

Government Employees Health Association, Inc. Benefit Plan

(800) 821-6136
<http://www.geha.com>



2012

A fee-for-service (high and standard option) health plan with a preferred provider organization

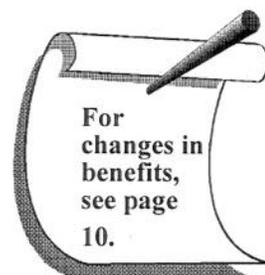
Sponsored and administered by:

Government Employees Health Association, Inc.

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits 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 2012.



Enrollment codes for this Plan:

- 311 High Option - Self Only
- 312 High Option - Self and Family
- 314 Standard Option - Self Only
- 315 Standard Option - Self and Family



URAC accreditation: GEHA for Health Network

URAC UM accreditation: InforMed for Health Utilization Management

NCQA accreditation: Healthcare Effectiveness Data and Information Set (HEDIS) Audit

JCAHO accreditation: Medco for Home Care Pharmacy Dispensing Services

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United States
Office of Personnel Management

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

RI 71-006

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$█ per person (\$█ per family) under the High and Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians and pathologists who are not preferred providers at the preferred provider rate.
- **YOU MUST GET PRECERTIFICATION FOR CERTAIN OUTPATIENT IMAGING PROCEDURES. FAILURE TO DO SO WILL RESULT IN A MINIMUM OF \$100 PENALTY.** Please refer to precertification information in Section 3 to be sure which procedures require precertification.

Benefits Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>		
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 <p>Note: See page 44 for coverage of Christian Science practitioners.</p>	<p>PPO: █ copayment (No deductible)</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █ copayment for office visits to primary care physicians; █ copayment for office visits to specialists (No deductible)</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Emergency room physician care (non-accidental injury) • During a hospital stay • At home • Professional services of a physician at an urgent care facility 	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
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 • X-rays • Non-routine mammograms • CAT Scans/MRI (outpatient requires precertification) • Double contrast barium enemas • Ultrasound • Electrocardiogram and EEG 	<p>PPO: █ of the Plan allowance</p> <p>Non-PPO: █% 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 or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% 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 or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Professional fees for automated lab tests 	<i>All charges</i>	<i>All charges</i>
Lab Card, service of Quest Diagnostics	High Option	Standard Option
<p>You may use this voluntary program for covered outpatient lab tests. You show your Lab Card Program identification card and tell your physician you would like to use the Lab Card benefit. If the physician draws the specimen, he/she can call (800) 646-7788 for pick up or you can go to an approved collection site and show your Lab Card along with the test requisition from your physician and have the specimen drawn there. Please Note: You must show your Lab Card each time you obtain lab work whether in the physician's office or collection site. To find an approved collection site near you, call (800) 646-7788 or visit the website at http://www.geha.com/more_benefits_programs/labcard.html</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 Lab Card Program) are subject to applicable deductibles and coinsurance.</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 Lab Card Program) are subject to applicable deductibles and coinsurance.</p>
Preventive care, adult	High Option	Standard Option
<p>Professional services, such as:</p> <ul style="list-style-type: none"> • Age and gender appropriate preventive medical examination <p>Routine screenings, limited to:</p> <ul style="list-style-type: none"> • Total blood cholesterol screenings • Chlamydial infection • Colorectal cancer screening, including <ul style="list-style-type: none"> - Annual coverage of one fecal occult blood test for members age 40 and older - Sigmoidoscopy (surgeon and facility charges) - Colonoscopy (surgeon and facility charges) 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Preventive care, adult (cont.)		
<ul style="list-style-type: none"> • Prostate cancer screening <ul style="list-style-type: none"> - Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older • Routine Pap test <ul style="list-style-type: none"> - Annual coverage of one Pap smear for women age 18 and older • Routine mammogram <ul style="list-style-type: none"> - Mammograms for diagnostic and/or routine screening • Osteoporosis screening <ul style="list-style-type: none"> - Bone density tests for routine screening for women 65 or older or women 60 or older who are at increased risk 	PPO: Nothing (No deductible) Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> • Professional fees for automated lab tests 	<i>All charges</i>	<i>All charges</i>
Preventive care, children	High Option	Standard Option
For dependent children under age 22: <ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, including one routine eye examination per person per calendar year, immunizations and care • Initial examination of a newborn child covered under a family enrollment 	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)	PPO: Nothing (No deductible) Non-PPO: Nothing, except any difference between our Plan allowance and the billed amount. (No deductible)
Vision examinations, limited to: <ul style="list-style-type: none"> • Examinations for amblyopia and strabismus 	PPO: \$█ copayment (No deductible) Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount	PPO: \$█ copayment for office visits to primary care physicians; \$█ copayment for office visits to specialists (No deductible) Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • Professional fees for automated lab tests 	<i>All charges</i>	<i>All charges</i>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Maternity care</p> <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care • Physician care such as sonograms <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 page 15 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. See <i>Hospital benefits</i> (Section 5(c)) and <i>Surgery benefits</i> (Section 5(b)). 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • Approved fetal monitors, skilled nursing services, intravenous/infusion therapy, and injections are covered the same as other medical benefits for diagnostic and treatment 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 new-born child are not covered under this or any other benefit in a surrogate mother situation.</p>	<p>PPO: ■% of the Plan allowance</p> <p>Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■% of the Plan allowance</p> <p>Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount</p>

