

Geisinger Health Plan

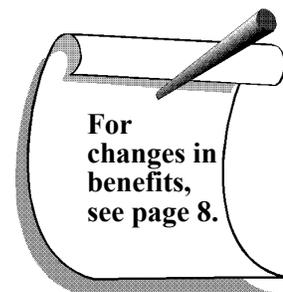
www.thehealthplan.com



2009

A Health Maintenance Organization (High and Standard Options)

Serving: Northeastern, Central and South Central Pennsylvania



Enrollment in this plan is limited. You must live in our geographic service area to enroll. See Pages 5-6 for requirements.

Enrollment codes for this Plan:

- GG1 High Option – Self Only
- GG2 High Option – Self and Family
- GG4 Standard Option – Self Only
- GG5 Standard Option – Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-849

**Important Notice from Geisinger Health Plan About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the Geisinger Health Plan prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and Geisinger Health Plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

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

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Geisinger Health Plan under our contract (CS 2911) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

Geisinger Health Plan 100 North Academy Avenue Danville, PA 17822-3220

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800-447-4000 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.

- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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

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

Visit these Web sites for more information about patient safety.

www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Option

Geisinger Health Plan's High Option is a Solutions HMO plan. You select a Primary Care Physician who will coordinate all of your care and provide referrals to specialty care when medically necessary. Most in-network medical and surgical services are covered 100% after you pay the appropriate copayment. Services include inpatient hospitalization, outpatient surgery, diagnostic testing, rehabilitation therapy, and other services as prescribed by your Primary Care Physician. There is a calendar year deductible of \$500 per person and \$1500 per family. This annual deductible must be met before the plan pays for certain services.

General features of our Standard Option

Similar to our High Option plan, our Standard Option offers the same benefits at higher copayment levels and also includes an annual deductible of \$750 per person and \$2250 per family. This annual deductible must be met before the Plan pays for certain services.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments, coinsurance or applicable deductible..

Your rights

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

- **More than 20 years experience**
- **A not-for-profit HMO**
- **Compliant with federal and state licensing requirements**

If you want more information about us, call 800-447-4000, or write to Geisinger Health Plan, Customer Services, 100 North Academy Avenue, Danville, PA 17822-3029. You may also contact us by fax at 570-271-5871 or visit our Web site at www.thehealthplan.com.

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in our Service Area. This is where our providers practice.

Our service area includes the following Pennsylvania counties: Adams, Berks, Blair, Bradford, Cambria, Cameron, Carbon, Centre, Clearfield, Clinton, Columbia, Cumberland, Dauphin, Huntingdon, Jefferson, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, York and portions of Bedford, Cumberland, Perry and Elk as denoted by the zip codes below:

Bedford: 15521, 15554, 16614, 16633, 16650, 16655, 16659, 16664, 16667, 16670, 16672, 16678, 16679 and 16695.

Elk: 15821, 15822, 15823, 15827, 15831, 15841, 15846, 15860 and 15868.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 How we changed for 2009

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

Changes to High Option

- We added an annual deductible of \$500 per person, \$1500 per family
- The primary care physician (PCP) office visit copay will change to \$20 from \$15 and the Specialist (SCP) office visit copay will change to \$35 from \$25.
- We are adding a copay and out of pocket maximum for certain high-cost drugs that are part of the medical benefit (Both High and Standard Options).
- We will now reimburse travel, meals and lodging expenses for the member and organ donor.
See Section 5(b) Organ/tissue transplants
- We will now cover ostomy supplies for patients with a stoma
- Retail Pharmacy - Members now pay a \$5 copay for generic formulary, \$35 for brand formulary and \$60 for non-formulary drugs
- Mail Order Pharmacy - Members now pay a \$10 copay for generic formulary, \$70 for brand formulary and \$120 for non-formulary drugs
- Cumberland and Perry counties are now full service counties

