

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	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

High and Standard Option

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
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Oral implants and transplants are not covered, including for the treatment of accidental injury</i> 	<i>Nothing</i>	<i>All charges</i>	<i>Nothing</i>	<i>All charges</i>

Section 5(h). Special features

Special features	Description
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • 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).
<p>Services for deaf and hearing impaired</p>	<p>TDD service is available at (800) 821-4833 for members who are hearing impaired.</p>
<p>High risk pregnancies</p>	<p>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.</p>
<p>Lab Card, service of Quest Diagnostics</p>	<p>The Lab Card Program gives you and your covered dependents the option of receiving 100% covered outpatient laboratory testing.</p> <p>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.</p> <p>Lab Card does not replace your current healthcare benefits; it simply gives you and your dependents the option of receiving 100% coverage for outpatient laboratory testing.</p> <p>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.</p> <p>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).</p>

	<p>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.</p>
Health Advice Line	<p>Call the toll-free GEHA 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. You will also have the option of a physician consultation by phone or video conference from any video-enabled computer, tablet or smartphone. The physician can evaluate and treat common adult pediatric illnesses such as ear infections, pink eye, sinus infections, urinary tract infections, headaches, joint aches and pains, and sunburn.</p> <p>The Health Advice Line allows you to conveniently manage your symptoms and treatment anywhere you have access to a phone, computer, tablet or smartphone.</p>
Health Rewards/Health Assessment	<p>Adults over age 18, in Self plus One and family enrollments are eligible to take the health risk assessment, which will provide valuable information about your health status and steps you can take to improve your health. GEHA’s Health Rewards program provides rewards for taking the health risk assessment and participating in activities that improve your health. The Health Rewards program is limited to two adults, over age 18, in self plus one and family enrollments.</p> <p>Your first step is completing an online health assessment. You will receive an individualized health report that can help you identify and address your health risks. This information is not shared with your employer. You will receive a \$75 gift card after completing the health assessment. In addition, you will earn 100 points (equivalent to \$100) by completing a biometric screening through Quest Diagnostics. You can earn up to an additional 75 points (equivalent to \$75) by participating in any of the following activities:</p> <ul style="list-style-type: none"> • Completion of on-line classes; such as weight management, stress management, or smoking cessation. • Tracking your nutrition and activity. • Participation in a targeted health program (by invitation). <p>The points you earn can be redeemed for health and wellness merchandise.</p> <p>Get more information and instructions for the first step, the health risk assessment, by going to www.geha.com/rewards.</p>
Obesity screening and management	<p>GEHA offers a number of services and tools for weight management.</p> <ul style="list-style-type: none"> • 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 precertified
Personal Health Record	<p>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.</p>

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
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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 (except Levitra) to treat impotency, you may purchase it through the CVS/caremark Mail Service Pharmacy (mail order), paying 100% of the discounted amount. To order, complete the form called CVS/caremark Mail Service Pharmacy Order Form. Mail this form along with your prescription and check or credit card number to:

CVS/caremark
P.O. Box 94467
Palatine, IL 60094-4467

If paying by check, please call first to obtain the cost of the medication. Full payment must be included with your order.

CVS/caremark ExtraCare®	www.cvs.com
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GEHA's members can receive additional savings on OTC products through the CVS/caremark ExtraCare® Health Card. The ExtraCare® Health Card provides GEHA members with a 20% discount on thousands of CVS/pharmacy brand name health-related items at www.cvs.com or in any CVS/pharmacy stores nationwide. Through www.cvs.com, members can access extensive health information and resources in addition to customized deals and savings information, including any ExtraSavings™ & ExtraBucks Rewards. Members also can turn their smartphone into a digital ExtraCare card with the CVS/pharmacy® application.

Connection Hearing® powered by TruHearing	(844) 224-2711	www.TruHearing.com/geha
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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 \$1,000 or \$2,000, depending on your specific health plan (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. If you are unsure of your allowed amount, TruHearing can verify your coverage.