Maternity care - continued on next page

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Maternity care (cont.)		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Home uterine monitoring devices, unless preauthorized by our Medical Director • Charges related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest • Charges for services and supplies incurred after termination of coverage 	<i>All charges</i>	<i>All charges</i>
Family planning		
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilizations (see <i>Surgical procedures</i> Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the <i>Prescription drug benefits</i> in Section 5(f).</p>	<p>PPO: ■ % of the Plan allowance</p> <p>Non-PPO: ■ % of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■ % of the Plan allowance</p> <p>Non-PPO: ■ % 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 and genetic screening • Preimplantation genetic diagnosis (PGD) • Expenses for sperm collection and storage 	<i>All charges</i>	<i>All charges</i>
Infertility services		
<ul style="list-style-type: none"> • Diagnosis and treatment of infertility except as shown in <i>Not covered</i> <p>Note: Benefits are limited to a maximum of \$3,000 per person per calendar year.</p>	<p>PPO: ■ % of the Plan allowance</p> <p>Non-PPO: ■ % of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■ % of the Plan allowance</p> <p>Non-PPO: ■ % 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"> • Infertility services after voluntary sterilizations • Fertility drugs • Genetic counseling and genetic screening • Preimplantation genetic diagnosis (PGD) 	<i>All charges</i>	<i>All charges</i>

Infertility services - continued on next page

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
 Infertility services (cont.) <i>Not covered: (continued)</i> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> - Artificial insemination - In vitro fertilization - Embryo transfer and gamete intrafallopian transfer (GIFT) - Intravaginal insemination (IVI) - Intra-cervical insemination (ICI) - Intrauterine insemination (IUI) • Services and supplies related to ART procedures • Cost of donor sperm • Cost of donor egg 	<i>All charges</i>	<i>All charges</i>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment, including materials (such as allergy serum) • Allergy testing is limited to \$500 per person per calendar year • Allergy injections 	PPO: █ % of the Plan allowance Non-PPO: █ of the Plan allowance and any difference between our allowance and the billed amount	PPO: █ % of the Plan allowance Non-PPO: █ % of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • Clinical ecology and environmental medicine • Provocative food testing and sublingual allergy desensitization 	<i>All charges</i>	<i>All charges</i>
 Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Antibiotic therapy – intravenous (IV)/Infusion (see *Note) • Outpatient cardiac rehabilitation • Chemotherapy and radiation therapy (precertification required) <p>Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants beginning on page 51.</p> <ul style="list-style-type: none"> • Dialysis – hemodialysis and peritoneal dialysis (precertification required) • Intravenous (IV)/Infusion Therapy (see *Note) • Respiratory and inhalation therapies 	PPO: █ % of the Plan allowance Non-PPO: █ % of the Plan allowance and any difference between our allowance and the billed amount	PPO: █ % of the Plan allowance Non-PPO: █ % of the Plan allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
 Treatment therapies (cont.)	High Option	Standard Option
<p>Note: Some medications required for treatment therapies may be available through Medco Pharmacy (mail order) or a Medco participating pharmacy. Medications obtained from these sources are covered under the <i>Prescription drug benefits</i> in Section 5(f).</p> <p>*Note: Please refer to the <i>Specialty drug benefits</i> beginning on page 35 for benefits which apply to some categories of prescription drug treatment including Growth Hormone Therapy (GHT).</p>	<p>PPO: █% 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: █% 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>Chelating therapy except for acute arsenic, gold or lead poisoning</i> • <i>Maintenance cardiac rehabilitation</i> • <i>Topical hyperbaric oxygen therapy</i> • <i>Prolotherapy</i> 	<i>All charges</i>	<i>All charges</i>