Changes to Standard Option

- We changed the annual deductible to \$750 per person from \$500 per person, \$2,250 per family from \$1,500 per family with an annual coinsurance maximum of \$4,000 per person and \$12,000 per family. (Deductible does not apply to coinsurance maximums)
- We will now reimburse travel, meals and lodging expenses for the member and organ donor.
See Section 5(b) Organ/tissue transplants
- We will now cover ostomy supplies for patients with a stoma
- Retail Pharmacy - Members now pay a \$5 copay for generic formulary, \$35 for brand formulary and \$60 for non-formulary drugs
- Mail Order Pharmacy - Members now pay a \$10 copay for generic formulary, \$70 for brand formulary and \$120 for non-formulary drugs
- Cumberland and Perry counties are now full service counties

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-447-4000 or write to us at Geisinger Health Plan, Customer Services, 100 North Academy Avenue, Danville, PA 17822-3229. You may also request replacement cards through our Web site www.thehealthplan.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site at www.thehealthplan.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site at www.thehealthplan.com.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You can complete a PCP selection form and mail it, or call us to make a selection.

- **Primary care**

Your primary care physician can be a general practitioner, family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call Customer Services at 800-447-4000 and we will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.

Here are some other things you should know about specialty care:

- **Referrals:** We require a referral for all covered services except for emergency services, obstetrical and gynecological services, and mental health and substance abuse services. Female members have direct access to obstetrical and gynecological care and may select a participating provider to provide maternity and gynecological care, including medically necessary follow-up care and diagnostic testing relating to maternity and gynecological care. Members also have direct access to providers who participate in our Behavioral Health Benefit Program to obtain mental health and substance abuse covered services without a referral from their Primary Care Physician. Mental health and substance abuse service will require prior authorization from the behavioral health vendor.

- **Standing Referrals:** If you require specialty care for a life-threatening degenerative or disabling disease or condition and you meet the established Plan standards for a standing referral, you may acquire a standing referral to a specialist with the clinical expertise to treat the disease or condition who will provide and coordinate your primary and specialty care. Standing referrals are subject to a treatment plan approved by the Plan, in consultation with you, the Primary Care Physician and as appropriate, the Specialist.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

• **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-447-4000. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

How to get approval for...

- **Your hospital stay** Hospital benefits may be provided at a Plan Participating Hospital on either an inpatient or outpatient basis or at an ambulatory surgical center as authorized in advance by your Primary Care Physician, by a participating specialist, by your obstetrical or gynecological Participating Health Care Provider (for services within their scope of practice) or by the Plan's designated Behavioral Health Benefit Program. Hospital benefits may also be authorized in advance by the Plan for covered services not available through a Participating Provider. Inpatient benefits are provided for as long as the hospital stay is determined medically necessary by the Plan and not determined to be Custodial, Convalescent or Domiciliary Care.
- **How to precertify an admission** It is the responsibility of your admitting physician to obtain prior authorization from the Plan for your inpatient hospital admission.
- **Maternity care** Female members have direct access to obstetrical and gynecological services. They may select a participating health care provider to obtain maternity and gynecological covered services including medically necessary and appropriate follow-up care and referrals for diagnostic testing relating to the maternity and gynecological care, without a referral from their primary care physician. Covered services must be within the scope of practice of the selected participating health care provider.
- **What happens when you do not follow the precertification rules when using non-network facilities** All covered services must be received by a Plan participating provider or facility. Any service or care received outside of this Plan's network or service area, without prior authorization from the Plan, except in the case of emergency care, will be the financial responsibility of the member. We will only pay for emergency services. We will not pay for any other health care services received outside of our service area or network unless the service has received prior Plan approval.
- **Circumstances beyond our control** Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.
- **Services requiring our prior approval** Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process Prior Authorization. Your physician must obtain Prior Authorization for :

 - Inpatient Hosp admissions
 - Skilled Nursing Facility admissions
 - Certain outpatient surgeries
 - Bariatric surgery for morbid obesity
 - Home health/hospice care
 - Durable medical equipment
 - OON referral requests
 - Transplant services
 - Non-emergency outpatient radiology testing such as MRI, MRA, CT, PET, nuclear cardiology
 - Inpatient and Outpatient MH and SA treatment
 - Certain injectable drugs
 - Acupuncture
 - Services associated with non-covered procedures
 - Inpatient and Outpatient PT/OT/ST

- Injection Therapy for back pain

Contact Customer Services at 800-447-4000 for a complete listing of services that require Prior Authorization.

