benefits, subject to deductible and coinsurance.

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

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 health care 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 percent 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 telephone 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 health care 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 Service Department by writing GEHA, P.O. Box 21542, Eagan, MN 55121 or calling 800-821-6136.

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

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care 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 his/her subordinate, who made the initial decision.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: GEHA, P.O. Box 21542, Eagan, MN 55121; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms. 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.

Step	Description
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 Employee 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 health care 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.

Step	Description
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 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 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent 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 health care expenses without regard to fault. This is called "double coverage".

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

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

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

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

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

Please see Section 4, *Your costs for covered services,* for more information about how we pay claims.

This plan always pays secondary to:

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

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

- **TRICARE and CHAMPVA**

TRICARE is the health care 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 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**

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.

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

- **Medicaid**

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

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

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

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

  Enforce its right of reimbursement, that is, recover any sums paid on your behalf from any payment(s) you or your representative obtain from other parties. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

  You must cooperate in doing what is reasonably necessary to assist us, and you must not take any action that may prejudice these rights of recovery. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your 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 GEHA on a first priority basis (i.e., before any other party) in full, up to the amount of benefits paid, out of any and all settlements, judgments, or other recoveries that you or your representative obtain, from any source and no matter how characterized, designated, or apportioned (for example, as "pain and suffering only"). GEHA enforces this right of reimbursement by asserting a lien against any and all recoveries obtained, including, but not limited to, first party Medpay, Personal Injury Protection, No-Fault coverage, Third-Party liability coverage, Uninsured and Underinsured coverage, personal liability umbrella coverage, and a workers compensation program or insurance policy. GEHA's lien consists of the total benefits paid to diagnose or treat the illness or injury. GEHA's lien applies first, regardless of the "make whole" and "common fund" doctrines. Your plan is not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan 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 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

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800-MEDICARE, 800-633-4227, TTY: 877-486-2048 for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 112.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.

  For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213, TTY: 800-325-0778.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits three months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213, TTY: 800-325-0778 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you did not take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

(Please refer to page 114 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

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

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

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

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

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

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

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

For members enrolled in High and Standard Option we waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- **Inpatient hospital benefits:** If you are enrolled in Medicare Part A, we waive the deductible and coinsurance. When you are enrolled in the high option, and you use a PPO facility, we will also waive the inpatient admission copayment.
- **Medical and surgery benefits and mental health/substance use disorder care**: If you are enrolled in Medicare Part B, we waive the deductible and coinsurance.
- **Office visits PPO providers and MinuteClinic** (where available): If you are enrolled in Medicare Part B, we waive the copayments for PPO office visits.
- **Prescription drugs**: If you have Medicare Parts A and B, you will pay a copayment or coinsurance for drugs through CVS Caremark and at retail pharmacies as shown beginning on page 85.
- **Manipulative Therapy benefits**: There is no change in benefit limits or maximums for manipulative therapy care when Medicare is primary. See page 49 for benefits.

- **Physical, speech and occupational therapy benefits:** There is no change in benefit limits or maximums for therapy when Medicare is primary.
- **We do NOT waive the $300 (High Option) or $500 (Standard Option) copayment for specialty pharmacy medications not dispensed by the CVS Specialty Pharmacy. If Medicare denies coverage, we do not waive the coinsurance.**
- If you obtain services from a non-Medicare provider, we will 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.

Please review the following table that illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, then we waive some costs because Medicare will be the primary payor.

Benefit Description	**Member Cost without Medicare (In-Network)**	**Member Cost with Medicare Part B primary (In-Network)**
Deductible	High and Standard: $350 Self Only/$700 Self Plus One or Self and Family	High/Standard: $0
Out-of-Pocket Maximum	High: $5,000 Self Only/ $10,000 Self Plus One or Self and Family Standard: $6,500 Self Only/ $13,000 Self Plus One or Self and Family	High: $5,000 Self Only/ $10,000 Self Plus One or Self and Family Standard: $6,500 Self Only/ $13,000 Self Plus One or Self and Family
Part B Premium Reimbursement Offered	High/Standard: N/A	High: Up to $600 Standard: N/A
Primary Care Physician	High: $20 copayment Standard: $15 copayment	High/Standard: $0
Specialist	High: $20 copayment Standard: $30 copayment	High/Standard: $0
Inpatient Hospital	High: $100 per admission and 10% of Plan allowance Standard: 15% of Plan allowance	High/Standard: $0
Outpatient Hospital	High: 10% of Plan allowance Standard: 15% of Plan allowance	High/Standard: $0