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Specialty drug benefits</p> <p>Specialty medications are those used to treat some severe, chronic medical conditions and are usually administered by injection or infusion including, but not limited to, those in the following categories: See Section 5(f) <i>Prescription drug benefits</i> for additional pharmacy related information.</p> <ul style="list-style-type: none"> • Hemophilia factor products such as Helixate FS, Recombinate; • Blood growth factors such as Aranesp, Leukine, Neupogen, Procrit, Promacta; • Medications for hyperparathyroidism such as Sensipar; • Growth Hormone medications such as Genotropin, Humatrope, Nutropin; • Immunoglobulin preparations such as Gammagard, Gammar-P, Vivaglobin; • Psoriasis medications such as Amevive; • Multiple Sclerosis medications such as Avonex, Betaseron, Rebif, Tysabri, Copaxone; • Hepatitis medications such as Intron A, Pegasys, Peg-Intron, Copegus, Rebetol, Ribavirin, Ribapak, Ribasphere; • Rheumatoid arthritis medications such as Kineret, Orencia, Enbrel and Humira. These drugs may also be indicated for other conditions. • Pulmonary medications such as Synagis (for RSV), Xolair (asthma), Pulmozyme and Tobi/inhaled tobramycin (for cystic fibrosis); • Aldurazyme and Naglazyme to treat Mucopolysaccharidosis; • Cerezyme to treat Gaucher's Disease; • Exjade as a blood modifier to treat iron overload; • Osteoporosis drug such as Forteo; • AIDS/HIV drug such as Fuzeon; • Orfadin for Hereditary Tyrosinemia; • Acromegaly drugs such as Octreotide and Sandostatin; • Pulmonary hypertension drugs such as Remodulin, Flolan, Tracleer and Ventavis, Letairis and Revatio; • Osteo-arthritis medications such as Synvisc, Supartz, Orthovisc, Hyalgan, Euflexxa; • Ophthalmic medications such as Lucentis (for macular degeneration); 	<p>Medications dispensed by Medco Specialty Pharmacies:</p> <p>When GEHA is primary:</p> <ul style="list-style-type: none"> • █% coinsurance up to a maximum of █ or up to a 30-day supply • \$█ maximum coinsurance for up to a 90-day supply <p>When Medicare is primary:</p> <ul style="list-style-type: none"> • █% coinsurance up to a maximum of \$█ for up to a 30-day supply • \$█ maximum coinsurance for up to a 90-day supply <p>If you choose a brand name specialty drug for which a generic drug exists, you will pay the 25% (non-Medicare)/15% (Medicare) coinsurance and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name specialty drug which will require preauthorization.</p> <p>Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals:</p> <ul style="list-style-type: none"> • PPO: █ copayment per prescription fill and █% of the Plan allowance • Non-PPO: \$█ copayment per prescription fill and █% of the Plan allowance • The \$█ copayment per prescription fill does not apply to the out-of-pocket maximum <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p>	<p>Medications dispensed by Medco Specialty Pharmacies:</p> <ul style="list-style-type: none"> • █% coinsurance up to a maximum of █ for up to a 30-day supply • █% coinsurance up to a maximum of █ for up to a 90-day supply <p>Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals:</p> <ul style="list-style-type: none"> • PPO: █ copayment per prescription fill and █% of the Plan allowance • Non-PPO: \$█ copayment per prescription fill and █% of the Plan allowance • The \$█ copayment per prescription fill does not apply to the out-of-pocket maximum <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p>

Specialty drug benefits - continued on next page

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Specialty drug benefits (cont.)</p> <ul style="list-style-type: none"> • Cancer medications such as Afinitor, Gleevec, Hycamtin, Nexavar, Revlimid, Sprycel, Sutent, Tarceva, Tasigna, Temodar, Thalomid, Tykerb and Zolanza; or infused medications, such as Herceptin, Erbitux, Rituxan; • Kuvan for Phenylketonuria (PKU); • Cystadane for Homocystinuria; and • Xenazine for Huntington's chorea. <p>Drugs in these categories are subject to the <i>Specialty drug benefits</i>. The medication examples provided above are not all inclusive. Call our customer service department at (800) 821-6136 to determine if other medications not listed apply to this benefit.</p> <p>Note: Coinsurance for medications dispensed by Medco Specialty Pharmacies go toward a \$4,000 (High Option) or \$6,000 (Standard Option) annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference in the cost of the generic and the brand multi-source specialty drugs.</p>	<p>Medications dispensed by Medco Specialty Pharmacies:</p> <p>When GEHA is primary:</p> <ul style="list-style-type: none"> • █ % coinsurance up to a maximum of \$█ for up to a 30-day supply • \$350 maximum coinsurance for up to a 90-day supply <p>When Medicare is primary:</p> <ul style="list-style-type: none"> • █ % coinsurance up to a maximum of \$█ for up to a 30-day supply • █ maximum coinsurance for up to a 90-day supply <p>If you choose a brand name specialty drug for which a generic drug exists, you will pay the █ % (non-Medicare) █ % (Medicare) coinsurance and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name specialty drug which will require preauthorization.</p> <p>Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals:</p> <ul style="list-style-type: none"> • PPO: \$█ copayment per prescription fill and █ % of the Plan allowance • Non-PPO: \$█ copayment per prescription fill and █ % of the Plan allowance • The \$█ copayment per prescription fill does not apply to the out-of-pocket maximum <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p>	<p>Medications dispensed by Medco Specialty Pharmacies:</p> <ul style="list-style-type: none"> • █ % coinsurance up to a maximum of █ for up to a 30-day supply • █ % coinsurance up to a maximum of \$█ for up to a 90-day supply <p>Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals:</p> <ul style="list-style-type: none"> • PPO: █ copayment per prescription fill and █ % of the Plan allowance • Non-PPO: \$█ copayment per prescription fill and █ % of the Plan allowance • The \$█ copayment per prescription fill does not apply to the out-of-pocket maximum <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p>

