

GEHA Benefit Plan

www.geha.com

800-821-6136

GEHA[®]

2023

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 2023: Page 14
- Summary of Benefits: Page 128

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 2023.

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



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United States
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<http://www.opm.gov/insure>

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

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.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).

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Introduction

This brochure describes the benefits of High Option and Standard Option under contract (CS 1063) between Government Employees Health Association, Inc. and 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.
310 NE Mulberry St.
Lee's Summit, MO 64086

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2023, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2023, and changes are summarized in Section 2, *Changes for 2023*. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means Government Employees Health Association, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review 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 HEALTHCARE FRAUD HOTLINE
877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form

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

You can also write to:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain 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 they are 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, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at: Office of Personnel Management Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director FEIO, 1900 E Street NW, Suite 3400 S, Washington, DC 20415-3610.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions, and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- 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 healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

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

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

Patient Safety Links

For more information on patient safety, please visit

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

Preventable Healthcare Acquired Conditions (“Never Events”)

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

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur 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 Choice Plus, UnitedHealthcare Options PPO, or UnitedHealthcare Select 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 healthcare facility. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation** We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)** Coverage under this plan qualifies as minimum essential coverage (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, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, disability leave, pensions, etc. you must also contact your employing or retirement office.

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

- **Types of coverage available for you and your family** Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family member. Family members include your spouse and your 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.

Contact your carrier to add a family member when there is already family coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a family member if you currently have a Self Only plan.

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 your spouse by a valid common-law marriage from a state that recognizes 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 below.

Natural children, adopted children, and stepchildren

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

Foster children

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

Children incapable of self-support

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

Married children

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

Children with or eligible for employer-provided health insurance

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

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

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

- **Children's Equity Act**

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

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If 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 processed according to the 2023 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2022 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). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn age 26, regardless of marital status, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance/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 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 healthcare 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 healthcare providers as "preferred providers." We assign you a "home network" based on the state where you live. Your home network is displayed on your GEHA ID card. Please refer to the chart below to determine your home network.

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

The PPO organ/tissue transplant network for all members is Emerging Therapy Solutions.

You have access to PPO providers throughout the United States based on your home network, which is displayed on your GEHA ID card. When you use a PPO provider in your home network, you are only responsible for the deductible, copayment, and coinsurance for covered charges.

To find PPO providers, use the provider search tool on the www.geha.com/Find-Care 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. You will be responsible for the difference between the plan allowance and the billed amount. 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 healthcare. Fee-for-service plans let you choose your own physicians, hospitals and other healthcare providers.

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

We offer a preferred provider organization (PPO) arrangement. This arrangement with healthcare 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 our Healthy Living resources for information on general health topics, healthcare news, cancer and other specific diseases, drugs/medication interactions, children's health and patient safety information.

Your rights and responsibilities

OPM requires that all 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 85 years, GEHA has provided health insurance benefits to Federal employees and retirees.
- GEHA is incorporated as a General Not-For-Profit Corporation pursuant to Chapter 355 of the Revised Statutes of the State of Missouri.
- GEHA's provider network includes over 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 2023

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 premium rate will increase for Self Only, Self Plus One and Family except for High Option Self Plus One which will decrease. See back cover.
- Preauthorization will now be required for all arthroplasty, including revisions to a prior arthroplasty. Previously, only arthroplasty for hip, shoulder and elbow required preauthorization. See Section 3, *Other services that require preauthorization*.
- We are adding coverage for bioelectric, computer programmed prosthetic devices and removing it from the not covered list in Section 5(a), *Orthopedic and prosthetic devices*.
- We are adding bone growth stimulators as a covered benefit requiring preauthorization. See Section 3, *Other services that require preauthorization* and Section 5(a), *DME Not Covered*.
- Diabetes education will now be unlimited. We are removing the 10-hour limit and the ADA certification requirement. See Section 5(a), *Educational classes and programs*.
- Gender affirming care will be expanded to include additional services, including pectoral muscle implants; hair removal including genital electrolysis, non-genital area electrolysis or laser hair removal (e.g., face, chest); liposuction/lipofilling specific to gender affirmation; facial contouring such as genioplasty, jaw and/or chin reshaping, lip shortening, scalp (hairline) advancement, hair grafts; voice modification including vocal feminization. See Section 5(b), *Reconstructive surgery*.
- We are adding coverage for iatrogenic infertility, to include collection and storage (up to 12 months) of eggs, sperm and embryos. See Section 3, *How You Get Care*; Section 5(a), *Infertility services*; and Section 10, *Definitions*.
- Self-injectable medications will be limited to fulfillment through the pharmacy benefit. Previously, members could obtain self-injectables either through the pharmacy benefit or through the medical benefit at their doctor or facility office. See Sections 5(a) and 5(f), *Important things you should keep in mind about these benefits*.
- We are adding coverage for corrective orthopedic appliances for non-dental and non-surgical treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Previously there was a benefit exclusion. See Section 5(a), *Orthopedic and prosthetic devices* and Section 6, *General Exclusions*.
- Certain drugs prescribed for weight loss that were previously excluded will now be covered, available through the pharmacy benefit and subject to Pharmacy Benefit Manager (PBM) formulary and utilization review. See Section 5(f), *Prescription Drug Benefits*.
- We are adding coverage for moderate sleep apnea, severe functional malocclusion, orthognathic procedures for reconstruction following injury or illness that causes a functional deficit, frenectomy, frenotomy or frenuloplasty for functional deficits unrelated to teeth or their supporting structure. We are removing coverage for alveoloplasty and for removal of tori for placement of dentures. See Section 5(b), *Oral and maxillofacial surgery*.
- Preauthorization will no longer be required for the following procedures: enteral/tube feeding, mastectomy performed prophylactically and septoplasty. See Section 3, *How You Get Care* and Sections 5(a), *Treatment therapies* and *Home Health service*.
- The following preventive care services are now available, per USPSTF guidelines:
 - Colorectal cancer screening age range has been updated to age 45-75 years. See Section 5(f), *Preventive care medications*.
 - Prediabetes screening age range has been updated to age 35-70 years.
 - Aspirin prevention for cardiovascular disease will no longer be covered under the preventive benefit.

- We have updated the preauthorization requirement for psychological testing. Previously, preauthorization was required after 6 hours of treatment, the new requirements will be after 8 hours of treatment. See Section 3, *Other services that require preauthorization* and Section 5(e), *Diagnostics*.
- We will now cover Rhogam at 100% of the Plan allowance (no deductible). See Section 5(a), *Maternity*.
- We have updated the Skilled Nursing Facility benefit. Previously, coverage was for up to \$700 per day for the first 21 days following acute stay in a hospital. The benefit will now be covered subject to calendar year deductible and plan coinsurance for up to 50 days per calendar year. See Section 5(c), *Extended care benefits/Skilled nursing care facility benefits*.
- We are adding coverage for the following diagnoses listed at the regular transplant benefit cost share. See Section 5(b), *Organ/tissue transplants*.
 - Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
 - Multiple sclerosis
 - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma
 - Immune deficiency diseases other than Severe Combined Immunodeficiency (SCID e.g., Wiskott-Aldrich syndrome, Kostmann's Syndrome, Leukocyte Adhesion Deficiencies) not amenable to more conservative treatments
- We will now cover Wigs/cranial hair prosthesis, one per lifetime, up to \$350 (not subject to calendar year deductible) when used for hair loss due to treatment of cancer. See Section 5(a), *DME*.

Changes to our High Option only

- Reimbursement for the Medicare Part B premium will increase from \$800 to \$1,000 per calendar year for eligible members enrolled in Medicare Parts A & B. See Section 5(h), *Wellness and Other Special Features*.
- The Plan will now cover outpatient lab services at \$0, regardless of location, for both professional and facility services (the separate QuestSelect benefit is no longer necessary or available). See Section 5(a), *Lab, X-ray, and other diagnostic tests* and *QuestSelect (formerly known as Lab Card)*; Section 5(c), *Outpatient hospital, clinic or ambulatory surgical center*, and Section 5(e), *QuestSelect (formerly known as Lab Card)*.

Changes to our Standard Option only

- We have updated the deductible for the Standard Option. There will now be separate in-network and out-of-network amounts that do not cross-accumulate. The in-network deductible will remain \$350 for Self and \$700 for Self Plus One and Self and Family. The out-of-network deductible will be \$700 for Self and \$1,400 for Self Plus One and Self and Family. Previously, all plan allowance amounts, both in-network and out-of-network, applied to one deductible (\$350 for Self and \$700 for Self Plus One and Self and Family). See Section 4, *Your Costs for Covered Services*.
- Standard Option copayments for in-network office visits to any primary care physician including family or general practitioners, pediatricians, OB/GYN, medical internists and mental health/substance use disorder treatment providers will increase to \$20 from \$15. See Section 5, *Overview Standard Option*; Sections 5(a), (b), (d), (e) where office visits are applicable; Section 9, and *Summary of Benefits Standard Option*.
- Standard Option copayments for in-network office visits to specialists will increase to \$35 from \$30. See Section 5, *Overview Standard Option*; Sections 5(a), (b), (d), (e) where office visits are applicable; Section 9 and *Summary of Benefits Standard Option*.
- Under the retail pharmacy benefit for preferred brand and non-preferred brand drugs for Standard Option, we have increased the copayment maximum to correspond with the appropriate days supply of Preferred and Non-Preferred medication at a retail pharmacy. The maximum for a 60-day supply will now be 2 times that for a 30-day supply. The maximum for a 90-day supply will now be 3 times that paid for a 30-day supply. See Section 5(f), *Prescription Drug Benefits*.

Section 3. How You Get Care

Identification cards

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

Balance Billing Protection

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

• Covered providers

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.

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

This plan provides Care Coordinators for complex conditions and can be reached at 888-216-8246 ext. 3984 or email us at proactivecaremanagement@geha.com for assistance.

- **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 in Section 5(c). *Services Provided by a Hospital or Other Facility, and Ambulance Services.*
- Hospital
 - An institution or distinct portion of an institution that is primarily engaged in providing: (1) general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities; or (2) specialized inpatient acute medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory); or (3) comprehensive specialized services relating to the individual's specific medical, physical, mental health, and/or substance use disorder therapy needs, and has, for each patient, an individualized written treatment plan, which includes diagnostic assessment of the patient and a description of the treatment to be rendered, and provides for follow-up assessments by, or under, the direction of the supervising doctor.
 - All services must be provided on its premises, under its control, or through a written agreement with a hospital or with a specialized provider of those facilities.

- A hospital must be operated pursuant to law, accredited as a hospital under the Hospital Accreditation Program of The Joint Commission (TJC) or meet the states' applicable licensing or certification requirements for a hospital, and is operating under the supervision of a staff of physicians with 24-hour-a-day registered nursing services.
- The term hospital does not include a convalescent home, extended care facility, skilled nursing facility, or any institution or part thereof which: (1) is used principally as a convalescent facility, nursing facility, or long-term care facility; (2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or (3) is operating as or is licensed as a school or residential treatment facility (except as listed in Section 5(e)).
- Residential Treatment Centers (RTCs)
 - An institution that is primarily engaged in providing: (1) 24-hour residential evaluation, treatment, and comprehensive specialized services relating to the individual's specific mental health, and/or substance use disorder therapy needs, all under the active participation and direction of a licensed physician who is practicing within the scope of the physician's license; and (2) specialized programs for persons who need short-term services designed to achieve predicted outcomes focused on fostering improvement or stability in mental health and/or substance use disorder, recognizing the individuality, strengths, and needs of the persons served; and (3) care that meets evidence-based treatment guidelines or criteria as determined by the plan.
 - The services are provided for a fee from its patients and include both: (1) room and board; and (2) 24-hour-a-day registered nursing services. Additionally, the RTC keeps adequate patient records which include: (1) the individualized treatment plan; and (2) the person's progress; and (3) discharge summary; and (4) follow-up programs. Benefits are available for services performed and billed by RTCs, as described in Section 5(e). *Mental Health and Substance Use Disorder Benefits*.
 - RTCs must be: (1) operated pursuant to law; and (2) accredited by a nationally recognized organization, and licensed by the state, district or territory to provide residential treatment for mental health conditions and/or substance use disorder; or (3) credentialed by a network partner.
 - The term RTC does not include a convalescent home, extended care facility, skilled nursing facility, group home, halfway house, sober home, transitional living center or treatment, or any institution or part thereof which: (1) is used principally as a convalescent facility, nursing facility, or long-term care; (2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or (3) is operating or licensed as a school.

• **Transitional care**

Specialty care: 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, refer to the back of your member ID card under the heading *Prior Authorization* for the contact information. If you do not have a member ID card, call our customer service department at 800-821-6136. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient 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 to obtain preauthorization before an inpatient hospital admission, Residential Treatment Center (RTC) admission, or for services requiring precertification are rendered. Refer to the back of your member ID card under the heading *Prior Authorization* for the contact information.

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

Next, provide the following information:

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

We will then tell the doctor and/or 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 prior to admission. Failure to do so will result in the following penalties:

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

Exceptions

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States;
- 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.

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

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

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

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

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

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

• **Other services that require preauthorization**

Some surgeries and procedures, services and equipment require precertification or preauthorization. GEHA has coverage policies for many services and procedures; refer to www.geha.com/Coverage-Policies for a complete list. Refer to the back of your member ID card under the heading *Prior Authorization* for the contact information.