Benefit Description	Member Cost without Medicare (In-Network)	Member Cost with Medicare Part B primary (In-Network)
Rx High Option	**Retail (30-day supply)** Generic: $10 Preferred: 25% of Plan allowance up to $150 Non-Preferred: 40% of Plan allowance up to $200 **Specialty (30-day supply)** Generic/Preferred: 25% of Plan allowance up to $150 Non-Preferred: 40% of Plan allowance up to $200	**Retail (30-day supply)** Generic: $10 Preferred: 20% of Plan allowance up to $150 Non-Preferred: 35% of Plan allowance up to $200 **Specialty (30-day supply)** Generic/Preferred: 15% of Plan allowance up to $150 Non-Preferred: 30% of Plan allowance up to $200
Rx Standard Option	**Retail (30-day supply)** Generic: $10 Preferred: 50% of Plan allowance up to $200 Non-Preferred: 50% of Plan allowance up to $300 **Specialty (30-day supply)** Generic/Preferred: 50% of Plan allowance up to $250 Non-Preferred: 50% of Plan allowance up to $400	**Retail (30-day supply)** Generic: $10 Preferred: 50% of Plan allowance up to $200 Non-Preferred: 50% of Plan allowance up to $300 **Specialty (30-day supply)** Generic/Preferred: 50% of Plan allowance up to $250 Non-Preferred: 50% of Plan allowance up to $400

You can find more information about how our Plan coordinates benefits with Medicare as outlined in our *Medicare + GEHA* booklet at www.geha.com/medicare.

- **Tell us about your Medicare coverage**

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

- **Private contract with your physician**

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

- **Medicare Advantage (Part C)**

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

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

  This Plan and another plan's Medicare Advantage plan: You may enroll in another 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, if you do go outside the Medicare Advantage plan's network and/or service area, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in 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 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 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:	Then you are responsible for:
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments.
Participates with Medicare and is **not** in our PPO network,	your deductibles, coinsurance, and any balance up to the Medicare approved amount.
Does not participate with Medicare,	your deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount.
Does not participate with Medicare and is not a member of our PPO network,	your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount.
Opts-out of Medicare via private contract,	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 he or she has 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.

If your physician **accepts** Medicare assignment, we waive some of your deductibles, copayments and coinsurance for covered charges.

If your physician **does not accept** Medicare assignment, you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of Terms We Use in This Brochure

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

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

Assignment An authorization by an enrollee or spouse for the Plan to issue payment of benefits directly to the provider. The Plan reserves the right to pay the member directly for all covered services.

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

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 Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts (see page 26).

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 GEHA benefit.

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

Copayment A copayment is a fixed amount of money you pay when you receive covered services (see page 26).

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

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

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

- Personal care such as help in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercise, and dressing;
- Homemaking, such as preparing meals or special diets;
- Moving the patient;
- Acting as companion or sitter;
- Supervising medication that can usually be self-administered; and
- Treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care. (Custodial care that lasts 90 days or more is sometimes known as long-term care.)

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services (see page 26).

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.

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

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

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

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

Group health coverage

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

Health care professional

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

Infertility

The condition of an individual who is unable to conceive or produce conception during a period of one year.

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. This Plan uses Milliman Care Guidelines to evaluate the appropriateness of observation services. See Section 3, How you get care, Covered facilities, for the definition of an Acute Inpatient and Residential Treatment Center.

Medical necessity

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Plan determines:

- Are appropriate to diagnose or treat the patient's condition, illness or injury;
- 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, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas, and any other relevant factors;
- 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; or
- In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Mental health/ substance 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. 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 Mental Health:

- Acute Care Hospital: See page 16 under Covered Facilities.
- Residential Treatment Center (RTC): See page 16 under Covered Facilities.