Specialty drug benefits - continued on next page

Benefits Description	You pay After the calendar year deductible...	
Specialty drug benefits (cont.)	High Option	Standard Option
<p>Non Specialty Pharmacy retail purchase</p> <p>If Medco Specialty Pharmacies are not used and you purchase medications in the above categories through a retail pharmacy, you must submit your claim to:</p> <p>Medco P.O. Box 14711 Lexington, KY 40512</p> <p>Reimbursement will be based on GEHA's costs had you used the specialty pharmacies.</p> <p>You must submit original drug receipts.</p> <p>Note: Coinsurance for medications dispensed at retail pharmacies go toward a \$4,000 (High Option) or \$6,000 (Standard Option) annual prescription out-of-pocket limit (for Self Only or for Self and Family enrollments) except for the difference in the cost of the generic and the brand multi-source specialty drugs.</p>	<p>When GEHA is primary:</p> <ul style="list-style-type: none"> • █ copayment per prescription fill and 25% of the Plan allowance (plus any difference between our allowance and the cost of the drug) <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p> <p>When Medicare is primary:</p> <ul style="list-style-type: none"> • █ copayment per prescription fill and 20% of the Plan allowance (and any difference between our allowance and the cost of the drug) <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p> <p>If you choose a brand name specialty drug for which a generic drug exists, you will pay the █% (non-Medicare), █% (Medicare) coinsurance and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name specialty drug which will require preauthorization.</p>	<ul style="list-style-type: none"> • █ copayment per prescription fill and █% of the Plan allowance (plus any difference between our allowance and the cost of the drug) <p>Note: A separate copayment applies per prescription fill up to a 30-day supply.</p>
Physical and occupational therapies	High Option	Standard Option
<ul style="list-style-type: none"> • 60 visits per person per calendar year for the combined services of the following: (One visit is two hours or less of physical or occupational therapy.) <ul style="list-style-type: none"> - Qualified physical therapists - Qualified occupational therapists 	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>

Physical and occupational therapies - continued on next page

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Physical and occupational therapies (cont.)</p> <p>All physical and occupational therapy visits require preauthorization. Please make an evaluation visit, then contact OrthoNet by phone at (877) 304-4399 or fax to (877) 304-4398 a copy of the evaluation to OrthoNet. Authorizations will be provided in blocks of time and progress reviewed prior to additional authorizations.</p> <p>To precertify physical and occupational therapy in Georgia contact Coventry at (800) 470-2004. In North and South Carolina contact WellPath at (800) 708-9355. In Pennsylvania contact HAPA at (800) 755-1135.</p> <p>Authorizations for physical and occupational therapy are based on medical necessity. In order to make individual-specific authorization decisions, OrthoNet will review the treating provider's evaluation; including diagnosis, duration of member's symptoms (chronic vs. acute), nature or severity of symptoms, timeframes for anticipated recovery or clinical milestones, measurements of joint motion or from standardized tools specific to the condition or affected body part (Simple Shoulder Test, HSS Knee Score, Oswestry, and DASH), and rehab potential. OrthoNet's on-going therapy management is concurrent and based on progress made in therapy.</p> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and when a physician:</p> <ul style="list-style-type: none"> - orders the care - identifies the specific professional skills the patient requires and the medical necessity for skilled services - indicates the length of time the services are needed <p>Note: When you receive medically necessary physical or occupational therapy on an outpatient basis from a qualified professional therapist at a skilled nursing facility, your therapy is covered up to plan limits.</p>	<p>PPO: █ % of the Plan allowance</p> <p>Non-PPO █ % of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █ % of the Plan allowance</p> <p>Non-PPO: █ % 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>Exercise programs</i> • <i>Long-term rehabilitative therapy</i> • <i>Hot and cold packs</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Speech therapy</p> <ul style="list-style-type: none"> • 30 visits per person per calendar year for the services of a qualified speech therapist (One visit is two hours or less of speech therapy.) <p>Note: We only cover speech therapy when a physician:</p> <ul style="list-style-type: none"> - orders the care - identifies the specific professional skills the patient requires and the medical necessity for skilled services - indicates the length of time the services are needed <p>All speech therapy visits require preauthorization. Please make an evaluation visit, then contact OrthoNet by phone at (877) 304-4399 or fax to (877) 304-4398 a copy of the evaluation to OrthoNet. Authorizations will be provided in blocks of time and progress reviewed prior to additional authorizations.</p> <p>To precertify speech therapy in Georgia contact Coventry at (800) 470-2004. In North and South Carolina contact WellPath at (800) 708-9355. In Pennsylvania contact HAPA at (800) 755-1135.</p> <p>Authorization for speech therapy is based on medical necessity. In order to make individual-specific authorization decisions, OrthoNet will review the treating provider's evaluation; including diagnosis, duration of member's symptoms, nature or severity of symptoms, time frames for anticipated recovery or clinical milestones, and rehab potential. OrthoNet's on-going therapy management is concurrent and based on progress made in therapy.</p> <p>Note: When you receive medically necessary speech therapy on an outpatient basis from a qualified speech therapist at a skilled nursing facility, your therapy is covered up to Plan limits.</p>	<p>PPO: ■% of the Plan allowance</p> <p>Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■% of the Plan allowance</p> <p>Non-PPO: ■% 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>Computer devices to assist with communications</i> • <i>Computer programs of any type, including but not limited to those to assist with speech therapy</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p> Hearing services (testing, treatment and supplies)</p> <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: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% 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 five years</p>	<p>PPO: All charges in excess of \$█ for each ear (No deductible)</p> <p>Non-PPO: All charges in excess of \$█ for each ear (No deductible)</p>	<p>PPO: All charges in excess of █ for each ear (No deductible)</p> <p>Non-PPO: All charges in excess of \$█ for each ear (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Hearing services that are not shown as covered 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Vision services (testing, treatment and supplies)</p> <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 visits by an ophthalmologist or optometrist 	<p>PPO █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% 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 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
 Foot care <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: █ copayment for the office visit (█) plus █% of the Plan allowance for other services performed during the visit</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █ copayment for the office visit to primary care physicians; \$█ copayment for office visits to specialists (No deductible); plus █% of the Plan allowance for other services performed during the visit</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> One pair of diabetic shoes per person per calendar year 	<p>PPO: All charges in excess of \$█ (No deductible)</p> <p>Non-PPO: All charges in excess of \$█ (No deductible)</p>	<p>PPO: All charges in excess of \$█ (No deductible)</p> <p>Non-PPO: All charges in excess of \$█ (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Cutting, trimming of toenails or removal of corns, calluses, or similar routine treatment of conditions of the foot, except as stated above</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
 Orthopedic and prosthetic devices <ul style="list-style-type: none"> Artificial limbs and eyes; Stump hose 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 <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: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% 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> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Orthopedic and prosthetic devices - continued on next page
High and Standard Option Section 5(a)