Section 4 Your costs for covered services

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

Copayments

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

Example of the High Option plan: When you see your primary care physician you pay a copayment of \$20 per office visit, or if you see a specialist you pay a \$35 copayment per office visit. If you visit the emergency room you will pay a \$100 copayment. This copayment is waived if you are admitted to the hospital. You will need to satisfy a deductible for certain services such as inpatient hospital stays before we pay for these services.

Example of the Standard Option plan: When you see your primary care physician you pay a \$20 copayment per office visit, or if you see a specialist you pay a \$35 copayment per office visit. If you visit an emergency room you will pay a \$100 copayment. This copayment is waived if you are admitted to the hospital. You will need to satisfy a deductible for certain services such as inpatient hospital stays before we pay for these services.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is \$500 per person under self only enrollment in our High Option. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,500.
- The calendar year deductible is \$750 per person under self only enrollment in our Standard Option. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$2250.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 50% for orthopedic devices.

Your catastrophic protection out-of-pocket maximum

We do not have a catastrophic protection out-of-pocket maximum. Your out-of-pocket expenses are limited to the copayments, deductibles and coinsurances required for benefits.

Carryover

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

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

High and Standard Option Benefits

See page 8 for how our benefits changed this year. Page 61 and page 62 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5 High & Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 800-447-4000 or at our Web site at www.thehealthplan.com

Each option offers the following unique features:

High Option: \$20 office visit copayment; \$35 specialist visit copayment; \$100 emergency room visit copayment; Annual deductible of \$500 per person/\$1,500 per family applies to most services except for copayment services.

Standard Option: \$20 office visit copayment; \$35 specialist visit copayment; \$100 emergency room visit copayment; Annual deductible of \$750 per person/\$2250 per family applies to most services except for copayment services.

**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.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- **Under Standard Option**, the calendar year deductible is \$750 per person (\$2,250 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- **Under High Option**, the calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
<p>Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies. There is no calendar year deductible for the High Option plan.</p>		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinion • At home 	\$20 per primary care physician (PCP) office visit \$35 per Specialist (SCP) office visit	\$20 per primary care physician (PCP) office visit \$35 per Specialist (SCP) office visit
<ul style="list-style-type: none"> • Injection or infusion of select high-cost drugs that are part of the medical benefit. Note: A list of these drugs can be provided through the Customer Services Department at 1-800-447-4000 	\$50 copay per injection or infusion up to \$1200 OOP Maximum per calendar year.	\$50 copay per injection or infusion up to \$1200 OOP Maximum per calendar year.
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing after deductible	20% after deductible
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Pathology • X-rays • CAT Scans/MRI • Ultrasound 	Nothing after deductible	20% after deductible

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

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Electrocardiogram and EEG 	Nothing after deductible	20% after deductible
Preventive care, adult	High Option	Standard Option
<p>Routine physical every 12 months which includes routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$20 PCP or \$35 SCP copayment if office visits ir required to receive services, otherwise nothing after deductible	\$20 PCP or \$35 SPC copayment if office visits is required to receive services, otherwise 20% after deductible
<p>Routine Pap test</p> <p>Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i>.</p>	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing	Nothing
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Preventive care, children	High Option	Standard Option
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing
Hearing aid devices through age 17 every three years limited to \$2,000	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing after deductible	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise 20% after deductible
Maternity care	High Option	Standard Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <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 30 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 extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. <p>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). (Note: calendar year deductible applies.)</p>	\$20 PCP office visit copayment (initial office visit only)	\$20 PCP office visit copayment (initial office visit only)
<i>Not covered: Routine sonograms to determine fetal age, size and sex</i>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (injection only) • Intrauterine devices (IUD) insertion • Diaphragm fitting <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing</p>	<p>\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs 	<p>\$35 per SCP office visit</p>	<p>\$35 per SCP office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> - <i>intrauterine insemination (IUI)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment 	<p>\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing</p>	<p>\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing</p>
<ul style="list-style-type: none"> • Allergy injections • Allergy Serum 	<p>Nothing</p>	<p>Nothing</p>