Intensive Day Treatment:

- Partial Hospital Program (PHP): An intensive facility based outpatient treatment program for mental health or substance use disorder conditions. The facility providing the service must meet GEHA's definition of a covered provider in Section 3. Sessions typically are 6-8 hours/ day, 5 days per week. Time frames and frequency will vary based upon diagnosis and severity of illness.
- Intensive Outpatient Treatment (IOP): A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance use disorders. It is an intermediate level of care between traditional outpatient therapy and partial hospitalization, delivered in an outpatient facility or outpatient professional office setting. If delivered in an outpatient facility, the facility must meet GEHA's definition of a covered facility in Section 3. Sessions typically do not exceed 3-4 hours/day, 3-5 days per week. Time frames and frequency will vary based upon diagnosis and severity of illness. If performed in a professional office setting the provider must meet GEHA's definition of a covered provider in Section 3.

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 health care 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. This Plan uses Milliman Care Guidelines to evaluate the appropriateness of observation services.

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 allowance

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

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

Non-PPO providers: To determine our non-PPO Plan allowance, we must first be provided an itemized bill that includes your diagnosis, the services or supplies you received, and the provider's charge for each, using the same types of standard codes, descriptions and other information required for processing by public health care plans like Medicare. If we are not provided the itemization of the services or supplies you received, we will assume they were equivalent to the level and extent of services and supplies typically provided by the providers or facilities most commonly used to treat other Plan members with the same principal diagnosis as yours. We will base these equivalent services on claims submitted to the Plan by providers in the same geographic region or a combination of similar geographic regions across the United States.

Based on the itemization of services or supplies you received, we will determine the amount of the maximum non-PPO Plan allowance by applying the following rules, in order:

1. We consult standard industry guides, such as national databases of prevailing health care charges from FAIR Health or another identified data source, that are available for our use in a given state or geographic area. After the data supplier removes outliers from the claim data they collect, they group the remaining data by percentiles. We use the 70th percentile. This means that out of every 100 reports remaining after outliers were removed, 30 charges billed may be more, but 70 charges will be the allowed amount or less.

2. For services or supplies obtained in a state or geographic area where the above data source is unavailable for our use, and also for dialysis centers and outpatient dialysis performed at a hospital our non-PPO Plan allowance is two times the Medicare participating provider allowance for the service or supply in the geographic area in which it was performed or obtained. This Medicare-based allowance is not used for those services where Medicare sets a fixed national payment amount that does not vary geographically (such as blood draws). Medicare fee schedule information for physician services may be obtained at www.cms.hhs.gov/PFSlookup.

Note: Labs drawn during the week of dialysis treatments and drugs provided on the day of dialysis are part of the bundled dialysis payment.

3. Some Plan allowances may be submitted to medical consultants who recommend allowances based on standard industry relative value guidelines. For services or supplies for which Medicare does not provide an allowance amount, we may use the current fee schedule used by the Federal Office of Workers Compensation (OWCP). OWCP fee schedule information may be obtained at www.dol.gov/OWCP/regs/feeschedule/fee.htm. For services or supplies that do not have a value currently established by public health care plans such as Medicare or Medicaid, or for implantable devices and surgical hardware, we may use medical consultants to determine an appropriate allowance. We may also conduct independent studies to determine the usual cost of a service or supply in a geographic area, or to establish allowances for services or supplies provided outside the United States.

Non-PPO Plan allowance amounts determined according to these guidelines include, but are not limited to, hospitals, ambulance, ambulatory surgery centers, dialysis centers, surgery, doctor's services, physical therapy, occupational therapy, speech therapy, lab testing and X-ray expenses, implantable devices and surgical hardware; and under the Standard Option, diagnostic and preventive dental services. For more information about the source of the data we are currently using you may call us at 800-821-6136.

Plan allowance for prescription drugs is determined using Average Wholesale Price or other industry-standard reference price data. Charges for some Plan allowances are stated in this brochure. These include limited benefits such as manipulative therapy care and routine dental care.

If we negotiate a reduced fee amount on an individual claim for services or supplies which is lower than the Plan allowance, covered benefits will be limited to the negotiated amount. Your coinsurance will be based on the reduced fee amount. If you choose to use a provider other than the one we negotiated a reduction with, you will be responsible for the difference in these amounts.

To estimate our maximum Plan allowance for a non-PPO 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.

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 health care service, treatment plan, drug, surgery, or durable medical equipment is medically necessary after review of medical information. Sometimes called prior approval.