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
 Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<p><i>Not covered: (continued)</i></p> <ul style="list-style-type: none"> • Bioelectric, computer programmed prosthetic devices 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)	High Option	Standard Option
<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 • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers <p>Note: Call us at (800) 821-6136 as soon as your physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p> <p>Note: We will pay only for the cost of the standard item. Coverage for specialty equipment such as all-terrain wheelchairs is limited to the cost of the standard equipment.</p>	<p>PPO: ■ % of the Plan allowance</p> <p>Non-PPO: ■ % of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■ % of the Plan allowance</p> <p>Non-PPO: ■ % 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 devices to assist with communications • Computer programs of any type 	<i>All charges</i>	<i>All charges</i>

Durable medical equipment (DME) - continued on next page

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Durable medical equipment (DME) (cont.)</p> <p><i>Not covered: (continued)</i></p> <ul style="list-style-type: none"> • <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 (page 103)</i> • <i>Lifts, such as seat, chair or van lifts</i> • <i>Wigs</i> • <i>Bone stimulators except for established non-union fractures</i> • <i>Devices or programs to eliminate bed wetting</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p> Home health services</p> <p>50 in-home visits per person per calendar year, not to exceed one visit up to two hours per day when:</p> <ul style="list-style-type: none"> • A registered nurse (R.N.) or a licensed practical nurse (L.P.N.) provides the services • The attending physician orders the care • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services • The physician indicates the length of time the services are needed <p>Note: Covered services are based on our review for medical necessity.</p> <p>Note: Please refer to the <i>Specialty drug benefits</i> beginning on page 35 for information on benefits for home infusion therapies.</p>	<p>PPO: ■% of the Plan allowance</p> <p>Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■% of the Plan allowance</p> <p>Non-PPO: ■% 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 medication</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</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>Inpatient private duty nursing</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Chiropractic</p> <p>Chiropractic services limited to:</p> <ul style="list-style-type: none"> • 12 visits per person per calendar year for manipulation of the spine • X-rays, used to detect and determine nerve interferences due to spinal subluxations or misalignments • \$25 per person per calendar year for chiropractic X-rays <p>Note: No other benefits for the services of a chiropractor are covered under any other provision of this Plan. In medically underserved areas, services of a chiropractor that are listed above are subject to the stated limitations. In medically underserved areas, services of a chiropractor that are within the scope of his/her license and are not listed above are eligible for regular Plan benefits.</p>	<p>PPO and Non-PPO:</p> <p>All charges in excess of \$█ per visit</p> <p>All charges in excess of \$█ for X-rays of the spine</p> <p>Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.</p>	<p>PPO and Non-PPO:</p> <p>All charges in excess of \$█ per visit</p> <p>All charges in excess of \$█ for X-rays of the spine</p> <p>Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Any treatment not specifically listed as covered • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p> Alternative treatments</p> <p>Acupuncture:</p> <ul style="list-style-type: none"> • Benefits are limited to 20 procedures per person per calendar year for medically necessary acupuncture treatments if performed by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) 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: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% 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 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p> Alternative treatments (cont.)</p> <p><i>Not covered: (continued)</i></p> <p><i>(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 11.)</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p> Educational classes and programs</p> <p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Tobacco Cessation – We cover counseling sessions including proactive telephone counseling, group counseling and individual counseling. Benefits are payable for up to two attempts per person per calendar year, with up to four counseling sessions per attempt. • In addition, we cover over the counter (with a physician's prescription) and prescription smoking cessation drugs approved by the FDA. The quantity of drugs reimbursed will be subject to recommended courses of treatment. You may obtain smoking cessation drugs with your Medco prescription card, through Medco Pharmacy (mail order) or a non-Network Retail pharmacy. (See page 45 for 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 – Provided by Certified Diabetes Educators or physician through a program certified by the American Diabetes Association up to \$250 per person per calendar year. 	<p>PPO: All charges in excess of \$█ (No deductible)</p> <p>Non-PPO: All charges in excess of \$█ (No deductible)</p>	<p>PPO: All charges in excess of \$█ (No deductible)</p> <p>Non-PPO: All charges in excess of \$█ (No deductible)</p>
<ul style="list-style-type: none"> • Nutritional Counseling – Provided by a dietician with state license or statutory certification up to \$250 per person per calendar year. Nutritional counseling must be ordered by a physician. 	<p>PPO: All charges in excess of \$█ (No deductible)</p> <p>Non-PPO: All charges in excess of \$█ (No deductible)</p>	<p>PPO: All charges in excess of \$█ (No deductible)</p> <p>Non-PPO: All charges in excess of \$█ (No deductible)</p>