Benefit Description	You pay	
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth Hormone Therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	<p>\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing after deductible</p>	<p>\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise 20% after deductible</p>
Physical and occupational therapies	High Option	Standard Option
<p>60 visits per condition per benefit year for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <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.</p>	<p>\$35 per office/outpatient visit</p> <p>Nothing per visit during covered inpatient admissions</p>	<p>\$35 per office/outpatient visit</p> <p>Nothing per visit during covered inpatient admissions</p>
<p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.</p>	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative (maintenance) therapy</i> • <i>Exercise programs</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Speech therapy	High Option	Standard Option
<p>60 visits per benefit year for the services of a qualified speech therapist.</p>	<p>\$35 per office visit/ outpatient visit</p> <p>Nothing per visit during covered inpatient admissions.</p>	<p>\$35 per office visit/ outpatient visit</p> <p>Nothing per visit during covered inpatient admissions.</p>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Diagnostic hearing exam to determine the need for hearing correction • Hearing testing for children through age 17 (see Preventive care, children) 	<p>\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing after deductible</p>	<p>\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise 20% after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

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

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Hearing aids, testing and examinations for them, except as shown above 	<i>All charges.</i>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> Diagnostic vision screening to determine the need for vision correction when necessitated by accidental injury Vision testing for children through age 17 (see <i>Preventive care, children</i>) Annual eye refractions to determine the refractive error of the eye 	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing
<p>Not covered:</p> <ul style="list-style-type: none"> Eyeglasses, contact lenses, and after age 17, testing and examinations for them except as shown above Fitting, repair or replacement of eye glasses and contact lenses Eye exercises and orthoptics Radial keratotomy and other refractive surgery. 	<i>All charges.</i>	<i>All charges.</i>
Foot care	High Option	Standard Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise Nothing after deductible	\$20 PCP or \$35 SCP copayment if office visit is required to receive services otherwise 20% after deductible
<p>Not covered:</p> <ul style="list-style-type: none"> Routine nail trimming Treatment of bunions (except capsular or bone surgery), corns, calluses, warts, fallen arches, flat feet, weak feet, chronic foot strain (except for diabetic conditions). 	<i>All charges.</i>	<i>All charges.</i>
Orthopedic and prosthetic devices	High Option	Standard Option
<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, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. 	Nothing up to a maximum Plan payment of \$5,000 per member per benefit year.	Nothing up to a maximum Plan payment of \$5,000 per member per benefit year.

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<p>Note: Your plan physician can make a referral to a participating durable medical equipment provider or you can call 800-447-4000 to procure a list of participating durable medical equipment providers.</p>	<p>Nothing up to a maximum Plan payment of \$2,500 per member per benefit year.</p>	<p>Nothing up to a maximum Plan payment of \$2,500 per member per benefit year.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Motorized wheelchairs • Deluxe equipment of any sort, or equipment which has been determined by the Plan to be non-standard. • Disposable items such as incontinent pads, catheters, irrigation kits, electrodes, ace bandages, elastic stockings, and dressings • Equipment which serves for comfort or convenience functions or is primarily for the convenience of a person caring for a member • Air conditioners • Humidifiers • Electric air cleaners • Exercise or fitness equipment • Elevators • Hot tubs • Hoyer lifts • Shower/bath bench • Special clothing of any type • Hearing devices of any type (except as noted above) • Replacement due to neglect • Batteries • Access ramps 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Home health services	High Option	Standard Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or other health care professional. • Services include intravenous therapy and medications, physical, occupational and speech therapy and social services. 	<p>\$20 PCP or \$35 SCP copayment for physician visits, otherwise Nothing</p> <p>Nothing for other participating professionals</p>	<p>\$20 PCP or \$35 SCP copayment for physician visits, otherwise Nothing</p> <p>Nothing for other participating professionals</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family; • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. • Services provided by any non-home health provider. 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay	
Home health services (cont.)	High Option	Standard Option
	<i>All charges.</i>	<i>All charges.</i>
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> • Direct access to American Specialty Health Network, Inc. participating providers for medically necessary chiropractic services to include new patient exams, adjunctive therapy, x-rays and clinical laboratory tests. • Maximum 15 visits per benefit year. 	\$20 per office visit	\$20 per office visit
<ul style="list-style-type: none"> • Chiropractic appliances • Contact American Specialty Health Network at 1-800-972-4226 for network information or log onto www.thehealthplan.com. 	\$50 maximum Plan allowance	\$50 maximum Plan allowance
<p>Not covered:</p> <ul style="list-style-type: none"> • Services for exams or treatment for conditions other than those related to neuromusculoskeletal disorders • Acupuncture • Biofeedback • Services received by providers not part of the ASHN network • Hypnotherapy, thermography, behavior training • Sleep therapy and weight programs • <i>MRI, CAT scans, bone scans, nuclear radiology, diagnostic radiology</i> • <i>DME, Prescription drugs and hospitalization</i> 	<i>All Charges</i>	<i>All Charges</i>
Alternative treatments	High Option	Standard Option
No benefit	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	High Option	Standard Option
<p>Our Care Coordination (CC) Department offers case and health management programs to members with chronic conditions. The Case Management nurse (Case Manager) contacts members with certain post-acute conditions (for example heart failure and pneumonia) after a hospital, rehabilitation, or skilled nursing home admission. Members are also contacted by a case manager if they have a history of inpatient, outpatient, and emergency department utilization. The purpose of all case manager contacts is to assess and identify areas of impact-use of community/social services, medication management, and/or coordination of care with primary and/or specialty provider services.</p>		