- ACI (Autologous Cultured Chondrocytes), 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 negative pressure wound therapy (wound vac systems);
- Applied behavioral therapy;
- Arthroplasty, including revisions to a prior arthroplasty;
- Back/spine surgeries;
- Bariatric procedures;
- Bone growth stimulators;
- Botox injections;
- Breast reconstruction except for diagnosis of cancer;
- Certain prescription drugs;
- Discectomy/fusion;
- Durable medical equipment (DME);
- ECT (electroconvulsive therapy);
- Epidural injections;
- Experimental/investigational surgery or treatment;
- Eyelid surgery or brow lift;
- Facet injections;
- Genetic testing;
- Growth hormone therapy (GHT);
- Gynecomastia treatment-cosmetic (see mammoplasty);
- Harvesting and storage of sperm/embryos/eggs for iatrogenic infertility diagnosis;
- High tech outpatient radiology/imaging;
- Hysterectomy except for diagnosis with cancer;
- Implantable cardiac monitoring;
- 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);
- Lower extremity angiography;
- Lower extremity invasive diagnostic and endovascular procedures;
- Mammoplasty, reduction (unilateral/bilateral);
- Morbid obesity surgeries;
- Non-surgical outpatient cancer treatment, including chemotherapy and radiation;

- Organ and tissue transplant procedures;
- Orthognathic surgery (jaw), including TMJ;
- Orthopedic and prosthetic devices over \$1,000;
- Psychological testing exceeding 8 hours/calendar year;
- Rhinoplasty;
- Scar revisions;
- Sleep studies (in-lab) attended or performed in a healthcare facility (home sleep studies do not require preauthorization);
- 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);
- TMS (Transcranial Magnetic Stimulation);
- Transplants, except cornea (for kidney transplant notification instructions, refer to Section 5(b), under *Organ/Tissue Transplants*); and
- UPPP Uvulopalatopharyngoplasty.

• **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. Refer to the back of your member ID card under the heading Prior Authorization for the contact information.

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.

Warning

You must get preauthorization for certain services. 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 your claim is in reference to a contraceptive, call 844-4-GEHARX or 844-443-4279.

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Overseas claims

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

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

If you have questions about the processing of overseas claims, contact us at 877-320-9469 or by email overseas@geha.com. Covered providers outside the United States will be paid at the PPO level of benefits, subject to deductible and coinsurance. We will provide translation and currency conversion for claims for overseas (foreign) services. The conversion rate will be based on the date services were rendered.

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

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.

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.

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.

High Option

PPO/Non-PPO: The calendar year deductible is \$350 per person under High 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; once that amount is reached, benefits become payable for all family members.

Standard Option

PPO: 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; once that amount is reached, benefits become payable for all family members. Only plan allowance paid for services or supplies from PPO providers counts toward this amount.

Non-PPO: 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 \$700. Under the Self Plus One and the Self and Family enrollments, once the calendar year deductible amount of \$700 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 \$1,400; once that amount is reached, benefits become payable for all family members. Only plan allowance paid for services or supplies from non-PPO providers counts toward this amount.

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

Example: If the billed amount is \$100, the 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 prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change 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.

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.

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 the 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 the bill.

The following 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 example shows the amount you pay if you have met your calendar year deductible.

EXAMPLE

PPO physician

Physician's charge: \$150

Our allowance: We set it at: \$100

We pay: 90% of our allowance: \$90

You owe: 10% of our allowance: \$10

+Difference up to charge?: No: \$0

TOTAL YOU PAY: \$10

Non-PPO physician

Physician's charge: \$150

Our allowance: We set it at: \$100

We pay: 75% of our allowance: \$75

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

+Difference up to charge?: Yes: \$50

TOTAL YOU PAY: \$75

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

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

For 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 unless meeting criteria to be reimbursed at the PPO rate (reference the No Surprises Act). 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;
- 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 prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

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

If we overpay you

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

When Government facilities bill us

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

Important Notice About Surprise Billing -- Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against “surprise billing” and “balance billing” under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating healthcare provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities, but you receive some care from nonparticipating providers.

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

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

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

The Federal Flexible Spending Account Program - FSAFEDS

- **Healthcare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you, your tax dependents, and your 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.

Section 5. High and Standard Option Benefits

See Section 2 for how our benefits changed this year. Pages 128 and 130 have a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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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 \$20 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 Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under the High Option, the calendar year deductible is \$350 per person (\$700 if enrollment is Self Plus One or Self and Family). Under the Standard Option, the calendar year deductible is \$350 per person (\$700 if enrollment is Self Plus One or Self and Family) if you use PPO providers; the calendar year deductible is \$700 per person (\$1,400 if enrollment is Self Plus One or Self and Family) if you use non-PPO providers. 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 services are rendered by non-PPO providers at a PPO hospital, we will pay up to the Plan allowable.
- 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 MUST GET PREAUTHORIZATION FOR CERTAIN OUTPATIENT IMAGING PROCEDURES.** Please refer to preauthorization information in Section 3 to be sure which procedures require preauthorization.
- We cover up to 16 tests for Urine Drug Testing (UDT) per person per calendar year.
- Benefits for certain self-injectable (self-administered) drugs are available for coverage only when dispensed by a pharmacy, under the pharmacy benefit.
- Medications may be available under the Prescription drug benefit and may require prior authorization. Specialty drugs obtained outside of the pharmacy benefit may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits*.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

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
<p>Professional services of physicians</p> <ul style="list-style-type: none"> • In physician's office • Routine physical examinations • Office medical consultations • Second surgical opinions • Advance care planning • Telehealth visit provided by a healthcare provider other than MDLIVE. <p>Note: See <i>Alternative treatments</i> for coverage of Christian Science practitioners.</p> <p>Note: For additional telehealth benefits see Telehealth with MDLIVE below.</p>	<p>PPO: \$20 copayment (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: \$20 copayment for office visits to primary care physicians; \$35 copayment for office visits to specialists (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • During a hospital stay • At home 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>MinuteClinic®</p> <p>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.</p> <p>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.</p>	<p>\$10 copayment for office visit (no deductible)</p>	<p>\$10 copayment for office visit (no deductible)</p>
<p>Telehealth with MDLIVE</p> <p>Telehealth professional services for:</p> <ul style="list-style-type: none"> • Minor acute conditions (see Section 10 for definition) • Dermatology conditions (see Section 10 for definition) <p>Note: For more information on telehealth benefits, please see Section 5(h), <i>Wellness and Other Special Features</i>.</p> <p>Note: Practitioners must be licensed in the state where the patient is physically located at the time services are rendered.</p>	<p>Nothing (no deductible)</p>	<p>Nothing (no deductible)</p>

Benefits Description	You pay After the calendar year deductible...	
Urgent care facility	High Option	Standard Option
<p>Outpatient medical services and supplies billed by an urgent care facility</p> <p>Note: This applies only to urgent care facilities, not providers that offer urgent care or after-hours services.</p>	<p>PPO: \$35 (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: \$35 (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>
Lab, X-ray and other diagnostic tests	High Option	Standard Option
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Prostate-Specific Antigen (PSA) tests 	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Note: If your PPO provider uses a non-PPO lab, we will pay non-PPO benefits for lab charges.</p>	<p>PPO: 15% of the Plan allowance (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Note: If your PPO provider uses a non-PPO lab, we will pay non-PPO benefits for lab charges.</p>
<p>Tests, such as:</p> <ul style="list-style-type: none"> • X-rays • Non-routine mammograms • Double contrast barium enemas • Ultrasound • Electrocardiogram and EEG • Specialized diagnostic genetic testing and screening (preauthorization required for genetic testing) <p>Note: Benefits are available for specialized diagnostic genetic testing and genetic screenings when it is medically necessary to diagnose and/or manage a patient's existing medical condition. Medical necessity is determined by the plan using evidence based medicine. Benefits are not provided for genetic panels when some or all of the tests included in the panel are experimental or investigational, or are not medically necessary.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>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.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>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.</p>