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$ [] per person ([] per family) under the High and Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the 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 preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians and pathologists who are not preferred providers at the preferred provider rate.
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

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 procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies - limited to children under the age of 18 unless there is a functional deficit (see <i>Reconstructive surgery</i>) 	PPO: []% of the Plan allowance Non-PPO: []% of the Plan allowance and any difference between our allowance and the billed amount	PPO: []% of the Plan allowance Non-PPO: []% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Surgical treatment of obesity (bariatric surgery) is covered only if: <ul style="list-style-type: none"> - eligible enrollee is 18 or over - clinical records support a body mass index of 40 or greater (or 35-40 when there is a co-morbid condition such as life-threatening cardiopulmonary problems or severe diabetes mellitus) for a period of six months - documentation of failure to lower the body mass index by a medically supervised program within the last twelve months of diet and exercise of at least six months duration <p>Note: Benefits are payable only for bariatric surgery which meets the above criteria and is performed at centers certified as “well qualified” by Centers for Medicare and Medicaid Services (CMS). Bariatric surgery must be precertified.</p> <ul style="list-style-type: none"> • Insertion of internal prosthetic devices (see Section 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information) • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • 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>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>PPO: ■% of the Plan allowance</p> <p>Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■% of the Plan allowance</p> <p>Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount</p>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Surgical procedures (cont.)		
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><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, 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: ■■■ % of the Plan allowance</p> <p>Non-PPO: ■■■ % of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■■■ % of the Plan allowance</p> <p>Non-PPO: ■■■ % of the Plan allowance and any difference between our allowance and the billed amount</p>

Reconstructive surgery - continued on next page
High and Standard Option Section 5(b)

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Reconstructive surgery (cont.)</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 sex transformation or sexual dysfunction</i> • <i>Surgeries to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit</i> • <i>Charges for photographs to document physical conditions</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Oral and maxillofacial surgery</p> <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 • Excision of cysts and incision of abscesses unrelated to tooth structure • Extraction of impacted (unerupted or partially erupted) teeth • Alveoloplasty, partial or radical removal of the lower jaw with bone graft • Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues • Open reduction of dislocations and excision, manipulation, aspiration or injection of temporomandibular joints • Removal of foreign body, skin, subcutaneous areolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones and incision/excision of salivary glands and ducts • Repair of traumatic wounds • Incision of the sinus and repair of oral fistulas • Surgical treatment of trigeminal neuralgia • Repair of accidental injury to sound natural teeth such as: expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. Masticating (biting or chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at 100% for charges incurred within 72 hours of an accident (see page 64). 	<p>PPO: ■■■ % of the Plan allowance</p> <p>Non-PPO: ■■■ % of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■■■ % of the Plan allowance</p> <p>Non-PPO: ■■■ % of the Plan allowance and any difference between our allowance and the billed amount</p>

Oral and maxillofacial surgery - continued on next page

High and Standard Option

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 surgery for the following conditions: <ul style="list-style-type: none"> - severe sleep apnea only after conservative treatment of sleep apnea has failed - cleft palate and Pierre Robin Syndrome - Orthognathic surgery for any other condition is not covered • Other oral surgery procedures that do not involve the teeth or their supporting structures 	PPO: ■% of the Plan allowance Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount	PPO: ■% of the Plan allowance Non-PPO: ■% 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 • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) • Orthodontic treatment • Any oral or maxillofacial surgery not specifically listed as covered • Orthognathic surgery, except as outlined above for severe sleep apnea, cleft palate and Pierre Robin Syndrome (even if necessary because of TMJ dysfunction or disorder) 	<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 prior authorization procedures.</p> <p>Solid organ transplants limited to</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral • Pancreas 	PPO: ■% of the Plan allowance Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount	PPO: ■% of the Plan allowance Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p> Organ/tissue transplants (cont.)</p> <p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. Refer to <i>Other services</i> in Section 3 for prior authorization 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 - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, pure red cell aplasia) - Chronic myelogenous leukemia - Hemoglobinopathy - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria 	<p>PPO: ■■■% of the Plan allowance</p> <p>Non-PPO: ■■■% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■■■% of the Plan allowance</p> <p>Non-PPO: ■■■% 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 prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) 	<p>PPO: ■■■% of the Plan allowance</p> <p>Non-PPO: ■■■% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: ■■■% of the Plan allowance</p> <p>Non-PPO: ■■■% 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

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p> Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Neuroblastoma - Amyloidosis <p>Autologous tandem transplants for</p> <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, - Breast cancer - Epithelial ovarian cancer - Childhood rhabdomyosarcoma - Advanced Ewing sarcoma - Advanced Childhood kidney cancers - Mantle Cell (Non-Hodgkin lymphoma) - Waldenstrom's macroglobulinemia 	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% 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-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization 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 - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia 	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% 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

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p> Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • 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>Tandem transplants for covered transplants: Subject to medical necessity.</p> <p>We will cover donor screening tests and donor search expenses for up to four potential donors for bone marrow or stem cell transplants.</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>
<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 us and if the donor's expenses are not otherwise covered.</p>		

Organ/tissue transplants - continued on next page

High and Standard Option

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 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>
<p>Limited Benefits</p> <ul style="list-style-type: none"> The process for preauthorizing organ transplants is more extensive than the normal precertification process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact our Medical Director 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 by our Medical Director. (Cornea and kidney transplants do not require preauthorization by GEHA's Medical Director.) 		