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Diabetes Care Program: Members in the Diabetes Care Program work with a case manager who provides education on topics like diet, medications, routine foot care and ways to improve blood sugar control. They also coordinates services for members such as eye exams and kidney screenings to assists members in taking control of diabetes. 	Nothing	Nothing
<ul style="list-style-type: none"> • Adult and Pediatric Asthma Care Program: Education is a key factor in the Asthma Care Program. Case managers help members and their families understand and manage asthma triggers and symptoms. • Chronic Kidney Disease (CKD) Program: The purpose of the CKD program is to improve the coordination of appropriate services with a PCP or nephrologists (kidney specialist) for members with kidney disease. Members learn the importance of proper nutrition, medications, blood pressure control, and receive other important health care information. • Heart Failure (HF) Program: An ongoing combination of education and follow-up by a case manager teaches members the importance of medications, diet and life-style habits to improve the management of heart failure. Heart-Failure Telephone Monitoring is an integral part of the program: Members call in 5 days/week to report heart failure signs and symptoms. If symptoms change, the case manager is notified, the member is contacted, and as indicated the health care provider is contacted for consideration of treatment change to improve symptoms. • Chronic Obstructive Pulmonary Disease (COPD) Program: The Chronic Obstructive Pulmonary Disease (COPD) Program helps members with COPD better manage the condition. Information about tobacco cessation, pulmonary function testing, medication management and lifestyle modification is provided. Rescue Kits (antibiotic and steroid combo) are coordinated for appropriate members so they can begin treatment at the first sign of an upper respiratory infection. • HeartWise Program: Managing risk factors and promoting proper medication management is the focus of the HeartWise Program for members with heart disease. Cholesterol and blood pressure management are key aspects of the program. Case managers provide education about diet and exercise, and coordinate recommended therapies with provicers. • Hypertension Program: Case managers assist members in learning what they can do to control blood pressure and reduce the risk of developing other health problems that can result from poorly controlled blood pressure 	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Osteoporosis Program: This program provides education to women and men at risk for osteoporosis, as well as those who have already been diagnosed. A case manager outlines steps to prevent osteoporosis and to reduce the risk of complications to include screening and treatment. • Tobacco Cessation Program: In the Tobacco Cessation Program, professional support is provided by case managers through phone, individual or group counseling over a course of five sessions. The program goal is to help break the addiction to tobacco products such as cigarettes, pipes and smokeless tobacco and help members quit. 	Nothing	Nothing

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.
- Plan physicians must provide or arrange your care.
- **Under Standard Option**, the calendar year deductible is \$750 per person (\$2,250 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- **Under High Option**, the calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. 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.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification .

Benefit Description	You pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies. There is no calendar year deductible for the High Option plan.		
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 (see <i>Reconstructive surgery</i>) 	Nothing after deductible	20% after deductible

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Surgical treatment of morbid obesity (bariatric surgery) Note: We cover medically necessary bariatric surgery if you are age 18 and over. We limit the covered bariatric procedures to laparoscopic band gastroplasty or roux-en-y gastric bypass (Roux-en-Y). Surgery for morbid obesity must be performed in a participating institution designated by either the American Society of Bariatric Surgery (ASBS) or American College of Surgeons (ACS) as a level 1 Bariatric Surgery Center of Excellence. You must satisfy all medical criteria. Please contact Plan for the complete medical policy. 	Nothing after deductible	20% after deductible
<ul style="list-style-type: none"> Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information Voluntary sterilization (e.g., tubal ligation, vasectomy) Treatment of burns Ostomy supplies; supplies are covered only for members who have had a surgical procedure which resulted in the creation of a stoma (artificial opening in the body which remains after surgery is completed). <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	Nothing after deductible	20% after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary sterilization</i> <i>Routine treatment of conditions of the foot; see Foot care</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. Examples of congenital anomalies are: protruding ear deformities; 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; 	Nothing after deductible	20% after deductible

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

Benefit Description	You pay	
Reconstructive surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <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>	Nothing after deductible	20% after deductible
<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</i> • <i>Surgeries related to sex transformation</i> 	<i>All Charges.</i>	<i>All Charges.</i>
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Surgery to correct TMJ is covered upon radiological determination of pathology. • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures. 	Nothing after deductible	20% after deductible
<p>Extraction of partially or totally bony impacted wisdom teeth (third molars).</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <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). • Orthognathic or prognathic surgery only to improve the appearance of a functioning structure 	<i>All charges.</i>	<i>All charges.</i>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney 	Nothing after deductible	20% after deductible

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

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Kidney/Pancreas • Liver • Lung • Pancreas* • 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 <p>*We limit coverage for pancreas (only) transplants to members who have had a previous successful kidney transplant</p>	Nothing after deductible	20% after deductible
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses; medical necessity limitation is considered satisfied for other tissue transplants 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 leukemia - Acute myelogenous leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic leukemia - Acute myelogenous leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma - Chronic myelogenous leukemia • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	Nothing after deductible	20% after deductible
<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 deficiency disease (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors 	Nothing after deductible	20% after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Breast cancer - Epithelial ovarian cancer 	Nothing after deductible	20% after deductible
<ul style="list-style-type: none"> • National Transplant Program (NTP) – Geisinger Health Plan utilizes an organ and bone marrow transplant management company with a network of approximately 40 facilities nationwide that provide transplant services. All transplants require prior authorization from the Plan Medical Director and all cases will be managed by Medical Management Nurses at the Plan in coordination with the transplant vendor case manager. <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We will reimburse travel, meals and lodging expenses for the member and organ donor up to a combined maximum of \$5000 per transplant procedure in accordance with Plan guidelines. Daily limit for lodging and meal reimbursements is \$200. For information on submitting receipts and the Plan's specific guidelines for reimbursement, contact the Customer Service Team at 1-800-447-4000.</p>	Nothing after deductible	20% after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Donor expenses related to donating organs or tissues to a non-member recipient • Implants of artificial organs • Transplants not listed as covered. 	<i>All Charges</i>	<i>All Charges</i>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	Nothing after deductible	20% after deductible
<ul style="list-style-type: none"> • Office visit 	\$20 per PCP office visit \$35 per SCP office visit	\$20 per PCP office visit \$35 per SCP office visit

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- In this Section, the calendar year deductible applies to almost all benefits. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under Standard Option**, the calendar year deductible is \$750 per person (\$2,250 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- **Under High Option**, the calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. 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 (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies. There is no calendar year deductible for the High Option plan.		
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; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing after deductible	20% after deductible
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood, blood plasma, and other biologicals • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services 	Nothing after deductible	20% after deductible