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

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Lab, X-ray and other diagnostic tests (cont.)</p> <p>Tests, such as:</p> <ul style="list-style-type: none"> • CT, MRI, MRA, Nuclear Cardiology and PET studies (outpatient requires preauthorization) <p>Note: See Section 5(c) for any applicable outpatient facility charges.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>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.</p>	<p>PPO: \$100 copayment (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>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.</p>
<p>In-Lab Attended Polysomnography (sleep study)</p> <ul style="list-style-type: none"> • Requires preauthorization <p>Note: Refer to Section 5(c) for outpatient facility fees</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Home Polysomnography (sleep study)</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Professional fees for automated lab tests.</i> • <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> • <i>Testing ordered by or on behalf of third parties (e.g., schools, courts, employers, etc.).</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...	
QuestSelect (formerly known as Lab Card)	High Option	Standard Option
<p>You may use this voluntary program for covered outpatient lab tests. You show your QuestSelect Program identification card and tell your physician you would like to use the QuestSelect benefit. If the physician draws the specimen, they can call 800-646-7788 for pick up or you can go to an approved collection site and show your QuestSelect card along with the test requisition from your physician and have the specimen drawn there. Please Note: You must show your QuestSelect 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.questselect.com.</p>	<p>Not Applicable</p> <p>Note: High Option members pay nothing for routine lab work at all GEHA contracted lab locations. See coverage details in the previous section <i>Lab, X-ray and other diagnostic tests</i> and Section 5(c), <i>Outpatient hospital, clinic, or ambulatory surgery center</i>.</p>	<p>Nothing (no deductible)</p> <p>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 QuestSelect Program) are subject to applicable deductibles and coinsurance.</p>
Preventive care, adult	High Option	Standard Option
<p>Routine physical every year.</p> <p>The following preventive services are covered at the age and frequency limits recommended at each of the links below.</p> <ul style="list-style-type: none"> • Immunizations such as Pneumococcal pneumonia, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Preventive screenings recommended by the U.S. Preventive Services Task Force (USPSTF) with A or B rating, such as: <ul style="list-style-type: none"> - Lung cancer - Osteoporosis - Depression - Diabetes - High blood pressure - Total blood cholesterol - HIV - Hepatitis C virus infection - Colorectal cancer screening, including fecal occult blood test, colonoscopy, sigmoidoscopy, FIT DNA. - For a complete list of screenings go to the USPSTF website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as: <ul style="list-style-type: none"> - Breast cancer screening - Cervical cancer screening (Pap smears) - Contraceptive methods and counseling - Annual counseling for sexually transmitted infections (including chlamydia, gonorrhea, HPV, HIV) - Gonorrhea prophylactic medication to protect newborns - Screening for interpersonal and domestic violence 	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Preventive care, adult (cont.)</p> <ul style="list-style-type: none"> - Perinatal depression counseling and interventions - For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder. <p>Note: Aspirin, fluoride, bowel prep, generic raloxifene, generic tamoxifen, exemestane, anastrozole, 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.</p> <p>Note: Counseling for tobacco cessation for adult males, pregnant and non-pregnant females, children and adolescents is covered as preventive. See Section 5(a) under <i>Educational classes and programs</i>.</p> <p>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.</p> <p>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.</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Routine mammogram – covered, including 3D mammograms. <ul style="list-style-type: none"> - This coverage will include breast ultrasound performed after inconclusive breast cancer screening exam 	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule. 	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Preventive care, children</p> <p>The following preventive services are covered at the time interval recommended at each of the links below.</p> <ul style="list-style-type: none"> Well-child visits examinations and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html You may also find a complete list of preventive care services recommended under the USPSTF online at https://www.uspreventiveservicestaskforce.org/uspstf/ To build your personalized list of preventive services go to https://health.gov/myhealthfinder <p>Note: Counseling for tobacco cessation for adult males, pregnant and non-pregnant females, children and adolescents is covered as preventive. See Section 5(a) under <i>Educational classes and programs</i>.</p> <p>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.</p> <p>Note: Screening and Counseling for childhood obesity is covered as preventive.</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Professional fees for automated lab tests.</i> <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, sports physicals, or travel.</i> <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Maternity care</p> <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Screening for gestational diabetes Prenatal care Delivery professional fees Postnatal care Sonograms <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> Hospital services are covered under Section 5(c) and Section 5(b), <i>Surgical benefits</i>. 	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Maternity care (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> 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). You do not need to precertify your vaginal delivery; see Section 3, <i>Maternity care</i> for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you must precertify. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. Skilled nursing services, intravenous/infusion therapy, and injections are covered the same as other medical benefits (not maternity) for diagnostic and treatment services. <p>Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p> <p>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.</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> Breastfeeding support and counseling for each birth. <p>Note: Refer to Section 5(a) under <i>Durable medical equipment (DME)</i> for obtaining breast pump and supplies. You can obtain the breast pump and supplies from a contracted provider.</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount for support and counseling.</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount for support and counseling.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Home uterine monitoring devices</i> <i>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</i> <i>Charges for services and supplies incurred after termination of coverage</i> <i>Childbirth education classes, services for birth coaching or labor support</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Family planning</p> <p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Contraceptive methods and counseling • Voluntary sterilizations (vasectomy and tubal ligation) • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover other contraceptives under the <i>Prescription Drug Benefits</i> in Section 5(f).</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilizations • Genetic counseling • Preimplantation genetic diagnosis (PGD) • Expenses for sperm collection and storage except in cases of iatrogenic infertility 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Infertility services</p> <p>Diagnosis and treatment of infertility except as shown in the Iatrogenic infertility section below or <i>Not covered</i></p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Iatrogenic infertility (see definition in Section 10)</p> <ul style="list-style-type: none"> • Standard fertility preservation procedures (retrieval of and freezing of eggs or sperm) for members who have been diagnosed with iatrogenic infertility include: <ul style="list-style-type: none"> - the collection of sperm - cryopreservation of sperm - collection of embryo - cryopreservation of embryo - collection of oocyte - cryopreservation of oocyte - benefits limited to up to 12 months of storage of sperm, oocytes and embryo • Also includes infertility associated with medical and surgical gender reassignment. <p>Note: Requires Preauthorization. See Section 3.</p> <p>Note: See Section 5(c) for facility related benefits.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Infertility services - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Infertility services (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Infertility services after voluntary sterilizations</i> • <i>Fertility drugs</i> • <i>Genetic counseling</i> • <i>Preimplantation genetic diagnosis (PGD)</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>Artificial insemination (AI)</i> - <i>In vitro fertilization (IVF)</i> - <i>Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)</i> - <i>Intravaginal insemination (IVI)</i> - <i>Intracervical insemination (ICI)</i> - <i>Intrauterine insemination (IUI)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Collection and storage of fertilized and/or unfertilized eggs/sperm except in cases of iatrogenic infertility</i> • <i>Ovulation induction cycles while on injectable medication to stimulate the ovaries</i> • <i>Infertility treatments such as in vitro fertilization that might be needed after the necessary medical intervention</i> • <i>Elective fertility preservation, such as egg freezing sought due to natural aging</i> • <i>Preimplantation diagnosis, testing, and/or screening of eggs, sperm, or embryos</i> • <i>Elective preservation for reasons other than listed above</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Testing and treatment, including materials (such as allergy serum)</i> • <i>Allergy injections</i> • <i>Allergy testing is limited to 100 tests per person per calendar year</i> <p><i>Note: Each individual test performed as part of a group or panel is counted individually against the 100 test limit.</i></p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Clinical ecology and environmental medicine</i> • <i>Provocative food testing</i> • <i>Non-FDA approved sublingual allergy desensitization drugs</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...	
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Antibiotic therapy - Intravenous (IV)/Infusion • Total Parenteral Nutrition (TPN) • Enteral/Tube feeding Nutrition, including Medical Foods for Inborn Errors of Metabolism (IEM). See Section 10 for definition. • Outpatient cardiac and pulmonary rehabilitation • Chemotherapy and radiation therapy (preauthorization required) <p>Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b). <i>Surgical and Anesthesia Services</i> and Section 5(f). <i>Prescription Drug Benefits</i>.</p> <ul style="list-style-type: none"> • Intravenous (IV)/Infusion Therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) <p>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 <i>Other services that require preauthorization</i> in Section 3.</p> <p>Note: Most medications required for treatment therapies are available under the Prescription drug benefit. Specialty benefits may apply. Please refer to Section 5(f).</p> <p>Applied Behavioral Therapy Benefit</p> <ul style="list-style-type: none"> • Required Diagnosis of ASD (Autism Spectrum Disorder) by a provider qualified to make the diagnosis: Board Certified Behavior Analyst (BCBA), psychiatrist, pediatrician. • Initiation of treatment and on-going treatment and intensity of treatment must be medically necessary and appropriate for the child. • A Functional Behavioral Assessment must be submitted prior to treatment and must demonstrate appropriateness of ABA Therapy. • Services must be directed by a Board Certified Behavior Analyst and services may be provided by Board Certified Assistant Behavior Analysts (BCaBA) or Registered Behavior Technicians (RBTs). • Approval of on-going services requires demonstrated involvement by family. • Services provided by the school are not reimbursable by the health plan. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Treatment therapies - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Treatment therapies (cont.)	High Option	Standard Option
<p>Dialysis</p> <ul style="list-style-type: none"> Dialysis - hemodialysis and peritoneal dialysis GEHA needs to be notified of the first date of your dialysis for coordination of benefits. Refer to GEHA's dialysis notification form located at www.geha.com/Dialysis 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. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Chelation therapy except for acute arsenic, gold or lead poisoning</i> <i>Maintenance cardiac and pulmonary rehabilitation</i> <i>Topical hyperbaric oxygen therapy</i> <i>Prolotherapy</i> <i>"Grocery" food items that can routinely be obtained online or in stores (e.g., gluten-free breads)</i> 	<i>All charges</i>	<i>All charges</i>
Physical, occupational, and speech therapy	High Option	Standard Option
<ul style="list-style-type: none"> Up to 60 outpatient therapy visits per person per calendar year for the combined services of the following: <ul style="list-style-type: none"> Qualified physical therapists Qualified occupational therapists Qualified speech therapists <p>Inpatient therapy services are not applied to the 60 visit benefit.</p> <p>Therapy must be therapeutic, consistent with medically-accepted standards of care, and not experimental, investigational, or solely educational in nature.</p> <p>Combined therapy visits may be used for rehabilitative therapy or habilitative therapy.</p> <ul style="list-style-type: none"> 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. <p>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.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Exercise programs</i> • <i>Long-term rehabilitation therapy</i> • <i>Maintenance therapy-measurable improvement is not expected or progress is no longer demonstrated</i> • <i>Hot and cold packs</i> • <i>Computers, tablets, computer programs/games used in association with communication aides, internet or phone services used in conjunction with communication devices</i> • <i>Hippotherapy</i> • <i>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)</i> • <i>Sensory Therapy, Auditory Therapy, or Sensory Integration Therapy</i> 	<i>All charges</i>	<i>All charges</i>
Cognitive Rehabilitation	High Option	Standard Option
<p>Provided when medically necessary following brain injury or traumatic brain injury. Services will only be covered when provided by:</p> <ul style="list-style-type: none"> • Speech, occupational and/or physical therapists • Psychologists • Physicians <p>while practicing within their scope of care.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
Hearing services (testing, treatment and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist <p>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) <i>Preventive care children</i>.</p> <ul style="list-style-type: none"> • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants <p>Note: For benefits for the devices, see Section 5(a), <i>Orthopedic and prosthetic devices</i>.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • External hearing aids <p>Note: Benefit is payable per person every 36 months for adults and every 12 months for children up to age 22.</p>	<p>PPO: All charges in excess of \$2,500 (no deductible)</p> <p>Non-PPO: All charges in excess of \$2,500 (no deductible)</p>	<p>PPO: All charges in excess of \$2,500 (no deductible)</p> <p>Non-PPO: All charges in excess of \$2,500 (no deductible)</p>

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

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
Hearing services (testing, treatment and supplies) (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Hearing services that are not shown as covered Over the counter hearing aids, enhancement devices accessories or supplies 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> 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 for treatment of convergence insufficiency up to a maximum of 24 visits per year for ages 5-18. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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 	<i>All charges</i>	<i>All charges</i>
Foot care	High Option	Standard Option
<ul style="list-style-type: none"> Routine foot care only when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes 	<p>PPO: \$20 copayment for the office visit (no deductible); plus 10% of the Plan allowance for other services performed during the visit</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: \$20 copayment for the office visit to primary care physicians; \$35 copayment for office visits to specialists (no deductible); plus 15% of the Plan allowance for other services performed during the visit</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> 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 	<p>PPO: All charges in excess of \$150 (no deductible)</p> <p>Non-PPO: All charges in excess of \$150 (no deductible)</p>	<p>PPO: All charges in excess of \$150 (no deductible)</p> <p>Non-PPO: All charges in excess of \$150 (no deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Cutting, trimming of toenails or removal of corns, calluses, or similar routine treatment of conditions of the foot, except as stated above 	<i>All charges</i>	<i>All charges</i>

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Orthopedic and prosthetic devices</p> <ul style="list-style-type: none"> • Artificial limbs and eyes • Orthopedic braces • 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 • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Bioelectric, computer programmed prosthetic devices <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b), <i>Surgical procedures</i>. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c). <i>Services provided by a hospital or other facility, and ambulance services</i>.</p> <p>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.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups</i> • <i>Over the counter hearing aids, enhancement devices accessories or supplies</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Durable medical equipment (DME)</p> <p>Durable medical equipment (DME) is equipment and supplies that:</p> <ul style="list-style-type: none"> - 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 <p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment.</p> <p>Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Rental of Dialysis equipment • Hospital beds • Wheelchairs 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

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
<ul style="list-style-type: none"> • Crutches • Walkers <p>Note: Most DME items can be preauthorized by your provider. We may contact you to recommend a provider in your area to decrease your out-of-pocket expense. If you need assistance locating a provider for the equipment, or if you have benefit coverage questions, call GEHA at 800-821-6136.</p> <p>Note: Coverage for specialty equipment such as specialty wheelchairs and beds is limited to the cost of the standard care and may be subject to a home evaluation.</p> <p>Note: Please see the definition for Medical Necessity in Section 10.</p> <p>Note: Refer to Section 5(f) for glucose meter and diabetic supplies.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Breast pump and supplies:</p> <ul style="list-style-type: none"> • 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 at the member's expense. <ul style="list-style-type: none"> - There is no cost to the member when the designated pump is obtained through a contracted provider. For more information visit www.geha.com/Maternity. - 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. 	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: All Charges</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: All Charges</p>
<p>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):</p> <ul style="list-style-type: none"> • Preauthorization required • Used for patients suffering from severe expressive speech disorders and have a medical condition that warrants the use of such device • Requires a formal speech and language evaluation by licensed speech therapist 	<p>PPO: All charges in excess of \$1,250 per calendar year (no deductible)</p> <p>Non-PPO: All charges in excess of \$1,250 per calendar year (no deductible)</p>	<p>PPO: All charges in excess of \$1,250 per calendar year (no deductible)</p> <p>Non-PPO: All charges in excess of \$1,250 per calendar year (no deductible)</p>
<p>Wigs/cranial hair prosthesis used for hair loss due to the treatment of cancer.</p> <p>Note: One wig/cranial hair prosthesis per lifetime</p>	<p>PPO: All charges in excess of \$350 (no deductible)</p> <p>Non-PPO: All charges in excess of \$350 (no deductible)</p>	<p>PPO: All charges in excess of \$350 (no deductible)</p> <p>Non-PPO: All charges in excess of \$350 (no deductible)</p>

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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Computers, tablets, computer programs/games used in association with communication aides, internet or phone services used in conjunction with communication devices</i> • <i>Air purifiers, air conditioners, heating pads, cold therapy units, whirlpool bathing equipment, sun and heat lamps, exercise devices (even if ordered by a doctor), and other equipment that does not meet the definition of durable medical equipment (see Section 10)</i> • <i>Lifts, such as seat, chair, hydraulic, or van lifts</i> • <i>Devices or programs to eliminate bed wetting</i> • <i>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.</i> • <i>Replacement of the wig/cranial hair prosthesis, maintenance and supplies</i> • <i>Hair transplants or surgical procedures that involve the attachment of hair or a wig/cranial hair prosthesis to the scalp.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Home health services	High Option	Standard Option
<p>50 in-home intermittent visits per person, per calendar year, not to exceed one visit up to six hours for specialty drug infusions or up to two hours per day for all other care when:</p> <ul style="list-style-type: none"> • 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 indicates the length of time the services are needed • Medical social services provided by a qualified* medical social worker may be covered under the home health service benefit when the member meets the following criteria: <ul style="list-style-type: none"> - 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. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Home health services - continued on next page

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
Home health services (cont.)	High Option	Standard Option
<p>* 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.</p> <p>Note: Covered services are subject to review for medical necessity and appropriateness of care.</p> <p>Note: Please refer to the <i>Specialty drug benefits</i> in Section 5(f). <i>Prescription Drug Benefits</i> for information on benefits for home infusion therapies.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medications.</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Custodial care (see Section 10)</i> • <i>Long-term care (see Section 10)</i> • <i>Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption</i> • <i>Hourly nursing where there is no skilled need (otherwise known as private duty nursing) or the need is beyond a two hour visit per day other than for specialty drug infusions that can require up to 6 hours of skilled nursing. Also not covered is nursing provided in the acute care facility, post-acute facilities (skilled nursing facilities), rehabilitation facilities, long-term acute care facilities, long-term care facilities.</i> • <i>On-going licensed/unlicensed dialysis assistance in the home after initial dialysis training</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Manipulative therapy	High Option	Standard Option
<p>Manipulative therapy services limited to:</p> <ul style="list-style-type: none"> • Chiropractic spinal and/or extraspinal manipulative treatment • Adjunctive procedures such as ultrasound, electrical muscle stimulation, and vibratory therapy • X-rays, used to detect and determine nerve interferences due to spinal subluxations or misalignments • 20 visits per person per calendar year 	<p>PPO: \$20 copayment (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: \$35 copayment (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any treatment not specifically listed as covered</i> • <i>Maintenance therapy - measurable improvement is not expected or progress is no longer demonstrated</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefits Description	You pay After the calendar year deductible...	
Alternative treatments	High Option	Standard Option
<p>Acupuncture:</p> <ul style="list-style-type: none"> Benefits are limited to 20 visits per person per calendar year for medically necessary acupuncture treatments for: <ul style="list-style-type: none"> Anesthesia Pain relief <p>Christian Science Practitioners:</p> <ul style="list-style-type: none"> Benefits are limited to 50 sessions per person per calendar year <p>Christian Science Facilities:</p> <ul style="list-style-type: none"> 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 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other alternative treatments, including clinical ecology and environmental medicine Any treatment not specifically listed as covered Naturopathic services 	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	High Option	Standard Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> Tobacco cessation – We cover counseling sessions including proactive phone 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. In addition, we 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 smoking cessation drugs with your plan identification card, through CVS Caremark Mail Service Pharmacy or a non-Network Retail pharmacy. (See filing instructions in Section 5(f), <i>Prescription drug benefits</i>.) 	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount (no deductible)</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount (no deductible)</p>
<ul style="list-style-type: none"> Diabetes Education – The following program criteria needs to be met: <ul style="list-style-type: none"> Consists of services by healthcare professionals (physicians, registered dietitians, registered nurses, registered pharmacists); Designed to educate the member about medically necessary diabetes self-care upon initial diagnosis 	<p>PPO: Nothing up to the Plan allowance (no deductible)</p> <p>Non-PPO: Nothing up to the Plan allowance and any difference between our allowance and the billed amount (no deductible)</p>	<p>PPO: Nothing up to the Plan allowance (no deductible)</p> <p>Non-PPO: Nothing up to the Plan allowance and any difference between our allowance and the billed amount (no deductible)</p>

Educational classes and programs - continued on next page

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
Educational classes and programs (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Nutritional Counseling – Provided by a dietitian with a state license or statutory certification. Nutritional counseling must be ordered by a physician 	<p>PPO: Nothing up to the Plan allowance (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing up to the Plan allowance (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> Childhood obesity screening programs and treatment interventions 	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (no deductible)</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under the High Option, the calendar year deductible is \$350 per person (\$700 if enrollment is Self Plus One or Self and Family). Under the Standard Option, the calendar year deductible is \$350 per person (\$700 if enrollment is Self Plus One or Self and Family) if you use PPO providers; the calendar year deductible is \$700 per person (\$1,400 if enrollment is Self Plus One or Self and Family) if you use non-PPO providers. 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 healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be PPO providers. If the services are rendered by non-PPO providers at a PPO hospital, we will pay up to the Plan allowable.
- 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 MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization.
- GEHA has coverage policies for many services and procedures; refer to www.geha.com/Coverage-Policies for a complete list.
- Medications may be available under the Prescription drug benefit and may require prior authorization. Specialty drugs obtained outside of the pharmacy benefit may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits*.