Organ/tissue transplants - continued on next page

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
 Organ/tissue transplants (cont.)	High Option	Standard Option
<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 are subject to the \$100,000 limit except expenses for aftercare such as outpatient prescription drugs are not a part of the \$100,000 limit. 	<p>PPO: █ copayment (No deductible)</p> <p>Non-PPO: █ % of the Plan allowance and any difference between our allowance and the billed amount</p> <p>If prior approval 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 █ per transplant. If we cannot refer a member in need of a transplant to a designated facility, the █ maximum will not apply.</p>	<p>PPO: █ copayment for office visits to primary care physicians; █ copayment for office visits to specialists (No deductible)</p> <p>Non-PPO: █ % of the Plan allowance and any difference between our allowance and the billed amount</p> <p>If prior approval 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 █ per transplant. If we cannot refer a member in need of a transplant to a designated facility, the █ 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: █ % of the Plan allowance</p> <p>Non-PPO: █ % of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █ % of the Plan allowance</p> <p>Non-PPO: █ % 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>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</i> 	<i>All charges</i>	<i>All charges</i>

High and Standard Option

Benefits Description	You pay After the calendar year deductible...	
 Anesthesia	High Option	Standard Option
Professional fees for the administration of anesthesia in: <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office 	PPO: ■% of the Plan allowance Non-PPO: ■% of the Plan allowance and any difference between our allowance and the billed amount	PPO: ■% of the Plan allowance Non-PPO ■% of the Plan allowance and any difference between our allowance and the billed amount

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added “(calendar year deductible applies)”. The calendar year deductible is \$350 per person (\$700 per family) under the High and Standard Option.
- A High Option per admission deductible 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, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or 5(b). See page 44 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 preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians and pathologists who are not preferred providers at the preferred provider rate.
- 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 with no invoice. Providers are encouraged to notify us on admission to determine benefits payable.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM \$500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefits Description	You pay	
Note: The calendar year deductible applies ONLY when we say below: “(calendar year deductible applies)”.		
Inpatient hospital	High Option	Standard Option
Room and board, such as: <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate.	PPO: Nothing Non-PPO: Nothing	PPO: █ % of the Plan allowance (calendar year deductible applies) Non-PPO: █ % of the Plan allowance (calendar year deductible applies)

Inpatient hospital - continued on next page

High and Standard Option

Benefits Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<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 medicines • 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 health-care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.</p>	<p>PPO: █ of the Plan allowance (\$100 per admission deductible applies)</p> <p>Non-PPO: █ of the Plan allowance (\$300 per admission deductible applies)</p>	<p>PPO: █ of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █ of the Plan allowance (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 page 15 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>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Delivery room, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced 	<p>PPO: Nothing</p> <p>Non-PPO: Nothing for room and board; █ of the Plan allowance for other hospital services (█ per admission deductible applies)</p>	<p>PPO: Nothing</p> <p>Non-PPO: █ of the Plan allowance (calendar year deductible applies)</p>

High and Standard Option

Benefits Description	You pay	
	High Option	Standard Option
<p>Inpatient hospital (cont.)</p> <p>Maternity Care - Inpatient Hospital <i>(continued)</i></p> <ul style="list-style-type: none"> • 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.) • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. 	<p>PPO: Nothing</p> <p>Non-PPO: Nothing for room and board; █% of the Plan allowance for other hospital services (█ per admission deductible applies)</p>	<p>PPO: Nothing</p> <p>Non-PPO: █% of the Plan allowance (calendar year deductible applies)</p>
<ul style="list-style-type: none"> • We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. <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 new-born child are not covered under this or any other benefit in a surrogate mother situation.</p>	<p>PPO: Nothing for room and board; █% of the plan allowance for other hospital services (█ per admission deductible applies)</p> <p>Non-PPO: Nothing for room and board; █% of the Plan allowance for other hospital services (\$█ per admission deductible applies)</p>	<p>PPO █% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █% of the Plan allowance (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Any part of a hospital admission that is not medically necessary (see definition), 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. • Custodial care; see definition • Non-covered facilities, such as nursing homes, schools 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Inpatient hospital - continued on next page