TruHearing offers a selection of more than 100 of the latest hearing aids from the top hearing aid manufacturers in the world. A TruHearing provider in your area can give you a hearing exam and recommend the right hearing aids for your lifestyle and budget.

When you use TruHearing, you also get:

- three follow-up visits with a provider for fitting and adjustments;
- a 45-day money-back guarantee;
- three-year manufacturer's warranty for repairs and one-time loss and damage replacement;
- and 48 free batteries per aid.

TruHearing is a free program available to all GEHA members and their families, including over-age children, domestic partners, same-sex spouses, parents and grandparents. If you think you or a loved one may benefit from hearing aids, call TruHearing at (844) 224-2711 to get the right hearing aids at a price you can afford.

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

At participating EyeMed locations, GEHA members also receive discounts off the retail price of lenses, frames, specialty items (such as tints, lightweight plastics, scratch-resistant coatings), as well as LASIK and PRK.

For a list of participating locations, select Connection Vision on the GEHA website at www.geha.com/vision.

You will receive a separate vision ID card from EyeMed to use for these services.

EyeMed will process all in-network claims systematically. Members will be responsible for copays at time of service. For out-of-network services, you will need to pay in full at the time of service and submit a copy of the itemized receipt with an out-of-network claim form for reimbursement to the following address:

EyeMed Vision Care
 Attn: OON Claims
 P.O. Box 8504
 Mason, OH 45040-7111

FSAFEDS Paperless Reimbursement Option	(877) 372-3337	www.FSAFEDS.com
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FSAFEDS, in partnership with Government Employees Health Association, Inc. Benefit Plan, offers a Paperless Reimbursement option allowing you to be reimbursed from your FSAFEDS health care account without submitting a claim! When you receive services through Government Employees Health Association, Inc. Benefit Plan, your out-of-pocket liability – the amount of money you paid to your provider – will be sent automatically to FSAFEDS for processing. FSAFEDS will review your claims and reimburse you for any eligible out-of-pocket expenses – no need for a claim form or receipt! In many cases, you will receive your reimbursement before your doctor's bill is due! Reimbursement will be made directly from your FSAFEDS account to you via Electronic Funds Transfer.

See Section 11 of this brochure, visit www.FSAFEDS.com, or call toll-free (877) FSAFEDS (877) 372-3337 to learn more about how you can save money on your out-of-pocket health care expenses.

Connection Fitness®	(800) 294-1500	www.globalfit.com/geha
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All GEHA health plan members can take advantage of special discounts available through our Connection Fitness® program by GlobalFit. This new program offers discounts on gym memberships at more than 10,000 health clubs nationwide, discounts on workout equipment and videos, and discounts on 12-week health coaching programs. Call GlobalFit or visit the GlobalFit website for more information.

Connection Dental®	(800) 296-0776	www.geha.com
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Free to all GEHA health plan members, Connection Dental® can reduce your costs for dental care. Connection Dental is a network of more than 140,000 provider locations nationwide. Participating providers have agreed to limit their charges to reduced fees for GEHA health plan members. As a GEHA health plan member, you can take advantage of this program in addition to receiving basic dental benefits provided under the GEHA health plan. To find a participating Connection Dental provider in your area, call (800) 296-0776 or visit www.geha.com. Please confirm provider participation prior to your visit.

CONNECTION Dental Plus®	(800)793-9335	www.geha.com/cdplus
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Available for an additional premium, Connection Dental Plus® is a supplemental dental plan that pays benefits for a wide variety of procedures, from cleanings and X-rays to crowns, dentures and orthodontia for children. This optional dental insurance is provided directly by GEHA. Certain waiting periods and limitations apply. 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.

When you also join the GEHA health plan, you pay a lower premium for Connection Dental Plus. When you purchase Connection Dental Plus you also have free access to GEHA's Vision powered by EyeMed and Connection Hearing® powered by TruHearing

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 prior approval 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 or supplies furnished 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 101), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare "limiting charge" (see page 101), services, drugs or supplies related to avoidable complications and medical errors, "Never Event" policies (see page 106) or State premium taxes however applied.
- Charges in excess of the "Plan allowance" as defined beginning on page 106.
- Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital.
- Inpatient private duty nursing.
- Stand-by physicians and surgeons.
- Clinical ecology and environmental medicine.
- Chelation therapy except for acute arsenic, gold, or lead poisoning.