Benefits Description	You pay 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: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy and non-routine colonoscopy procedures • Biopsy procedures • Removal of tumors and cysts 	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
High and Standard Option Section 5(b)

Benefits Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Correction of congenital anomalies - limited to children under the age of 18 unless there is a functional deficit (see Reconstructive surgery) • Requirements for bariatric surgery: <ul style="list-style-type: none"> - Eligible members must be age 18 or over; or for adolescents, have achieved greater than 95% of estimated adult height and a minimum Tanner Stage of 4, and - Have a minimum Body Mass Index (BMI) of 40 or greater than or equal to 35 (with at least one co-morbid condition present), and - Failure to lower the body mass index within a medically supervised program of at least 6 months duration immediately preceding surgical authorization. See the clinical coverage policy at www.geha.com/Coverage-Policies for requirements for the supervised program; and - Complete a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation. - Refer to GEHA's Bariatric surgery coverage policy at www.geha.com/Coverage-Policies for a complete list of preauthorization requirements. • Insertion of internal prosthetic devices (see Section 5(a), <i>Orthopedic and prosthetic devices</i> 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. <p>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.</p> <p>Note: Voluntary sterilizations, surgically implanted contraceptives, injectable contraceptive drugs, intrauterine devices (IUDs), and diaphragms are listed as covered under Section 5(a), <i>Family planning</i>.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Surgical procedures - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	High Option	Standard Option
<p>When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are:</p> <ul style="list-style-type: none"> • For the primary procedure based on: <ul style="list-style-type: none"> - Full Plan allowance • For the secondary and subsequent procedures based on: <ul style="list-style-type: none"> - One-half of the Plan allowance <p>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.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby physician or surgeon</i> • <i>Routine treatment of conditions of the foot (see Foot care)</i> • <i>Surgical treatment of hyperhidrosis unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful</i> 	<i>All charges</i>	<i>All charges</i>
Reconstructive surgery	High Option	Standard Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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 or lumpectomy, such as: <ul style="list-style-type: none"> - 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), <i>Orthopedic and prosthetic devices</i> for coverage) <p>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.</p> <p>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.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Reconstructive surgery (cont.)</p> <ul style="list-style-type: none"> • Gender Affirming Surgery <ul style="list-style-type: none"> - Surgical treatment of gender dysphoria such as surgical change of sex characteristics including bilateral mastectomy, augmentation mammoplasty, genital reconstructive surgeries (vulvoplasty, orchiectomy, urethroplasty, penectomy, vaginoplasty, labiaplasty and clitoroplasty, hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, metoidioplasty, phalloplasty, colpectomy/vaginectomy, colpocesis, perineoplasty, vulvectomy, scrotoplasty, implantation of erection and/or testicular prosthesis); pectoral muscle implants; hair removal including genital electrolysis, non-genital area electrolysis or laser hair removal (e.g., face, chest); liposuction/lipofilling specific to gender affirmation; facial contouring such as genioplasty, jaw and/or chin reshaping, lip shortening, scalp (hairline) advancement, hair grafts; voice modification including vocal feminization and masculinization surgery. - Requirements <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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. <p>Note: Voice training specific to gender affirmation is covered under speech therapy benefits. See Section 5(a), <i>Physical, occupational, and speech therapy</i>.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sexual dysfunction</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Reconstructive surgery - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Reconstructive surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Surgeries to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit • Charges for photographs to document physical conditions • Gender affirming procedures not specifically listed above, such as: rhinoplasty, face-lifting, blepharoplasty, reduction thyroid chondroplasty, augmentation thyroid chondroplasty, jaw implant, calf implants, mons lift/mons reduction, chin or nose implants, brow lift, forehead contouring, malar (cheek) implants, buttocks implant, transgender reversal unless secondary to surgical complications. 	All charges	All charges
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate, and severe functional malocclusion • Excision of cysts and incision of abscesses unrelated to tooth structure • Extraction of impacted (unerupted or partially erupted) teeth • Partial or radical removal of the lower jaw with bone graft • Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues when unrelated to teeth and supporting structures • Open reduction of dislocations and excision, manipulation, aspiration or injection of temporomandibular joints • Removal of foreign body, skin, subcutaneous areolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones and incision/excision of salivary glands and ducts • 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 under the High Option. See also Section 5(g). <i>Dental Benefits</i>. • Orthognathic surgery for the following conditions: <ul style="list-style-type: none"> - Moderate or severe sleep apnea only after conservative treatment of sleep apnea has failed - Craniofacial congenital anomalies - Severe functional malocclusion not able to be corrected by conservative treatment options 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Oral and maxillofacial surgery - continued on next page

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Oral and maxillofacial surgery (cont.)		
<ul style="list-style-type: none"> - Orthognathic procedures used for reconstruction following injury or illness causing a functional deficit - Orthognathic surgery requires preauthorization and is not covered for any other condition • Other oral surgery procedures that do not involve the teeth or their supporting structures • Frenectomy, frenotomy, or frenuloplasty when the patient has a functional deficit unrelated to teeth and their supporting structure 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • Oral implants and transplants; including for the treatment of accidental injury • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) including removal of tori for placement of dentures • Orthodontic treatment • Any oral or maxillofacial surgery not specifically listed as covered • Orthognathic surgery, except as outlined above for moderate or severe sleep apnea, craniofacial congenital anomalies, severe malocclusion, or used as reconstructive procedure (even if necessary because of TMJ dysfunction or disorder) 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants	High Option	Standard Option
<p>These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to <i>Other services</i> in Section 3 for preauthorization procedures.</p> <p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Allogeneic islet • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/Lung • Intestinal transplants <ul style="list-style-type: none"> - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p>- 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 Choice Plus, UnitedHealthcare Options PPO or UnitedHealthcare Select Plus provider, please call UHC Provider Services for benefit verification at 877-343-1887.</p> <ul style="list-style-type: none"> • Kidney/Pancreas • Liver • Lung single/bilateral/lobar • Pancreas <p>Limited Benefits</p> <ul style="list-style-type: none"> • 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.) 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as indicated below. Refer to <i>Other services</i> in Section 3 for preauthorization procedures.</p> <p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - 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 - Beta Thalassemia Major 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Hemoglobinopathy - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: <ul style="list-style-type: none"> - 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 - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Ependymoblastoma - Epithelial ovarian cancer - Medulloblastoma - Multiple sclerosis - Neuroblastoma - Scleroderma - Scleroderma-SSC (severe, progressive) - Systemic sclerosis 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Benefits Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Advanced neuroblastoma - Immune deficiency diseases other than Severe Combined Immunodeficiency (SCID, e.g., Wiskott-Aldrich syndrome, Kostmann’s Syndrome, Leukocyte Adhesion Deficiencies) not amenable to more conservative treatments - Infantile malignant osteopetrosis - Mucopolysaccharidoses/Mucopolipidoses - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for: <ul style="list-style-type: none"> - 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 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Mini-transplants performed in a clinical trial setting (non-myoablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for preauthorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Organ/tissue transplants - continued on next page
High and Standard Option Section 5(b)

Benefits Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle Cell disease • Autologous transplants for: <ul style="list-style-type: none"> - 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 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for preauthorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for: <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Donor expenses</p> <ul style="list-style-type: none"> • We will cover donor screening tests and donor search expenses for up to four potential donors of organ/tissue transplants. <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>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.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Organ/tissue transplants (cont.)</p> <p>Transportation Benefit</p> <ul style="list-style-type: none"> 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. 	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing (no deductible)</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing (no deductible)</p>
<ul style="list-style-type: none"> 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. 	<p>PPO: \$20 copayment (no deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>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.</p>	<p>PPO: \$20 copayment for office visits to primary care physicians; \$35 copayment for office visits to specialists (no deductible)</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>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.</p>
<ul style="list-style-type: none"> 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. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Organ/tissue transplants (cont.)		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Donor screening tests and donor search expenses, except those listed above</i> • <i>Expenses for sperm collection and storage except in cases of iatrogenic infertility</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia		
<p>Professional fees for the administration of anesthesia in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office <p>Note: We cover anesthesia services related to dental procedures when necessitated by a non-dental physical impairment and the patient qualifies for dental treatment in a hospital or outpatient facility (see Section 5(c) for facility coverage). We do not cover the dental procedures.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Anesthesia related to non-covered surgeries or procedures.</i> 	<i>All charges</i>	<i>All charges</i>

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)”. Under the High Option, the calendar year deductible is \$350 per person (\$700 if enrollment is in Self Plus One or in Self and Family). Under the Standard Option, the calendar year deductible is \$350 per person (\$700 if enrollment is Self Plus One or Self and Family) if you use PPO providers; the calendar year deductible is \$700 per person (\$1,400 if enrollment is Self Plus One or Self and Family) if you use non-PPO providers.
- 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 Section 5(a), *Alternative treatment for coverage of a Christian Science facility*.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be PPO providers. If services are rendered by non-PPO providers at a PPO hospital, we will pay up to the Plan allowable.
- 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.
- 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 INPATIENT STAYS, INCLUDING OBSERVATION CARE EXCEEDING 48 HOURS, UNLESS DUE TO A MEDICAL EMERGENCY. FAILURE TO DO SO WILL RESULT IN A FINANCIAL PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification. Confinements which are considered not medically necessary will not be covered. Penalties are not subject to the catastrophic limit.
- We cover up to 16 tests for Urine Drug Testing (UDT) per person per calendar year.
- Medications may be available under the Prescription drug benefit and may require prior authorization. Specialty drugs obtained outside of the pharmacy benefit may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits*.

Benefits Description	You pay	
Note: The calendar year deductible applies ONLY when we say below: “(calendar year deductible applies)”.		
Inpatient hospital	High Option	Standard Option
<p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodation • General nursing care • Meals and special diets <p>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.</p> <p>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.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • 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.) <p>Note: We base payment on whether the facility or a healthcare professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay hospital benefits and when the anesthesiologist bills, we pay surgery benefits.</p>	<p>PPO: \$100 per admission copayment and 10% of the Plan allowance</p> <p>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</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>
<p>Maternity care – Inpatient hospital</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see Section 3, <i>Maternity care</i> 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. 	<p>PPO: Nothing</p> <p>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</p>	<p>PPO: Nothing</p> <p>Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>

Benefits Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • 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.) <p>Note: We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>PPO: Nothing</p> <p>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</p>	<p>PPO: Nothing</p> <p>Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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.</i> • <i>Any part of a hospital admission that is related to a non-covered surgery or procedure</i> • <i>Custodial care (see Section 10)</i> • <i>Long-term care (see Section 10)</i> • <i>Non-covered facilities such as nursing homes or schools</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Inpatient hospital - continued on next page

Benefits Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Personal comfort items such as phone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>	<i>All charges</i>
Inpatient residential treatment centers (RTC)	High Option	Standard Option
<p>Precertification is required in advance of admission.</p> <p>Note: Non-PPO facilities must, prior to admission, agree to abide by the terms established by the Plan for the care of the particular member and for the submission and processing of related claims.</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> • 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 Section 5(e), <i>Professional services</i> for services billed by professional providers.) <p>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.</p> <p>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.</p> <p>Note: We limit covered facilities for medically necessary treatment to a hospital and/or RTC.</p>	<p>PPO: \$100 per admission copayment and 10% of the Plan allowance</p> <p>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</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>
<p><i>Benefits are not available for non-covered services, including:</i></p> <ul style="list-style-type: none"> • <i>Pastoral, marital, educational counseling or training services</i> • <i>Therapy for sexual dysfunction or inadequacy</i> • <i>Services performed by a non-covered provider</i> • <i>Treatment for learning and intellectual disabilities</i> • <i>Travel time to the member's home to conduct therapy</i> • <i>Services rendered or billed by schools, halfway houses, sober homes, group homes, similar types of facilities or billed by their staff</i> • <i>Marriage counseling</i> • <i>Services that are not medically necessary</i> 	<i>All charges</i>	<i>All charges</i>