High and Standard Option

Benefits Description	You pay	
	High Option	Standard Option
Inpatient hospital (cont.)	High Option	Standard Option
<p><i>Not covered: (continued)</i></p> <ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>	<i>All charges</i>
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 medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood or blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, splints, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Cardiac rehabilitation 	<p>PPO: █% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █% of the Plan allowance (calendar year deductible applies)</p>	<p>PPO: █ of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █% of the Plan allowance (calendar year deductible applies)</p>
<p>Note: Please refer to page 35 for information on benefits for <i>Specialty drug benefits</i> 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><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Maintenance cardiac rehabilitation</i> 	<i>All charges</i>	<i>All charges</i>
Maternity Care – Outpatient Hospital	High Option	Standard Option
<ul style="list-style-type: none"> • Delivery room, recovery, observation, and other treatment rooms • Prescribed drugs and medicines • 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>PPO: Nothing</p> <p>Non-PPO: █% of the Plan allowance (calendar year deductible applies)</p>	<p>PPO: Nothing</p> <p>Non-PPO: █ of the Plan allowance (calendar year deductible applies)</p>

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

High and Standard Option

Benefits Description	You pay	
<p> Outpatient hospital, clinic or ambulatory surgical center (cont.)</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 new-born child are not covered under this or any other benefit in a surrogate mother situation.</p>	<p>High Option</p> <p>PPO: Nothing</p> <p>Non-PPO: █ of the Plan allowance (calendar year deductible applies)</p>	<p>Standard Option</p> <p>PPO: Nothing</p> <p>Non-PPO: █ of the Plan allowance (calendar year deductible applies)</p>
<p>Extended care benefits/Skilled nursing care facility benefits</p> <ul style="list-style-type: none"> Inpatient confinement at a Skilled Nursing Facility for the first 14 days following transfer from acute inpatient confinement when skilled care is still required. Benefits limited to \$700 per day. No other benefits are payable for inpatient skilled nursing facility charges. <p>Note: Medicare Part A pays for the first 14 days of Skilled Nursing Facility confinements during a Medicare benefit period. No benefits are payable by us including during a readmission during the same benefit period as defined by Medicare.</p>	<p>High Option</p> <p>Charges in excess of █ per day</p> <p>█</p>	<p>Standard Option</p> <p>Charges in excess of \$█ per day</p> <p>█</p>
<p>Hospice care</p> <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 \$15,000 for hospice care provided in an outpatient setting or for room, board, and care while receiving hospice care in an inpatient setting. Services may include a combination of inpatient and outpatient care up to a maximum of \$15,000. <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>High Option</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>Standard Option</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>

Hospice care - continued on next page

High and Standard Option

Benefits Description	You pay	
Hospice care (cont.)	High Option	Standard Option
<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><i>Not covered:</i></p> <ul style="list-style-type: none"> 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>All charges</i>	<i>All charges</i>
Ambulance - accidental injury	High Option	Standard Option
<p>Ambulance service within 72 hours of an accident is covered as follows:</p> <ul style="list-style-type: none"> Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary). Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons. 	<p>PPO: Nothing up to the Plan allowance</p> <p>Non-PPO: Nothing up to the Plan allowance</p>	<p>PPO: Nothing up to the Plan allowance</p> <p>Non-PPO: Nothing up to the Plan allowance</p>
Ambulance - non-accidental injury	High Option	Standard Option
<ul style="list-style-type: none"> Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary). 	<p>PPO: █% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █ of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: █% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>

Ambulance - non-accidental injury - continued on next page

High and Standard Option

Benefits Description	You pay	
Ambulance - non-accidental injury (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons. 	<p>PPO: █ of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █ of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: █% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means</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.
- The calendar year deductible is \$350 per person (\$700 per family) under the High and Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. However, if the services are rendered at a PPO hospital, we will pay up to the Plan allowable for services of radiologists, anesthesiologists, emergency room physicians and pathologists who are not preferred providers at the preferred provider rate.

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.

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
<p>If you receive care for your accidental injury within 72 hours, we cover:</p> <ul style="list-style-type: none"> • Treatment outside a hospital or in the outpatient/emergency room department of a hospital or urgent care facility • Related outpatient physician care <p>Note: Emergency room charges associated directly with an inpatient admission are considered “Other charges” under <i>Inpatient hospital benefits</i> (see page 58) 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.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Only the difference between our allowance and the billed amount (No deductible)</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Only the difference between our allowance and the billed amount (No deductible)</p>

Accidental injury - continued on next page

High and Standard Option Option

Benefits Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Accidental injury (cont.)</p> <p>If you receive care for your accidental injury after 72 hours, we cover:</p> <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>	<p>PPO: █% 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: █% 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>Medical emergency</p> <ul style="list-style-type: none"> • Outpatient medical or surgical services and supplies billed by a hospital, for emergency room treatment or outpatient medical or surgical services and supplies billed by an urgent care facility. <p>Note: We pay hospital benefits if you are admitted.</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: █% of the Plan allowance</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Ambulance - accidental injury</p> <p>Ambulance service within 72 hours of an accident is covered as follows:</p> <ul style="list-style-type: none"> • Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary). • Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons. 	<p>PPO: Nothing up to the Plan allowance (no deductible)</p> <p>Non-PPO: Nothing up to the Plan allowance (no deductible)</p>	<p>PPO: Nothing up to the Plan allowance (no deductible)</p> <p>Non-PPO: Nothing up to the Plan allowance (no deductible)</p>
<p>Ambulance - non-accidental injury</p> <ul style="list-style-type: none"> • Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary). 	<p>PPO: █ of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: █ of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: █% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>

Ambulance - non-accidental injury - continued on next page