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	Nothing after deductible	20% after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care, unless medically necessary • Blood and blood plasma, if not donated or replaced. 	<i>All Charges</i>	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <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>	Nothing after deductible	20% after deductible
<p><i>Not covered: Blood and blood plasma, if not donated or replaced</i></p>	<i>All charges.</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits	High Option	Standard Option
<p>Extended care benefit:</p> <ul style="list-style-type: none"> • Room and board • General nursing care 	Nothing after deductible	20% after deductible
<p>Skilled nursing facility (SNF):</p> <p>A comprehensive range of benefits for short-term stays in a Plan participating skilled nursing facility for up to sixty (60) days per period of confinement when medically necessary. Readmission within six (6) months from discharge for the same condition is considered a continuation of the prior period of confinement.</p>	Nothing after deductible	20% after deductible
<p><i>Not covered: Custodial, domiciliary or convalescent care</i></p>	<i>All Charges.</i>	<i>All Charges.</i>

Benefit Description	You pay	
Hospice care	High Option	Standard Option
<p>You are eligible for supportive and palliative care up to a maximum of \$10,000 per member per lifetime. Services include inpatient and outpatient care, family counseling and medical social services. Services are provide under the direction of your primary care doctor who certifies the terminal stage of illness with a life expectancy of six (6) months or less.</p>	Nothing	Nothing
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<i>All Charges</i>	<i>All Charges</i>
Ambulance	High Option	Standard Option
<p>Local professional ambulance service when medically necessary</p>	Nothing	Nothing

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option**, the calendar year deductible is \$750 per person (\$2,250 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- **Under High Option**, the calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area

In an emergency situation, you should call an emergency information center or safely proceed immediately to the nearest Emergency Services Health Care Provider. Emergency services do not require preauthorization or a referral from your PCP. If the emergency service results in hospitalization, the Emergency Services Health Care Provider is responsible to notify the Plan within 48 hours or the next business day. Medically necessary follow up care with a participating provider must be authorized in advance by your PCP for it to be covered by us. Medically necessary follow up care by non-participating providers must be authorized in advance by the Health Plan. For your PCP's phone number, please refer to the front of your ID card or contact our Customer Service Team at 1-800-447-400 (TDD 1-800-4472833).

Emergencies outside our service area

Emergency services outside of our service area are covered the same as emergency services within our service area as described above.

Benefit Description	You pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies. There is no calendar year deductible for the High Option plan.		
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office 	\$20 per PCP office visit \$35 per SPC office visit	\$20 per PCP office visit \$35 per SPC office visit
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$35 per visit	\$35 per visit
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctors’ services Note: We waive the ER copay if you are admitted to the hospital directly from the emergency room.	\$100 per visit (\$20 if referred to ER by PCP) – deductible applies to authorized admission	\$100 per visit (\$20 if referred to ER by PCP) – deductible and coinsurance apply to authorized admission

Emergency within our service area - continued on next page

Benefit Description	You pay	
Emergency within our service area (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Elective care or non-emergency care • Follow-up care recommended by plan providers that has not been authorized in advance by members PCP or by non-plan providers that has not been approved by the Health Plan. 	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services • Note: We waive the ER copay if you are admitted to the hospital directly from the emergency room 	<p>Same as for Emergency care within our service area</p>	<p>Same as for Emergency care within our service area</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>
Ambulance	High Option	Standard Option
<p>Professional ambulance service when medically necessary, including air transport (LifeFlight)</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>Nothing</p>	<p>Nothing</p>