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

Benefits Description	You pay	
Inpatient residential treatment centers (RTC) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> 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. <p>Note: We cover professional services as described in Section 5(e), Professional services when they are provided and billed by a covered professional provider acting within the scope of their license.</p>	All charges	All charges
Outpatient hospital, clinic or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> Operating, recovery, observation, and other treatment rooms Prescribed drugs and medications X-rays 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 Outpatient cardiac and pulmonary rehabilitation Observation care is covered up to a maximum of 48 hours as an outpatient hospital service, see Section 10. <p>Note: Please refer to Section 5(f) for information on benefits for Specialty drug medications dispensed by hospitals.</p> <p>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.</p>	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>
<p>Outpatient diagnostic and treatment services performed and billed by a facility, such as but not limited to:</p> <ul style="list-style-type: none"> Laboratory tests (blood tests, urinalysis, non-routine Pap tests, Prostate-Specific Antigen (PSA) tests) and pathology services <p>Note: If your PPO provider uses a non-PPO lab, we will pay non-PPO benefits for lab charges.</p>	<p>PPO: Nothing</p> <p>Non-PPO: 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>

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

Benefits Description	You pay	
Outpatient hospital, clinic or ambulatory surgical center (cont.)	High Option	Standard Option
<p>Tests, such as:</p> <ul style="list-style-type: none"> • CT, MRI, MRA, Nuclear Cardiology and PET studies (outpatient requires preauthorization) <p>Note: Preauthorization required for these tests.</p> <p>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.</p>	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: \$150 copay per facility per day</p> <p>Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Maintenance cardiac and pulmonary rehabilitation</i> • <i>Services that are related to a non-covered surgery or procedure</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Maternity care – Outpatient hospital</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	<p>PPO: Nothing</p> <p>Non-PPO: 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: Nothing</p> <p>Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>

Benefits Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	High Option	Standard Option
<p>Inpatient confinement at a skilled nursing facility when the following criteria are met:</p> <ul style="list-style-type: none"> • Precertification is obtained prior to admission • Admission must follow transfer from an authorized acute inpatient confinement when skilled care is still required <p>Benefits are limited to 50 days per calendar year.</p> <p>Note: When Medicare Part A is primary, the initial days paid in full by Medicare are considered part of the 50 days per calendar year benefit.</p>	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 25% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 35% of the Plan allowance plus the difference between the Plan allowance and the billed amount (calendar year deductible applies)</p>
Hospice care	High Option	Standard Option
<p>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.</p> <ul style="list-style-type: none"> • We pay up to \$30,000 for hospice care provided in an outpatient setting, or for room, board, and care while receiving hospice care in an inpatient setting. Services may include a combination of inpatient and outpatient care up to a maximum of \$30,000. <p>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:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	<p>PPO: Nothing up to the Plan limits (calendar year deductible applies)</p> <p>Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)</p>	<p>PPO: Nothing up to the Plan limits (calendar year deductible applies)</p> <p>Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefits Description	You pay	
Ambulance	High Option	Standard Option
<p>Local ambulance service, within 100 miles, only when medically necessary and the patient cannot be transported by other means to:</p> <ul style="list-style-type: none"> the first hospital where treated from the first hospital to the next nearest hospital or other medical facility with medically necessary treatment, only if necessary treatment is unavailable or unsuitable at the first hospital the home, only when the patient requires the assistance of medically trained personnel during transportation <p>*Member is responsible for all charges for 100 miles or greater when medically necessary treatment is available within 100 miles.</p>	<p>PPO: 10% of the Plan allowance within 100 miles* (calendar year deductible applies)</p> <p>Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount within 100 miles* (calendar year deductible applies)</p>	<p>PPO: 15% of the Plan allowance within 100 miles* (calendar year deductible applies)</p> <p>Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount within 100 miles* (calendar year deductible applies)</p>
<p>Air ambulance to nearest hospital is only covered when medically necessary, and the severity of the member's condition warrants immediate evacuation, and:</p> <ul style="list-style-type: none"> the pick-up location is inaccessible by other means, or transportation by any other means could further endanger the member's health, and the patient is transported to the nearest facility where medically necessary treatment is available. <p>Note: Medical Necessity review is required for all air ambulance transportation.</p>	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 10% of the Plan allowance (calendar year deductible applies)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 15% of the Plan allowance (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Ambulance transportation when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means</i> <i>All ground ambulance charges for 100 miles or greater when medically necessary treatment is available within 100 miles</i> <i>Non-ambulance transportation including wheelchair van, gurney van, commercial air flights, or any other vehicle not licensed as ambulance</i> <i>Air ambulance will not be covered if transport is beyond the nearest available medically suitable facility, but is requested by patient or physician for continuity of care or other reasons</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under the High Option, the calendar year deductible is \$350 per person (\$700 if enrollment is Self Plus one or Self and Family). Under the Standard Option, the calendar year deductible is \$350 per person (\$700 if enrollment is Self Plus One or Self and Family) if you use PPO providers; the calendar year deductible is \$700 per person (\$1,400 if enrollment is Self Plus One or Self and Family) if you use non-PPO providers. 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 PPO providers. If you receive non-PPO services at a PPO hospital, we will pay up to the Plan allowance according to the No Surprises Act.
- 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.

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: <ul style="list-style-type: none"> • Treatment in an outpatient facility or in the outpatient/emergency room department of a hospital • Related outpatient physician care • Related diagnostic services 	PPO: Nothing (no deductible) Non-PPO: Only the difference between our allowance and the billed amount (no deductible)	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount

Accidental injury - continued on next page

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Accidental injury (cont.)		
If you receive care for your accidental injury within 72 hours, we cover outpatient medical services and supplies billed by an urgent care facility.	PPO: Nothing (no deductible) Non-PPO: Only the difference between our allowance and the billed amount (no deductible)	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)
If you receive care for your accidental injury within 72 hours, we cover professional services of physicians in the physician's office. Note: Emergency room charges associated directly with an inpatient admission are considered "Other charges" under <i>Inpatient hospital</i> benefits in Section 5(c) 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: \$20 copayment for office visits to primary care physicians; \$35 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 you receive care for your accidental injury after 72 hours, we cover: <ul style="list-style-type: none"> • Non-surgical physician services and supplies • Surgical care <p>Note: We pay hospital benefits if you are admitted.</p>	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
<i>Not covered:</i> <ul style="list-style-type: none"> • Oral implants and transplants; including for the treatment of accidental injury 	<i>All charges.</i>	<i>All charges.</i>
Medical emergency	High Option	Standard Option
<ul style="list-style-type: none"> • Outpatient medical or surgical services and supplies billed by a hospital for emergency room treatment. <p>Note: We will provide PPO benefits if you are admitted to a non-PPO hospital due to a medical emergency.</p>	PPO: 10% of the Plan allowance Non-PPO: 10% of the Plan allowance	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance
Urgent Care Facility	High Option	Standard Option
Outpatient medical services and supplies billed by an urgent care facility Note: This applies only to urgent care facilities, not providers that offer urgent care or after-hours services.	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
<p>Local ambulance: Please see Section 5(c), <i>Ambulance</i> for complete ambulance benefit coverage information.</p>	<p>PPO: Nothing up to the Plan allowance within 100 miles* (no deductible)</p> <p>Non-PPO: Nothing up to the Plan allowance within 100 miles* (no deductible)</p>	<p>PPO: 15% of the Plan allowance within 100 miles* (calendar year deductible applies)</p> <p>Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount within 100 miles* (calendar year deductible applies)</p>
<p>Air Ambulance: Please see Section 5(c), <i>Ambulance</i> for complete ambulance benefit coverage information.</p> <p>Note: Medical Necessity review is required for all air ambulance transportation.</p>	<p>PPO: Nothing (no deductible)</p> <p>Non-PPO: Nothing up to the Plan allowance (no deductible)</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 15% of the Plan allowance (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Ambulance transportation when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means</i> • <i>All ground ambulance charges for 100 miles or greater when medically necessary treatment is available within 100 miles</i> • <i>Non-ambulance transportation including wheelchair van, gurney van, commercial air flights, or any other vehicle not licensed as ambulance</i> • <i>Air ambulance will not be covered if transport is beyond the nearest available medically suitable facility, but is requested by the patient or physician for continuity of care or other reasons</i> 	<p><i>All charges</i></p>	<p>All charges</p>

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.
- Under the High Option, the calendar year deductible is \$350 per person (\$700 if enrollment is in Self Plus one or in Self and Family). Under the Standard Option, the calendar year deductible is \$350 per person (\$700 if enrollment is Self Plus One or Self and Family) if you use PPO providers; the calendar year deductible is \$700 per person (\$1,400 if enrollment is Self Plus One or Self and Family) if you use non-PPO providers. 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 ALL INPATIENT STAYS INCLUDING OBSERVATION CARE EXCEEDING 48 HOURS, RESIDENTIAL TREATMENT CENTERS AND INTENSIVE DAY TREATMENT UNLESS DUE TO A MEDICAL EMERGENCY. FAILURE TO PRECERTIFY THESE SERVICES WILL RESULT IN A FINANCIAL PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification. Refer to requirements for covered facilities shown in Section 3. Penalties are not subject to the catastrophic limit.
- Outpatient mental health 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*.
- We cover up to 16 tests for Urine Drug Testing (UDT) per person per calendar year.
- 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.
- Medications may be available under the Prescription drug benefit and may require prior authorization. Specialty drugs obtained outside of the pharmacy benefit may be subject to additional cost share as outlined in Section 5(f), *Specialty drug benefits*.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

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.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Treatment and counseling (including individual, group or in-home therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive day treatment in a provider’s office or other professional setting (requires preauthorization) • Telehealth visit provided by a health care provider other than MDLIVE Note: For additional telehealth benefits see Telehealth with MDLIVE below.	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: \$20 copayment per office visit (no deductible) Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> • 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 Mental health professional telehealth services for: <ul style="list-style-type: none"> • Behavioral health counseling • Substance use disorder counseling 	Nothing (no deductible)	Nothing (no deductible)

Professional services - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Professional services (cont.)	High Option	Standard Option
<p>Note: For more information on telehealth benefits, please see Section 5(h). <i>Wellness and Other Special Features</i>.</p> <p>Note: Practitioners must be licensed in the state where the patient is physically located at the time services are rendered.</p>	Nothing (no deductible)	Nothing (no deductible)
Diagnostics	High Option	Standard Option
<ul style="list-style-type: none"> 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 <p>Note: Certain diagnostic tests are not subject to the deductible. See Section 5(a), <i>Lab, X-ray and other diagnostic tests</i>.</p> <ul style="list-style-type: none"> Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment (requires preauthorization for testing exceeding 8 hours/calendar year) 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
QuestSelect (formerly known as Lab Card)	High Option	Standard Option
<p>You may use this voluntary program for covered outpatient lab tests. You show your QuestSelect Program identification card and tell your physician you would like to use the QuestSelect benefit. If the physician draws the specimen, they can call 800-646-7788 for pick up or you can go to an approved collection site and show your QuestSelect card along with the test requisition from your physician and have the specimen drawn there. Please Note: You must show your QuestSelect 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.questselect.com.</p>	<p>Not Applicable</p> <p>Note: High Option members pay nothing for routine lab work at all GEHA contracted lab locations. See coverage details in Section 5(a), <i>Lab, X-ray and other diagnostic tests</i> and Section 5(c), <i>Outpatient hospital, clinic, or ambulatory surgery center</i>.</p>	<p>Nothing (no deductible)</p> <p>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 QuestSelect Program) are subject to applicable deductibles and coinsurance.</p>
Inpatient hospital	High Option	Standard Option
<p>Room and board, such as:</p> <ul style="list-style-type: none"> Ward, semiprivate, or intensive care accommodations General nursing care Meals and special diets Ancillary charges 	<p>PPO: 10% of the Plan allowance, no deductible (\$100 per admission copayment applies)</p> <p>Non-PPO: 25% of the Plan allowance, no deductible (\$300 per admission copayment applies) and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Inpatient hospital - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Inpatient hospital (cont.)	High Option	Standard Option
<p>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.</p> <p>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.</p> <p>Note: We limit covered facilities for medically necessary substance use disorder treatment to a hospital and/or RTC.</p>	<p>PPO: 10% of the Plan allowance, no deductible (\$100 per admission copayment applies)</p> <p>Non-PPO: 25% of the Plan allowance, no deductible (\$300 per admission copayment applies) and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
Inpatient residential treatment centers (RTC)	High Option	Standard Option
<p>Precertification is required in advance of admission.</p> <p>Note: Non-PPO facilities must, prior to admission, agree to abide by the terms established by the Plan for the care of the particular member and for the submission and processing of related claims.</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets • Ancillary charges • Covered therapy services when billed by the facility (see <i>Professional services</i> for services billed by professional providers.) <p>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.</p> <p>Note: We limit covered facilities for medically necessary treatment to a hospital and/or RTC.</p>	<p>PPO: 10% of the Plan allowance, no deductible (\$100 per admission copayment applies)</p> <p>Non-PPO: 25% of the Plan allowance, no deductible (\$300 per admission copayment applies) and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>

Benefits Description	You pay After the calendar year deductible...	
Outpatient hospital	High Option	Standard Option
<ul style="list-style-type: none"> Services such as partial hospitalization or intensive day treatment programs 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 35% of the Plan allowance and any difference between our allowance and the billed amount</p>
Emergency room - non-accidental injury	High Option	Standard Option
<ul style="list-style-type: none"> Outpatient services and supplies billed by a hospital for emergency room treatment <p>Note: We pay hospital benefits if you are admitted.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount</p>
Services we do not cover	High Option	Standard Option
<p><i>Benefits are not available for non-covered services, including:</i></p> <ul style="list-style-type: none"> <i>Pastoral, marital, educational counseling or training services</i> <i>Therapy for sexual dysfunction or inadequacy</i> <i>Services performed by a non-covered provider</i> <i>Treatment for learning and intellectual disabilities</i> <i>Travel time to the member's home to conduct therapy</i> <i>Services rendered or billed by schools, halfway houses, sober homes, or billed by their staff</i> <i>Marriage counseling</i> <i>Services that are not medically necessary</i> <i>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.</i> <i>Testing ordered by or on behalf of third parties (e.g., schools, courts, employers, etc.).</i> <p><i>Note: We cover professional services as described in Section 5(e), Professional services when they are provided and billed by a covered professional provider acting within the scope of his or her license.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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 *CVS Caremark Formulary* for additional information.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some medications must be approved by GEHA and/or CVS Caremark, our Pharmacy Benefit Manager, before they are a covered benefit. Your prescribers must obtain preauthorizations for certain prescription drugs and supplies before coverage applies. Medication may be limited as to its quantity, total dose, duration of therapy, age, gender or specific diagnosis. 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, and a mail order form.
- As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including names of your prescribing physicians, to any treating physician or dispensing pharmacies.
- CVS Specialty Pharmacy is the exclusive provider for specialty medications. You may contact the Specialty Pharmacy at 800-237-2767.
- **Federal Law prohibits the return of prescription medications.** Medication cannot be returned to CVS Caremark or retail pharmacies and you will be responsible for the cost. Be sure to check the cost of your medication before filling the prescription.
- Refills cannot be obtained until **80%** of the drug has been used. 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.