Precertification The process of collecting information and obtaining authorization from the health plan prior to an inpatient admission or other selected ambulatory procedures and services.

Primary care physician For purposes of the office visit copayment for the Standard Option benefits, primary care physicians are individual doctors (M.D. or D.O.) whose medical practice is limited to family/general practice, internal medicine, pediatrics/adolescent medicine, obstetrics/gynecology (OB/Gyn) or geriatrics, psychiatrists, licensed clinical psychologists, licensed clinical social worker, licensed professional counselors or licensed marriage and family therapists. Doctors listed in provider directories or advertisements under any other medical specialty or sub-specialty area (such as internal medicine doctors also listed under cardiology, or pediatric sub-specialties such as pediatric allergy) are considered specialists, not primary care physicians. Chiropractors, eye doctors, dentists, and audiologists are not considered primary care physicians.

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.

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.

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

- Waiting could seriously jeopardize your life or health;

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

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

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

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

You You refers to the enrollee and each covered family member.

Index

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

Abortion.....38-39, 97-98
Accidental injury...56-57, 69-72, 76, 91-92, 116
Admission...19, 21, 63-65, 70-71, 73, 75, 102, 109-110, 116, 119
Advanced Control Specialty Formulary (ACSF).....78-83
Allergy tests.....41
Allogeneic (donor) bone marrow transplant 57-62
Alternative treatment.....49
  Acupuncture.....49
  Christian Science Practitioners.....49
Ambulance.....69, 72
Ambulatory surgical center.....16-18, 62, 67
Anesthesia.....49, 62, 67
Applied Behavioral Therapy (ABA)...22-23, 41-42
Artificial insemination.....40
Assignment.....114-116
Assisted reproductive technology.....40
Autologous bone marrow transplant...41-42, 57-62
Biopsy.....51-57
Blood or blood plasma.....64-65, 67
Breast prostheses.....45, 55-56
Breast pump and supplies.....38-39, 46-47
Calendar year.....116
Cardiac rehabilitation.....41-42, 67
Casts.....64-65, 67
Catastrophic out-of-pocket max.....28
Changes for 2020.....14-15
Chemotherapy.....22-23, 41-42, 57-62
Circumcision.....38-39, 64-65
Claims.....99
Clinical trials.....107-108, 116
Coinsurance.....26, 116
Compound medication.....79, 116-122
Congenital anomalies...22-23, 51-56, 97-98, 116-122
Contraceptive devices and drugs...35-37, 40, 51-55, 89-90
Coordination of benefits.....105-115
Copayment.....26, 116
Cosmetic.....55-56, 90, 97-98, 116
Cost containment.....28
Cost-sharing.....26, 116
Coverage information.....7
Covered facilities.....16-18
Covered providers.....16
Covered services.....116
Custodial care.....47-48, 64-65, 117
Deductible.....26, 117
Definitions.....116-122
Dental care.....91-92, 96
Diabetic supplies.....81-83
Disputed claims review.....102-104
Dressings.....64-65, 90
Durable medical equipment...22-23, 46-47, 117
Educational classes and programs...49-50
Elective surgery.....117
Emergency.....21, 70-72
Environmental medicine.....41, 49, 97-98
Expense.....117
Experimental or investigational.....117-118
Family planning.....40
Flexible benefits option.....93
Foot care.....45
Foster children.....7-9
Fraud.....3
Gamete intrafallopian transfer.....40
GEHA 24-Hour Health Advice Line...93-95
General exclusions.....97-98
Group health coverage.....118
Health care professional.....118
Hearing services.....44
High and Standard Option benefits.....32
Home health services.....47-48
Home nursing care.....99-101
Home uterine devices.....38-39
Hospice care.....68
Hospital.....63-69
Immunizations.....35-38, 89-90
Impacted teeth.....56-57
Infertility.....40, 90, 118
Inpatient hospital.....19, 64-65, 75, 118
Intensive day treatment.....22-23, 77, 119
Lab and pathological services.....34-35
Lab Card Program.....35, 94
Mail Service Pharmacy.....78-90
Mammograms.....34-37
Manipulative Therapy.....49
Maternity.....21, 38-39, 64-65, 67, 94
Medicaid.....106
Medical necessity.....118-119
Medicare.....105-115
Members.....7-9
Mental Health/Substance use disorder...73--77, 119
Never Events.....5-6, 119
Newborn.....21, 38-39, 64-65, 67
NICU cases.....21
No-fault.....105-107
Non-FEHB Benefits.....96
Nurse
  Licensed Practical Nurse (L.P.N.)...47-48, 99
  Nurse Anesthetist.....16, 64-65
  Nurse Midwife.....16
  Nurse Practitioner.....16
  Registered Nurse (R.N.)...16, 47-48, 51-55
Nursing School Administered Clinic.....16
Observation care.....63, 67, 73, 119
Obstetrical care.....38-39, 121
Ocular injury.....44
Office visits.....33-34, 45, 57-62
Oral and maxillofacial surgery.....56-57
Orthopedic devices.....45
Ostomy supplies.....79-83
Out-of-pocket expenses.....28
Overseas claims.....25, 100
Oxygen.....46-47, 64-65, 67
Pap test.....34-37
Patient Safety Links.....5-6
Physical and occupational therapies...22-23, 42-43
Physical examinations.....33-34
Physician.....16, 33-34, 51, 121
Plan allowance.....27, 119-121
Post-service claims.....100, 121
Pre-service claims.....24, 121
Preauthorization...46-47, 57-62, 78-79, 87-88
Precertification...19, 22-23, 33, 51, 57-63, 73, 77, 87-88, 121
Preferred Provider Organization.....12
Prescription Drugs.....22-23, 78-90, 96, 99
  Inpatient Hospital.....64-65
  Outpatient hospital.....67
Preventive care
  Adult/Children.....35-38
Primary care physician.....121
Private room.....64-65, 75
Prosthetic devices.....22-23, 45
Psychologist.....16, 73-74, 121
Radiation therapy.....41-42
Radiology/Imaging.....22-23
Renal dialysis.....22-23, 41-42, 46-47
Room and board.....64-65, 75
Second surgical opinions.....33-34
Skilled nursing care facility.....68
Sleep Studies.....22-23
Smoking cessation/E-cigarettes...49-50, 89-90, 93
Social worker.....16, 73-74
Sound natural tooth.....121
Specialty drugs.....87-88, 121
Speech therapy.....16, 22-23, 42-43
Splints.....64-65, 67
Sterilization procedures.....40
Subrogation.....106-107, 121
Substance use disorder.....22-23, 73-77, 119
Summary of benefits.....125-126
Surgery
  Anesthesia.....51-62, 67
  Bariatric.....22-23, 51-55, 94
  Multiple procedures.....51-55
  Oral.....56-57
  Reconstructive.....51-56