- Treatment for impotency, even if there is an organic cause for impotency. (Exclusion applies to medical/surgical treatment as well as prescription drugs.)
- Treatment other than surgery of temporomandibular joint dysfunction and disorders (TMJ).
- Computer devices to assist with communications.
- Surgical treatment of hyperhidrosis unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful.
- Computer programs of any type, including but not limited to those to assist with vision therapy or speech therapy.
- Weight loss programs.
- Home test kits including but not limited to HIV and drug home test kits.
- Genetic counseling and genetic screening.
- Services, drugs, or supplies ordered or furnished by a non-covered provider.
- Applied Behavior Analysis (ABA)

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.

- **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, 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.)
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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.

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.

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, then we waive some of your deductibles, copayment and coinsurance for covered charges.

If your physician **does not accept** Medicare assignment, then 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	<p>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.</p> <p>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:</p> <ul style="list-style-type: none">• 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.• 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.• 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 25).
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 Section 4, page 25).
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	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>The Carrier determines which services are custodial care. (Custodial care that lasts 90 days or more is sometimes known as long-term care.)</p>
Deductible	<p>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 25).</p>
Durable medical equipment	<p>Equipment and supplies that:</p> <ul style="list-style-type: none"> • 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	<p>The date the benefits described in this brochure are effective:</p> <ul style="list-style-type: none"> • 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	<p>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.</p>
Expense	<p>An expense is "incurred" on the date the service or supply is rendered.</p>
Experimental or investigational services	<p>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.</p> <p>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.</p>

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.
Intensive day treatment	Outpatient treatment of mental conditions or substance abuse rendered at and billed by a facility which is accredited under the Hospital Accreditation Program of the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) or is licensed by the state as an outpatient day treatment program.
Medical necessity	<p>Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Plan determines:</p> <ul style="list-style-type: none">• 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.<ul style="list-style-type: none">- 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. <p>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.</p>

Mental health/substance abuse	Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by the Plan; or disorders listed in the ICD requiring treatment for abuse or dependence upon substances such as alcohol, narcotics, or hallucinogens.
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	<p>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.</p> <p>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.</p>
Plan allowance	<p>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:</p> <p><i>PPO providers:</i></p> <p>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.</p> <p><i>Non-PPO providers:</i></p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> 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, 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, prior approval, or a referral and (2) where failure to obtain precertification, prior approval or a referral results in a reduction of benefits.

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	Sound and Natural Tooth is a whole or properly restored tooth that has no condition that would weaken the tooth or predispose it to injury prior to the accident, such as decay, periodontal disease, or other impairments. For purposes of the Plan, damage to a restoration, such as a prosthetic crown or prosthetic dental appliance (i.e., bridgework), would not be covered as there is no injury to the natural tooth structure.
Specialty Medication	Specialty medications are biotech or biological drugs that are oral, injectable or infused, or may require special handling. To maximize patient safety, all specialty medications require prior authorization. These drugs are used in the treatment of severe, 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	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.</p> <p>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.</p>
Us/We	Us and we refer to Government Employees Health Association, Inc.
You	You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose Self Only, Self Plus One, or Self and Family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money.

Annuitants are not eligible to enroll.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is \$2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is \$5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **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.

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at (877) FSAFEDS, (877) 372-3337, Monday through Friday, 9 a.m. until 9 p.m. Eastern Time, TTY: (800) 952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.

Vision Insurance

All Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM websites at www.opm.gov/dental and www.opm.gov/vision. These sites also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call (877) 888-3337, TTY: (877) 889-5680.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call (800) LTC-FEDS, (800) 582-3337, TTY: (800) 843-3557 or visit www.ltcfeds.com.