- Benefits for certain self-injectable (self-administered) drugs are available for coverage only when dispensed by a pharmacy, under the pharmacy benefit.

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 *CVS Caremark Formulary* 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 877-418-4746;
- Drugs to treat gender dysphoria (gonadotropin-releasing hormone (GnRH) antagonists and testosterone);
- 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 non-preferred 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 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. Formularies are reviewed quarterly and medications may change formulary status. You will receive notification if your cost share increases due to a formulary change. In an effort to continue to help promote affordable and clinically appropriate products, there are a select number of drugs that are excluded from the formulary and not covered by the Plan. For these drugs, generics and/or alternative medications in the same drug class are readily available. If one of these excluded drugs is medically necessary, a preauthorization for medical necessity is required. We do not cover excluded drugs unless we determine the medical necessity to treat a medical condition based on objective clinical data. New drugs and supplies may be added to the list as they are introduced and may require medical necessity review until the formulary status is determined. Please 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 and 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 healthcare 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.

Coordinating with other drug coverage - continued on next page

Coordinating with other drug coverage (cont.)

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.
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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 secondary and tertiary claim payment is the lesser of:

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

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

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

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

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

Mail Order - 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 diabetic supplies.

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 found at www.geha.com/Medication; 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 at 844-4-GEHARX or 844-443-4279 available 24 hours a day, 7 days a week. Forms necessary for refills will be provided each time you receive a supply of medication.

Mail to:

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

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

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

Refilling your medication: To be sure you never run short of your prescription medication, you should re-order on or after the 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.

High and Standard Option

Benefits Description	You pay	
Covered medications and supplies – when GEHA is primary	High Option	Standard Option
<p>Network Retail Pharmacy</p> <p>All copayments are for up to a 30-day supply per prescription. Copay maximums apply per each 30-day supply.</p> <p>A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when an FDA approved generic drug is available. If there is no generic equivalent available, you pay the applicable plan coinsurance.</p> <p>If you or your physician 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 they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.</p> <p>Note: Medications to treat some complex and chronic medical conditions are only available through CVS Specialty. See CVS Caremark formulary for the categories of drugs in this program.</p>	<p>Generic: \$10 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>Preferred: 25% of Plan allowance up to a maximum of \$150, for up to a 30-day supply</p> <p>Non-Preferred: 40% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>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).</p>	<p>Generic: \$10 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>Preferred: 50% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>Non-Preferred: 50% of Plan allowance up to a maximum of \$300, for up to a 30-day supply</p> <p>Retail fills eligible for a greater than a 30-day supply will be subject to 50% of Plan allowance and the applicable copay maximum per each 30-day supply.</p>
<p>ACE Inhibitors/Beta Blockers (blood pressure medication)</p> <p>Network Retail Pharmacy</p> <p>Benefit applies to certain generic oral medications. All copayments are for up to a 30-day supply per prescription.</p> <p>Note: This benefit is not available at non-network retail pharmacies or CVS Caremark Mail Service.</p>	<p>Generic: \$10 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>For preferred or non-preferred medications, please see regular Plan benefits.</p> <p>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).</p>	<p>Generic: \$3 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>For preferred or non-preferred medications, please see regular Plan benefits.</p>

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
<p>Non-Network Retail Pharmacy</p> <p>If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to:</p> <p>CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136</p> <p>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.</p> <p>All copayments are for up to a 30-day supply per prescription. Copay maximums apply per each 30-day supply.</p> <p>If you or your physician 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 they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.</p>	<p>Generic: \$10 or the retail pharmacy's usual and customary cost of the drug whichever is less</p> <p>Preferred: 25% of Plan allowance up to a maximum of \$150, for up to a 30-day supply</p> <p>Non-Preferred: 40% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>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.</p> <p>You pay the difference between our allowance and the cost of the drug.</p>	<p>Generic: \$10 or the retail pharmacy's usual and customary cost of the drug whichever is less</p> <p>Preferred: 50% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>Non-Preferred: 50% of Plan allowance up to a maximum of \$300, for up to a 30-day supply</p> <p>Retail fills eligible for a greater than a 30-day supply will be subject to 50% of Plan allowance and the applicable copay maximum per each 30-day supply</p> <p>You pay the difference between our allowance and the cost of the drug.</p>
<p>CVS Caremark Mail Service Pharmacy</p> <p>All copayments are for up to a 90-day supply per prescription.</p> <p>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.</p> <p>If you or your physician 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 they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.</p>	<p>Generic: \$20 or the cost of the drug, whichever is less</p> <p>Preferred: 25% of Plan allowance up to a maximum of \$350, for up to a 90-day supply</p> <p>Non-Preferred: 40% of Plan allowance up to a maximum of \$500, for up to a 90-day supply</p> <p>Maintenance Choice lets you choose how to get a 90-day supply of your maintenance medications through mail service or at a CVS Pharmacy.</p>	<p>Generic: \$20 or the cost of the drug, whichever is less</p> <p>Preferred: 50% of Plan allowance up to a maximum of \$500, for up to a 90-day supply</p> <p>Non-Preferred: 50% of Plan allowance up to a maximum of \$600, for up to a 90-day supply</p>

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
<p>Preferred Insulin</p> <p>Network Retail Pharmacy</p> <p>All copayments are for up to a 30-day supply per prescription. Copay maximums apply per each 30-day supply.</p> <p>If you or your physician 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.</p> <p>Note: This benefit is not available at non-network retail pharmacies.</p>	<p>Preferred: 25% of Plan allowance up to a maximum of \$150, for up to a 30-day supply</p> <p>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).</p> <p>For generic or non-preferred medications, please see regular Plan benefits.</p>	<p>Preferred: 25% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>Retail fills eligible for a greater than a 30-day supply will be subject to 25% of Plan allowance and the applicable copay maximum per each 30-day supply</p> <p>For generic or non-preferred medications, please see regular Plan benefits.</p>
<p>Preferred Insulin</p> <p>CVS Caremark Mail Service Pharmacy</p> <p>All copayments are for up to a 90-day supply per prescription.</p> <p>If you or your physician 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.</p>	<p>Preferred: 25% of Plan allowance up to a maximum of \$350, for up to a 90-day supply</p> <p>Maintenance Choice lets you choose how to get a 90-day supply of your maintenance medications through mail service or at a CVS Pharmacy.</p> <p>For generic or non-preferred medications, please see regular Plan benefits.</p>	<p>Preferred: 25% of Plan allowance up to a maximum of \$500, for up to a 90-day supply</p> <p>For generic or non-preferred medications, please see regular Plan benefits.</p>
<p>Contraceptive drugs and devices as listed in the ACA/HRSA site.</p> <p>Network and Non-Network Retail CVS Caremark Mail Service Pharmacy</p> <p>Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). For more information regarding prescription contraceptives, please refer to Section 5(f), <i>Preventive care medications</i>. Some contraceptives and services are covered under the medical benefit; see Section 5(a), <i>Family Planning</i>. Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described on GEHA’s website at www.geha.com/Contraception or by calling CVS Caremark at 844-4-GEHARX or 844-443-4279.</p> <p>Reimbursement for over-the-counter contraceptives (prescription required) can be submitted by sending in your original prescription receipt obtained from your pharmacy to:</p> <p>CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136</p>	<p>Nothing (no deductible)</p>	<p>Nothing (no deductible)</p>

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
<p>Note: Members are encouraged not to use an HSA, health FSA, or HRA (including any related debit card) to purchase contraception for which the individual intends to seek reimbursement from their FEHB plan.</p>	Nothing (no deductible)	Nothing (no deductible)
Covered medications and supplies – Medicare A & B primary	High Option	Standard Option
<p>Network Retail Pharmacy</p> <p>All copayments are for up to a 30-day supply per prescription. Copay maximums apply per each 30-day supply.</p> <p>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.</p> <p>If you or your physician 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 they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.</p> <p>Note: Medications to treat some complex and chronic medical conditions are only available through CVS Specialty.</p>	<p>Generic: \$10 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>Preferred: 20% of Plan allowance up to a maximum of \$150, for up to a 30-day supply</p> <p>Non-Preferred: 35% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>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.</p>	<p>Generic: \$10 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>Preferred: 50% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>Non-Preferred: 50% of Plan allowance up to a maximum of \$300, for up to a 30-day supply</p> <p>Retail fills eligible for a greater than a 30-day supply will be subject to the 50% of Plan allowance and the applicable copay maximum per each 30-day supply</p>
<p>ACE Inhibitors/Beta Blockers (blood pressure medication)</p> <p>Network Retail Pharmacy</p> <p>Benefit applies to certain generic oral medications. All copayments are for up to a 30-day supply per prescription.</p> <p>Note: This benefit is not available at non-network retail pharmacies or CVS Caremark Mail Service.</p>	<p>Generic: \$10 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>For preferred or non-preferred medications, please see regular Plan benefits.</p> <p>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).</p>	<p>Generic: \$3 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>For preferred or non-preferred medications, please see regular Plan benefits.</p>

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
<p>Non-Network Retail Pharmacy</p> <p>If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to:</p> <p>CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136</p> <p>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.</p> <p>All copayments are for up to a 30-day supply per prescription. Copay maximums apply per each 30-day supply.</p> <p>If you or your physician 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 they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.</p>	<p>Generic: \$10 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>Preferred: 20% of Plan allowance up to a maximum of \$150, for up to a 30-day supply</p> <p>Non-Preferred: 35% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>You pay the difference between our allowance and the cost of the drug.</p>	<p>Generic: \$10 or the retail pharmacy’s usual and customary cost of the drug, whichever is less</p> <p>Preferred: 50% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>Non-Preferred: 50% of Plan allowance up to a maximum of \$300, for up to a 30-day supply</p> <p>Retail fills eligible for a greater than a 30-day supply will be subject to 50% of Plan allowance and the applicable copay maximum per each 30-day supply</p> <p>You pay the difference between our allowance and the cost of the drug.</p>
<p>CVS Caremark Mail Service Pharmacy</p> <p>All copayments are for up to a 90-day supply per prescription.</p> <p>A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written (DAW), when an FDA approved generic drug is available. If there is no generic equivalent available, you pay the brand name coinsurance.</p> <p>If you or your physician 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 they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.</p>	<p>Generic: \$15 or the cost of the drug, whichever is less</p> <p>Preferred: 15% of Plan allowance up to a maximum of \$350, for up to a 90-day supply</p> <p>Non-Preferred: 30% of Plan allowance up to a maximum of \$500, for up to a 90-day supply</p> <p>Maintenance Choice lets you choose how to get 90-day supplies of your maintenance medications through mail service or at a retail CVS Pharmacy.</p>	<p>Generic: \$20 or the cost of the drug, whichever is less</p> <p>Preferred: 50% of Plan allowance up to a maximum of \$500, for up to a 90-day supply</p> <p>Non-Preferred: 50% of Plan allowance up to a maximum of \$600, for up to a 90-day supply</p>

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
<p>Preferred Insulin</p> <p>Network Retail Pharmacy</p> <p>All copayments are for up to a 30-day supply per prescription. Copay maximums apply per each 30-day supply.</p> <p>If you or your physician 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.</p> <p>Note: This benefit is not available at non-network retail pharmacies.</p>	<p>Preferred: 20% of Plan allowance up to a maximum of \$150, for up to a 30-day supply</p> <p>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).</p> <p>For generic or non-preferred medications, please see regular Plan benefits.</p>	<p>Preferred: 25% of Plan allowance up to a maximum of \$200, for up to a 30-day supply</p> <p>Retail fills eligible for a greater than a 30-day supply will be subject to 25% of Plan allowance and the applicable copay maximum per each 30-day supply</p> <p>For generic or non-preferred medications, please see regular Plan benefits.</p>
<p>Preferred Insulin</p> <p>CVS Caremark Mail Service Pharmacy</p> <p>All copayments are for up to a 90-day supply per prescription.</p> <p>If you or your physician choose a brand name medication when generic is available, you will be charged the generic copay plus the difference in cost between the brand name and the generic.</p>	<p>Preferred: 15% of Plan allowance up to a maximum of \$350, for up to a 90-day supply</p> <p>Maintenance Choice lets you choose how to get a 90-day supply of your maintenance medications through mail service or at a CVS Pharmacy.</p> <p>For generic or non-preferred medications, please see regular Plan benefits.</p>	<p>Preferred: 25% of Plan allowance up to a maximum of \$500, for up to a 90-day supply</p> <p>For generic or non-preferred medications, please see regular Plan benefits.</p>
<p>Contraceptive drugs and devices as listed in the ACA/HRSA site.</p> <p>Network and Non-Network Retail CVS Caremark Mail Service Pharmacy</p> <p>Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). For more information regarding prescription contraceptives, please refer to Section 5(f), <i>Preventive care medications</i>. Some contraceptives and services are covered under the medical benefit; see Section 5(a), <i>Family Planning</i>. Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described on GEHA’s website at www.geha.com/Contraception or by calling CVS Caremark at 844-4-GEHARX or 844-443-4279.</p> <p>Reimbursement for over-the-counter contraceptives (prescription required) can be submitted by sending in your original prescription receipt obtained from your pharmacy to:</p> <p>CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136</p>	<p>Nothing (no deductible)</p>	<p>Nothing (no deductible)</p>

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
Note: Members are encouraged not to use an HSA, health FSA, or HRA (including any related debit card) to purchase contraception for which the individual intends to seek reimbursement from their FEHB plan.	Nothing (no deductible)	Nothing (no deductible)

Specialty drug benefits

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

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

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

Outpatient, non-surgical cancer treatments require preauthorization. You or your provider need to call us at 800-821-6136 or visit www.geha.com.