Take-home items.....64-65
Temporary Continuation of Coverage (TCC) 10
Temporomandibular Joints.....56-57, 97-98
Tobacco cessation/E-cigarettes...49-50, 89-90
Transplants (organ/tissue).....22-23, 57-62
Treatment therapies.....41-42
Urgent care claims.....20, 121-122
Urgent care facility.....34, 71
Us/We.....122
Vision services
Contact lenses/Eyeglasses.....44
Eye examinations.....44, 96
Vitamins.....90
Well child care.....38
Workers' Compensation.....105-107
X-rays.....34-35, 49, 56-57, 64-65, 67, 91
You.....122

Summary of Benefits for the High Option of the Government Employees Health Association, Inc. 2020

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

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

Below, an asterisk (*) means the item is subject to the $350 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a non-PPO physician or other health care professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $20 copay per covered office visit and 10%* of the covered professional services including X-ray and lab Non-PPO: 25%* of covered professional services	33
Services provided by a hospital:		
• Inpatient	PPO: 10% of room and board and other hospital charges, inpatient $100 per admission copayment applies Non PPO: 25% of room and board and other hospital charges, inpatient $300 per admission copayment applies	64
• Outpatient	PPO: 10%* of other hospital charges Non PPO: 25%* of other hospital charges	67
Emergency benefits:		
• Accidental injury	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident	70
• Medical emergency	Regular benefits*	71
Mental health and substance use disorder treatment:	Regular cost-sharing*	73
Prescription drugs:		
• Retail pharmacy	Network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/25% preferred drugs for up to a maximum of $150 for up to a 30-day supply/40% non-preferred drugs for up to a maximum of $200 for up to a 30-day supply/$10 plus the difference in cost between the brand name and the generic for up to a 30-day supply for the initial fill and first refill. For subsequent refills, you pay the greater of 50% or the amount described above (except for Maintenance Choice).	84