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

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Summary of benefits for the High Option of the Government Employees Health Association, Inc. 2016

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. 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:		
<ul style="list-style-type: none"> • 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	31 - 45
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient 	PPO: Nothing for room and board, 10% of other hospital charges, inpatient \$100 per admission copayment applies Non PPO: Nothing for room and board, 25% of other hospital charges, inpatient \$300 per copayment deductible applies	56 - 58
<ul style="list-style-type: none"> • Outpatient 	PPO: 10%* of other hospital charges Non PPO: 25%* of other hospital charges	59
Emergency benefits:		
<ul style="list-style-type: none"> • Accidental injury 	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident	62 - 63
<ul style="list-style-type: none"> • Medical emergency 	Regular benefits*	63
Mental health and substance abuse treatment:		
	Regular cost-sharing*	65 - 68
Prescription drugs:		
<ul style="list-style-type: none"> • 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).	75 - 77

High Option Benefits	You pay	Page
<ul style="list-style-type: none"> Retail pharmacy <i>(continued)</i> 	<p>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.</p> <p>Copayments and coinsurance go toward a \$5,500 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic and the coinsurance for non-preferred step therapy medications.</p>	75 - 77
<ul style="list-style-type: none"> Mail order 	<p>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</p> <p>Copayments and coinsurance go toward a \$5,500 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic and the coinsurance for non-preferred step therapy medications.</p>	76
Dental care:	Charges in excess of the scheduled amounts for diagnostic and preventive service, restorations, and extractions	81 - 82
Special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, Health Advice Line, Health Assessment and Personal Health Record	83 - 84
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	<p>Nothing after \$5,500 Self Only (\$7,000 Self Plus One or Self and Family) per year for PPO providers</p> <p>Nothing after \$7,500 Self Only (\$9,000 Self Plus One or Self and Family) per year for Non-PPO providers</p> <p>Some costs do not count toward this protection</p>	26 - 27

Summary of benefits for the Standard Option of the Government Employees Health Association, Inc. 2016

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. 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:		
<ul style="list-style-type: none"> 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	31 - 45
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	56 - 58
<ul style="list-style-type: none"> Outpatient 	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	59
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident	62 - 63
<ul style="list-style-type: none"> Medical emergency 	Regular benefits*	63
Mental health and substance abuse treatment:		
	Regular cost-sharing*	65 - 68
Prescription drugs:		
<ul style="list-style-type: none"> 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 \$6,000 annual out-of-pocket limit (for Self Only or Self and Family enrollment) except for the coinsurance for non-preferred step therapy medications.	75 - 77

Standard Option Benefits	You pay	Page
<ul style="list-style-type: none"> • Mail order 	<p>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</p> <p>Copayments and coinsurance for prescription drugs go toward a \$6,000 annual out-of-pocket limit (for Self Only or Self and Family enrollment) except for the coinsurance for non-preferred step therapy medications.</p>	76
Dental care:	50% up to Plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions	81 - 82
Special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, Health Advice Line, Health Assessment and Personal Health Record	83 - 84
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	<p>Nothing after \$6,000 Self Only (\$7,500 Self Plus One or Self and Family) per year for PPO providers</p> <p>Nothing after \$8,000 Self Only (\$9,500 Self Plus One or Self and Family) per year for Non-PPO providers</p> <p>Some costs do not count toward this protection</p>	26 - 27

Notes

2016 Rate Information for Government Employees Health Association, Inc. (GEHA) Benefit Plan

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 Postal Service employees.

Postal Category 1 rates apply to career employees.

Postal Category 2 rates apply to career non-bargaining unit employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
(877) 477-3273, option 5
TTY: (866) 260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

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	213.37	100.35	462.30	217.43	88.49	100.35
High Option Self Plus One	313	461.02	229.16	998.88	496.51	203.55	229.16
High Option Self and Family	312	488.50	256.93	1,058.42	556.68	229.79	256.93
Standard Option Self Only	314	155.37	51.79	336.64	112.21	42.99	51.79
Standard Option Self Plus One	316	334.04	111.35	723.76	241.25	92.42	111.35
Standard Option Self and Family	315	367.43	122.48	796.10	265.37	101.66	122.48