Some specialty medications may not be available in a 30-day supply, your coinsurance will be based on days of therapy.

Benefits Description	You pay	
Specialty drug benefits	High Option	Standard Option
<p>CVS Specialty Pharmacy</p> <p>All copayments are for up to a 30-day supply per prescription. Copay maximums apply per each 30-day supply.</p> <p>If you or your physician 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 they determine there is medical necessity for the brand therapy. If approved, your coinsurance will be the applicable brand name coinsurance.</p> <p>Specialty Plan benefits apply to limited distribution specialty medications when CVS Specialty Pharmacy does not have access to dispense.</p>	<p>When GEHA is primary:</p> <ul style="list-style-type: none"> • 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 <p>When Medicare is primary:</p> <ul style="list-style-type: none"> • 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 	<p>When GEHA is primary:</p> <ul style="list-style-type: none"> • 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 <p>When Medicare is primary:</p> <ul style="list-style-type: none"> • 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

Specialty drug benefits - continued on next page

Benefits Description	You pay	
Specialty drug benefits (cont.)	High Option	Standard Option
<p>Specialty medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals may be paid under the medical benefit.</p> <p>Recurring oral medications must be obtained through the pharmacy benefit.</p>	<p>You pay after the calendar year deductible:</p> <ul style="list-style-type: none"> • 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 <p>When Medicare is Primary and denies claim:</p> <ul style="list-style-type: none"> • 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 	<p>You pay after the calendar year deductible:</p> <ul style="list-style-type: none"> • Generic and Preferred: \$500 copayment applies per prescription fill and 50% of the Plan allowance, up to a 30-day supply • Non-Preferred: \$500 copayment applies per prescription fill and 50% of the Plan allowance, up to a 30-day supply <p>When Medicare is Primary and denies claim:</p> <ul style="list-style-type: none"> • Generic and Preferred: \$500 copayment applies per prescription fill and 50% of the Plan allowance, up to a 30-day supply • Non-Preferred: \$500 copayment applies per prescription fill and 50% of the Plan allowance, up to a 30-day supply
Preventive care medications	High Option	Standard Option
<p>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). Please refer to the U. S. Preventive Services Task Force website for current A & B recommendation coverages at www.uspreventiveservicestaskforce.org/uspstf/. Age restrictions apply.</p> <p>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.</p> <ul style="list-style-type: none"> • Aspirin - All single ingredient generic oral dosage forms ≤81mg OTC only (requires a prescription) for the prevention of pre-eclampsia after 12 weeks of gestation. Limit of 100 units per fill. • Colorectal Cancer Prevention - Bowel prep products - generic Rx, and brand name only when generic or over the counter (OTC) equivalent is not available, requires a prescription, age 45 -75 years. 	<p>Nothing (no deductible)</p>	<p>Nothing (no deductible)</p>

Preventive care medications - continued on next page

Benefits Description	You pay	
Preventive care medications (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Fluoride supplements (not toothpaste or rinses) - Single ingredient brand name and generic prescription products in an oral dosage form ≤ 0.5mg for children five years of age and younger. • Folic acid supplements - Single ingredient generic 0.4mg and 0.8mg tabs. OTC only (requires a prescription) for women 55 years of age and younger. Limit of 100 units per fill. • Generic Naloxone - Limited to three doses annually (requires a prescription). • Generic tamoxifen, raloxifene, exemestane and anastrozole-with prescription for women ages 35 and over for the prevention of breast cancer. • HIV Pre-Exposure Prophylaxis – Prior authorization may be required for coverage. CVS Specialty Pharmacy is GEHA's exclusive Specialty Pharmacy. • Iron supplements - Single ingredient pediatric oral liquids (requires a prescription) for children age 6-12 months. • Statins - low to moderate dose of certain generic statins for individuals age 40-75 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. 	<p>Nothing (no deductible)</p>	<p>Nothing (no deductible)</p>
<ul style="list-style-type: none"> • Immunizations: Vaccines; childhood and adult, Rx only, coverage dependent on vaccine type. <ul style="list-style-type: none"> - GEHA members can go to a participating retail pharmacy to receive certain vaccinations. Influenza vaccine is commonly administered by retail pharmacies. Other vaccines, such as those for pneumococcal pneumonia (Pneumovax), varicella/shingles (Shingrix) and hepatitis B may also be available through retail pharmacies. - 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. 	<p>Nothing (no deductible) for most vaccines. Please check with CVS Caremark at 844-4-GEHARX or 844-443-4279 for coverage benefits.</p>	<p>Nothing (no deductible) for most vaccines. Please check with CVS Caremark at 844-4-GEHARX or 844-443-4279 for coverage benefits.</p>

Preventive care medications - continued on next page

Benefits Description	You pay	
Preventive care medications (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Tobacco cessation <ul style="list-style-type: none"> - 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 previous section <i>Covered medications and supplies</i> for filing instructions). 	<p>Nothing (no deductible), day supply limits apply depending on therapy</p>	<p>Nothing (no deductible), day supply limits apply depending on therapy</p>
Non-covered medications and supplies	High Option	Standard Option
<p><i>The following medications and supplies are not covered under the GEHA prescription drug benefit:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins, nutrients and food supplements (alone or in combination) not listed as a covered benefit or that do not require a prescription are not covered, including enteral formula/tube feeding nutrition available without a prescription</i> • <i>Nonprescription medications not shown as covered</i> • <i>Medical devices, or supplies such as dressings and antiseptics</i> • <i>Drugs which are investigational</i> • <i>Drugs to treat infertility</i> • <i>Drugs to treat impotency</i> • <i>Certain prescription drugs that have an over-the-counter (OTC) equivalent drug or treatment are not covered</i> • <i>Certain compounding chemicals including, but not limited to, OTC products, experimental, investigational, bulk powders, bulk chemicals, and certain bases</i> • <i>Drugs to enhance athletic performance</i> • <i>Services or supplies for the administration of a non-covered medication</i> <p><i>Note: OTC or prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit, through a participating network retail pharmacy, CVS Caremark Mail Service Pharmacy or a non-network retail pharmacy. See above.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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 under the High Option. Services incurred after 72 hours are paid at regular Plan benefits.

Dental benefit description	You pay			
	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	You pay			
	High Option Scheduled Allowance We Pay	High Option Scheduled Allowance You Pay	Standard Option Scheduled Allowance We Pay	Standard Option Scheduled Allowance You Pay
Dental Services (cont.)				
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). Wellness and Other 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>TTY service is available at 800-821-4833 for members who are hearing impaired.</p>
<p>Medicare Premium Reimbursement for High Option members enrolled in both Medicare Parts A and B</p>	<p>High Option members enrolled in both Medicare Part A <i>and</i> Part B are eligible to be reimbursed up to \$1,000 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.</p>
<p>Health Rewards/Health Assessment</p>	<p>The GEHA Health Rewards program provides rewards for participation in activities that promote health improvements. Members age 18 and over can earn rewards up to an annual total of \$250 each (maximum \$500 per household). Rewardable activities include, but may not be limited to, the following:</p> <ol style="list-style-type: none"> 1. Health assessment 2. Preventive screenings such as cervical, colon and mammogram 3. Telehealth visit with MDLIVE 4. Flu shot 5. First trimester prenatal care 6. Online wellness portal classes, such as weight management, stress management, and smoking cessation 7. Participation in a targeted health program (by invitation) <p>Members will be issued a rewards account with a reloadable debit card, which can be used for eligible medical expenses.</p> <p>For detailed information about eligibility requirements and how to access the health risk assessment and all available rewards, visit www.geha.com/HealthRewards.</p>

Special features	Description
<p>QuestSelect (formerly known as Lab Card)</p>	<p>The QuestSelect Program gives you and your covered dependents the option of receiving 100% covered outpatient laboratory testing.</p> <p>QuestSelect is an optional program. If you choose not to use QuestSelect, you will not be penalized. You will simply pay the deductible, coinsurance or copay portion of your lab work.</p> <p>QuestSelect 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 QuestSelect 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 QuestSelect Program) are subject to applicable deductibles and coinsurance.</p> <p>QuestSelect 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 QuestSelect benefit and shown your QuestSelect 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>QuestSelect 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>
<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>24-hour Health Advice Line</p>	<p>Call the 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.</p> <p>The 24-hour Health Advice Line allows you to conveniently manage your symptoms and treatment anywhere you have access to a phone.</p>
<p>Telehealth</p>	<p>Telehealth is available at a reduced cost through MDLIVE. Go to https://members.mdlive.com/geha-callmd/ or call 888-912-1183 to access on demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions (see Section 10 for definition), dermatology conditions (see Section 10 for definition) and counseling for behavioral health and substance use disorder.</p> <p>Note: This benefit is available at reduced cost only through the MDLIVE contracted telehealth provider network.</p> <p>Note: Practitioners must be licensed in the state where the patient is physically located at the time services are rendered.</p>
<p>Obesity screening and management</p>	<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 <i>Educational Classes and Programs</i>, Section 5(a)) • Behavior change programs with coaching for members who qualify • Discounts for gym memberships and other services through Connection Fitness • Bariatric surgery, when medically necessary. Bariatric surgery must be preauthorized.

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 chronic conditions. 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.

CVS ExtraCare® Health Benefit - www.cvs.com

The CVS ExtraCare Health Benefit provides a 20% discount on items purchased for the healthcare 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% to 60% off the average retail price of hearing aids with TruHearing, making it affordable to address your unique hearing needs. GEHA also offers you a hearing aid allowance of \$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 an 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® powered by the Active - 800-821-6136 - www.geha.com/Fitness

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

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 year round 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 Section 9, *Coordinating Benefits with Medicare and Other Coverage*), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare "limiting charge" (see Section 9), services, drugs or supplies related to avoidable complications and medical errors, "Never Event" policies (see *Preventing Medical Mistakes*) or State premium taxes however applied.
- Charges in excess of the "Plan allowance" as defined in Section 10.
- Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital.
- Stand-by physicians and surgeons.
- Clinical ecology and environmental medicine.
- Chelation therapy except for acute arsenic, gold, or lead poisoning.
- Treatment for impotency, even if there is an organic cause for impotency. Exclusion applies to medical/surgical treatment as well as prescription drugs.

- Treatments other than surgery or orthopedic appliances for temporomandibular joint dysfunction and disorders (TMJ).
- 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 (otherwise called private duty nursing) or the need is beyond a two hour visit per day other than for specialty drug infusions that can require up to 6 hours of skilled nursing. Also not covered is nursing provided in the acute care facility, post-acute facilities (skilled nursing facilities), rehabilitation facilities, long-term acute care facilities, long-term care facilities.
- 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.
- Services or supplies we are prohibited from covering under the Federal law.

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 ADA form, a claim form that includes the information shown below, or visit www.geha.com/Claim. Bills and receipts should be itemized and show:

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

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

In addition:

- If another health plan is your primary payor, you must send a copy of the Explanation of Benefits (EOB) form you received from any primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse and should include nursing notes.
- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing provider's name, date, and charge. A copy of the provider's script must be included with prescription drugs purchased outside the United States.

Post-service claims procedures

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

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

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

Records

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

Deadline for filing your claim

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

Overseas claims

For covered services you receive by providers and 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.

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

If you have questions about the processing of overseas claims, contact us at 877-320-9469 or by email overseas@geha.com. Covered providers outside the United States will be paid at the PPO level of benefits, subject to deductible and coinsurance. We will provide translation and currency conversion for claims for overseas (foreign) services. The conversion rate will be based on the date services were rendered.