High Option Benefits	You pay	Page
• Retail pharmacy	Non-network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/25% preferred drugs for up to a maximum of $150 for up to a 30-day supply/40% non-preferred drugs for up to a maximum of $200 for up to a 30-day supply /$10 plus the difference in cost between the brand name and the generic for up to a 30-day supply for the initial fill and first refill. For subsequent refills you pay the greater of 50% or the amount described above and any difference between our allowance and the cost of the drug. Copayments and coinsurance go toward a $5,000 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic.	84
• Mail order	Member pays lesser of $20 or the cost of the drug for generic drugs/25% preferred drugs for up to a maximum of $350 for up to a 90-day supply/40% non-preferred drugs for up to a maximum of $500 for up to a 90-day supply/$20 plus the difference in cost between the brand name and the generic for up to a 90-day supply. Copayments and coinsurance go toward a $5,000 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic.	85
Dental care:	Charges in excess of the scheduled amounts for diagnostic and preventive service, restorations, and extractions	91
Wellness and other special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, 24-hour Health Advice Line, Health Assessment and Personal Health Record	93
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $5,000 Self Only ($10,000 Self Plus One or Self and Family) per year for PPO providers Nothing after $7,000 Self Only ($14,000 Self Plus One or Self and Family) per year for non-PPO providers Some costs do not count toward this protection	28

Summary of Benefits for the Standard Option of the Government Employees Health Association, Inc. 2020

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.geha.com/sbc**.** On this page we summarize specific expenses we cover; for more detail, look inside.

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

Below, an asterisk (*) means the item is subject to the $350 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a non-PPO physician or other health care professional.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $15 copay primary care physician; $30 copay specialist for covered office visits and 15%* of other covered professional services including X-ray and lab Non-PPO: 35%* of covered professional services	33
Services provided by a hospital:		
• Inpatient	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	64
• Outpatient	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	67
Emergency benefits:		
• Accidental injury	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident	70
• Medical emergency	Regular benefits*	71
Mental health and substance use disorder treatment:	Regular cost-sharing*	73
Prescription drugs:		
• Retail pharmacy	Network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/50% brand name for up to a maximum of $200 for up to a 30-day supply Non-network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/50% brand name for up to a maximum of $200 for up to a 30-day supply and any difference between our allowance and the cost of the drug. Copayments and coinsurance for prescription drugs go toward a $6,500 annual out-of-pocket limit except for the difference in cost between the brand name and the generic.	84

Standard Option Benefits	You pay	Page
• Mail order	Member pays lesser of $20 or the cost of the drug for generic drugs/50% brand name for up to a maximum of $500 for up to a 90-day supply Copayments and coinsurance for prescription drugs go toward a $6,500 annual out-of-pocket limit except for the difference in cost between the brand name and the generic.	85
Dental care:	50% up to Plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions	91
Wellness and other special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, 24-hour Health Advice Line, Health Assessment and Personal Health Record	93
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $6,500 Self Only ($13,000 Self Plus One or Self and Family) per year for PPO providers Nothing after $8,500 Self Only ($17,000 Self Plus One or Self and Family) per year for Non-PPO providers Some costs do not count toward this protection	28

Notes

2020 Rate Information for Government Employees Health Association, Inc. (GEHA) 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**.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, and NPMHU.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on https://liteblue.usps.gov/fehb.
- **Postal Category 2 rates** apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career employees represented by the NRLCA agreement. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center
877-477-3273, option 5
Federal Relay Service 800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution 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	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	311	$235.77	$105.42	$510.84	$228.41	$102.14	$92.32
High Option Self Plus One	313	$504.12	$246.51	$1,092.26	$534.11	$239.51	$218.50
High Option Self and Family	312	$546.47	$304.39	$1,184.02	$659.51	$296.80	$274.04
Standard Option Self Only	314	$181.64	$60.54	$393.54	$131.18	$58.12	$50.25
Standard Option Self Plus One	316	$390.53	$130.18	$846.16	$282.05	$124.97	$108.05
Standard Option Self and Family	315	$466.56	$155.52	$1,010.88	$336.96	$149.30	$129.08