When members living abroad are stateside and seeking medical care, contact us at 800-821-6136, or visit 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 healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

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

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

Section 8. The Disputed Claims Process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer 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 healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

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

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> 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. <p>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.</p>

Step	Description
<p>2</p>	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. <p>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.</p> <p>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.</p>
<p>3</p>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • 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. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>

Step	Description
4	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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 family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage or auto insurance

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

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

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

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

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

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

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

This plan always pays secondary to:

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

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

• TRICARE and CHAMPVA

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

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

- **Workers' Compensation**

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

We do not cover services that:

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

If 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

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

• 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 in Section 5(f), *Covered medications and supplies - Medicare A & B primary*.
- **Manipulative Therapy benefits:** There is no change in benefit limits for manipulative therapy care when Medicare is primary. See Section 5(a), *Manipulative therapy* for benefits.

- **Physical, speech and occupational therapy benefits:** There is no change in benefit limits or maximums for therapy when Medicare is primary.

We will NOT waive out-of-pocket costs as follows:

- **Specialty pharmacy medications not dispensed by CVS Specialty Pharmacy:** If Medicare denies coverage, we do not waive the coinsurance and we do NOT waive the \$300 (High Option) or \$500 (Standard Option) copayment.
- **Services obtained 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 examples which 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.

Member Cost without Medicare (In-Network)

Deductible: High and Standard: \$350 Self Only/\$700 Self Plus One or Self and Family

Catastrophic Protection 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

Part B Premium Reimbursement Offered: High/Standard: N/A

Primary Care Physician: High: \$20 copayment; Standard: \$20 copayment

Specialist: High: \$20 copayment; Standard: \$35 copayment

Inpatient Hospital: High: \$100 per admission and 10% of Plan allowance; Standard: 15% of plan allowance

Outpatient Hospital: High: 10% of Plan allowance; Standard: 15% of Plan allowance

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

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

Member Cost with Medicare Part B primary (In-Network)

Deductible: High and Standard: \$0

Catastrophic Protection 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

Part B Premium Reimbursement Offered: High: Up to \$1,000; Standard: N/A

Primary Care Physician: High/Standard: \$0

Specialist: High/Standard: \$0

Inpatient Hospital: High/Standard: \$0

Outpatient Hospital: High/Standard: \$0

Rx High Option: 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

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

- **Tell us about your Medicare coverage** You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.
- **Private contract with your physician** If you are enrolled in Medicare Part B, a physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. Regardless of whether the physician requires you to sign an agreement, we will still limit our payment to the coinsurance amount we would have paid after Original Medicare's payment based on our Plan allowable and the type of service you receive. You may be responsible for paying the difference between the billed amount and the amount we paid.
- **Medicare Advantage (Part C)** If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another 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 or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season, unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

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

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

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payor for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

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

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

If you:

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

Then, for your inpatient hospital care:

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

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

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

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

If your physician:

Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,

Then you are responsible for: your deductibles, coinsurance, and copayments.

If your physician:

Participates with Medicare and is **not** in our PPO network,

Then you are responsible for: your deductibles, coinsurance, and any balance up to the Medicare approved amount.

If your physician:

Does not participate with Medicare,

Then you are responsible for: your deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount.

If your physician:

Does not participate with Medicare and is not a member of our PPO network,

Then you are responsible for: your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount.

If your physician:

Opts-out of Medicare via private contract,

Then you are responsible for: your deductibles, coinsurance, copayments, and any balance your physician charges.

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

Physicians who opt-out of Medicare

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

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

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

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

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	<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. 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 <i>does not</i> 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 <i>does not</i> cover these costs.
Coinsurance	See Section 4. <i>Your Costs for Covered Services.</i>
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	See Section 4. <i>Your Costs for Covered Services.</i>
Cosmetic	Any procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.
Cost-sharing	See Section 4. <i>Your Costs for Covered Services.</i>
Covered services	Services we provide benefits for, as described in this brochure.

Custodial care	<p>We do not provide benefits for custodial care, regardless of who recommends the care or where it is provided. The Carrier or its delegated medical professionals determine which services are custodial care.</p> <p>Custodial care includes treatment, supplies or services, that are provided to a patient mainly to help with activities of daily living. These activities include but are not limited to:</p> <ul style="list-style-type: none"> • Service, supplies, and treatment that are designed mainly to train or assist the patient in personal hygiene or other activities of daily living rather than provide therapeutic treatment; or • Personal care such as help ambulating, getting in and out of bed, eating by spoon, tube or gastrostomy, exercise, and dressing; • Homemaking, such as preparing meals or special diets; • Acting as companion or sitter; • Supervising medication that can usually be self-administered; • Physical, emotional, or behavioral treatment or services that can be provided by non-licensed caregivers with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems; and • Services or treatment where further medical professional intervention is not expected to result in significant improvement in the member's condition. The member's condition is no longer demonstrating measurable progress towards established treatment goals that have been documented in the patient's treatment record.
Deductible	See Section 4. <i>Your Costs for Covered Services.</i>
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	<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	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	<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> <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.</p> <p>Determination of experimental/investigational status may require review of appropriate government publications such as those of the National Institute of Health, National Cancer Institute, Agency for Healthcare Policy and Research, Food and Drug Administration, 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.</p>
Group health coverage	Healthcare coverage that a member or covered dependent is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, dental or other healthcare services or supplies, including extension of any of these benefits through COBRA.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Iatrogenic infertility	An impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs including gonadotoxic therapies, or ovary or testicle removal for treatment of disease; also includes infertility associated with medical and surgical gender reassignment.
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. See Section 3, <i>How you get care</i> , Covered facilities, for the definition of an Acute Inpatient and Residential Treatment Center.
Long-term acute care	Often referred to as LTCH or LTAC, these facilities provide services for patients who need extended intensive or critical, hospital-level of care beyond that of the traditional short hospital stay. LTCH's specialize in treating patients who have more than one serious condition yet have the potential to improve with time and care and return to their previous health status. Generally, services are focused on respiratory therapy, head trauma treatment, and pain management.

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

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

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

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

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

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

Medical necessity Services, drugs, supplies or equipment provided by a hospital or covered provider of the healthcare 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;
- In the case of inpatient care, cannot be provided safely on an outpatient basis or
- Is not custodial or long-term care (see the Plan's definition on the previous page).

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 Section 3 under Covered Facilities.
- Residential Treatment Center (RTC): See Section 3 under Covered Facilities.

Intensive Day Treatment:

- Intensive day treatment programs are outpatient services that must be rendered on an outpatient basis. Regardless of where services are rendered, the provider and/or the facility, must be licensed to provide intensive day mental health and/or substance use treatment and must meet GEHA's definition of a covered provider in Section 3. GEHA does not cover room and board during intensive day treatment programs. Under the direction of a physician, services must be provided for at least two hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive psychiatric medication management.
 - Partial Hospitalization Program (PHP): facility based outpatient treatment program for mental health and/or substance use disorder conditions not requiring 24-hour care. Twenty or more hours of care per week is usually delivered at a minimum of four hours a day, five days a week. Time frames and frequency will vary based on condition, severity, and individual treatment plan.
 - Intensive Outpatient (IOP): A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions for mental health and/or substance use disorder conditions. It is an intermediate level of care between traditional outpatient therapy and partial hospitalization, delivered in an outpatient facility or outpatient professional office setting. Nine or more hours of care per week is usually delivered at a minimum of three hours a day, three days a week. Time frames and frequency will vary based on condition, severity, and individual treatment plan.

Minor acute conditions

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

Never event policies

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

Observation care

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

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

Plan 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 healthcare 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. For emergent services, air ambulance, and services performed by non-PPO providers rendered at PPO facilities, the Plan allowance will be the "recognized amount" as defined by the federal law.
2. 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.
3. 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.

4. 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 Programs (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 healthcare 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 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.

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

Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims 1) that require precertification or preauthorization and 2) where failure to obtain precertification or preauthorization results in a reduction of benefits.
Preauthorization	A decision made by your health plan that a healthcare service, treatment plan, drug, surgery, or durable medical equipment is medically necessary after review of medical information. Sometimes called prior approval.
Precertification	The process of collecting information and obtaining authorization from the health plan prior to an inpatient admission or other selected ambulatory procedures and services.
Primary care 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.
Telehealth	Online/virtual doctor visits provided remotely by means of telecommunications technology.

Urgent care claims

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer 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.

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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. 2023

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

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

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 healthcare professional.

High Option Benefits	You pay	Page
<p>Medical services provided by physicians: Diagnostic and treatment services provided in the office</p> <p>Note: Certain diagnostic tests are not subject to the calendar year deductible. See Section 5(a).</p>	<p>PPO: \$20 copay per covered office visit and 10%* of the covered professional services including X-ray and lab</p> <p>Non-PPO: 25%* of covered professional services</p>	33
<p>Services provided by a hospital: Inpatient</p>	<p>PPO: 10% of room and board and other hospital charges, inpatient \$100 per admission copayment applies</p> <p>Non-PPO: 25% of room and board and other hospital charges, inpatient \$300 per admission copayment applies</p>	65
<p>Services provided by a hospital: Outpatient</p>	<p>PPO: 10%* of other hospital charges</p> <p>Non-PPO: 25%* of other hospital charges</p>	68
<p>Emergency benefits: Accidental injury</p>	<p>Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident</p>	72
<p>Emergency benefits: Medical emergency</p>	<p>Regular benefits*</p>	73
<p>Mental health and substance use disorder treatment:</p>	<p>Regular cost-sharing*</p>	76
<p>Prescription drugs: Retail pharmacy</p>	<p>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).</p>	86

High Option Benefits	You pay	Page
Prescription drugs: Retail pharmacy	<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 \$5,000 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic.</p>	87
Prescription drugs: 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 \$5,000 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic.</p>	87
Dental care:	Charges in excess of the scheduled amounts for diagnostic and preventive service, restorations, and extractions	96
Wellness and other special features:	Flexible benefits options, Services for deaf and hearing impaired, Medicare Premium Reimbursement for High Option members enrolled in both Medicare Parts A and B, High risk pregnancies, 24-hour Health Advice Line, Telehealth, Obesity screening and management, Health Rewards/Health Assessment, Personal Health Record, and Value Added Programs and Services.	98
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	<p>Nothing after \$5,000 Self Only (\$10,000 Self Plus One or Self and Family) per year for PPO providers</p> <p>Nothing after \$7,000 Self Only (\$14,000 Self Plus One or Self and Family) per year for non-PPO providers</p> <p>Some costs do not count toward this protection</p>	27

Summary of Benefits for the Standard Option of the Government Employees Health Association, Inc. 2023

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

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

Below, an asterisk (*) means the item is subject to the \$350 Self Only or \$700 Self Plus One or Self and Family calendar year deductible when you use PPO providers; or subject to \$700 Self Only or \$1,400 Self Plus one or Self and Family calendar year deductible when you use non-PPO providers. 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 healthcare professional.

Standard Option Benefits	You pay	Page
<p>Medical services provided by physicians: Diagnostic and treatment services provided in the office</p> <p>Note: Certain diagnostic tests are not subject to the calendar year deductible. See Section 5(a).</p>	<p>PPO: \$20 copay primary care physician; \$35 copay specialist for covered office visits and 15%* of other covered professional services including X-ray and lab</p> <p>Non-PPO: 35%* of covered professional services</p>	33
<p>Services provided by a hospital: Inpatient</p>	<p>PPO: 15%* of covered hospital charges</p> <p>Non-PPO: 35%* of covered hospital charges</p>	65
<p>Services provided by a hospital: Outpatient</p>	<p>PPO: 15%* of covered hospital charges</p> <p>Non-PPO: 35%* of covered hospital charges</p>	68
<p>Emergency benefits: Accidental injury</p>	<p>Regular benefits*</p>	72
<p>Emergency benefits: Medical emergency</p>	<p>Regular benefits*</p>	73
<p>Mental health and substance use disorder treatment:</p>	<p>Regular cost-sharing*</p>	76
<p>Prescription drugs: Retail pharmacy</p>	<p>Network pharmacy: Member pays lesser of \$10 or pharmacy's usual and customary cost for generic drugs/50% preferred for up to a maximum of \$200 (\$300 for non-preferred) for up to a 30-day supply</p> <p>Non-network pharmacy: Member pays lesser of \$10 or pharmacy's usual and customary cost for generic drugs/50% preferred for up to a maximum of \$200 (\$300 for non-preferred) for up to a 30-day supply and any difference between our allowance and the cost of the drug.</p> <p>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.</p>	86

Standard Option Benefits	You pay	Page
Prescription drugs: Mail order	Member pays lesser of \$20 or the cost of the drug for generic drugs/50% preferred for up to a maximum of \$500 (\$600 for non-preferred) 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.	87
Dental care:	50% up to Plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions	96
Wellness and other special features:	Flexible benefits options, Services for deaf and hearing impaired, High risk pregnancies, QuestSelect Program, 24-hour Health Advice Line, Telehealth, Obesity screening and management, Health Rewards/Health Assessment, Personal Health Record, and Value Added Programs and Services.	98
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	27

Notes

Notes

2023 Rate Information for Government Employees Health Association, Inc. (GEHA) Benefit Plan

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

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

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

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	311	\$259.72	\$105.74	\$562.73	\$229.10
High Option Self Plus One	313	\$560.52	\$243.49	\$1,214.46	\$527.56
High Option Self and Family	312	\$611.42	\$304.39	\$1,324.74	\$659.52
Standard Option Self Only	314	\$206.33	\$68.77	\$447.04	\$149.01
Standard Option Self Plus One	316	\$443.62	\$147.87	\$961.17	\$320.39
Standard Option Self and Family	315	\$542.77	\$180.92	\$1,176.00	\$392.00