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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 or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- **Under Standard Option**, the calendar year deductible is \$750 per person (\$2,250 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- **Under High Option**, the calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
<p>Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies. There is no calendar year deductible for the High Option plan.</p>		
Mental health and substance abuse benefits	High Option	Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$35 per SCP office visit</p>	<p>\$35 per SCP office visit after deductible</p>
<p>Diagnostic tests</p> <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing after deductible</p>	<p>20% after deductible</p>
<p><i>Not covered:</i></p>	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Services we have not approved</i> • <i>Evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.</i> • <i>Testing for learning disabilities, school related issues, or for the purposes of obtaining or maintaining employment</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another. Treatment plan with DSM cannot be excluded.</i></p>	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>
<p>Preauthorization</p>	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>Geisinger Health Plan offers mental health and substance abuse benefits through our designated behavioral health vendor. Benefits include a wide range of services including inpatient hospitalization, partial hospitalization and outpatient counseling.</p> <p>You do not need a referral from your primary care physician for these services, but you must contact our designated behavioral health vendor for all non-emergency mental health and substance abuse services. You can contact Geisinger Health Plan's behavioral health vendor by calling 888-839-7972.</p> <p>Emergency services do not require prior authorization. However, you or a family member will need to contact your primary care physician or the designated behavioral health vendor after receiving emergency services and before receiving any follow-up care.</p>	
<p>Limitation</p>	<p>We may limit your benefits if you do not obtain a treatment plan.</p>	

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- There is no calendar year deductible for Prescription drug benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A plan provider or a provider to whom you have been referred must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan participating pharmacy, or for maintenance medications by mail using a participating mail order pharmacy.
- **We use a formulary.** The purpose of our formulary is to optimize patient care through appropriate selection and use of drugs that ensure quality, cost-effective prescribing. Our formulary is a collaboration of input from practicing physicians and pharmacists. Medications in all therapeutic classes have been reviewed for effectiveness, safety and cost. Our formulary is based on a three-tier structure:
 - Tier One: Includes most generic drugs and these medications generally do not require prior authorization to be covered.
 - Tier Two: Includes certain formulary brand name drugs that do not have a generic equivalent. Prior authorization may be required for certain drugs in Tier Two in order to be covered.
 - Tier Three: Includes certain formulary brand name drugs with a generic equivalent and non-formulary brand name drugs. Prior authorization is required for certain drugs in Tier Three in order to be covered.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan participating or referral physician and obtained at a Plan participating pharmacy will be dispensed for up to a 34-day supply per prescription or refill. Prescribed maintenance medication can be ordered using our mail order participating pharmacy. You get a 90-day supply for two times the copayment plus the convenience of having the medications delivered right to your home.
- The Health Plan has developed a **Specialty Vendor Medication Program** which is utilized to help manage certain high-cost and/or limited-access pharmaceuticals, such as injectable and biologic products. Typically these agents require prior authorization and must be filled through our contracted Specialty Pharmacy network. Quantity limits often apply. For a complete list of products, please contact the Pharmacy Services Department at 1-800-988-4861.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs are the chemical equivalent of a corresponding brand name drug and is less expensive cost which may reduce your out-of-pocket prescription drugs costs.
- **When you do have to file a claim.** Normally, you won't have to submit a claim to us for prescriptions. In the event you are required to make a payment in excess of your required prescription copayment at the time your prescription is filled, we will reimburse you by check. Simply request a claim form from our Customer Service Team at 800-447-4000. Send us your receipt, including your Member ID Number as soon as possible. You must submit claims by December 31 in the year following the year in which the prescription was filled. Refer to *Section 7. Filing a claim for covered services*.

Benefit Description	You pay	
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Plan approved diabetic supplies and pharmacological agents, or devices used to assist in insulin injection (injection aids) including insulin syringes and needles, blood glucose test strips and lancets • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Contraceptive drugs and devices <p>Note: The Health Plan has developed a Specialty Vendor Medication Program which is utilized to help manage certain high-cost and/or limited-access pharmaceuticals, such as injectable and biologic products. Typically these agents require prior authorization and must be filled through our contracted Specialty Pharmacy network. Quantity limits often apply. For a complete list of products, please contact the Pharmacy Services Department at 1-800-988-4861.</p>	<p>At a participating retail pharmacy: \$5 (generic)/\$35 (preferred brand)/\$60 (non-preferred brand) copayment up to a 34-day supply per prescription or refill</p> <p>From a participating mail order pharmacy: \$10(generic)/\$70 (preferred brand)/\$120 (non-preferred brand) copayment for a 90 day supply per prescription or refill</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>	<p>At a participating retail pharmacy: \$5 (generic)/\$35 (preferred brand)/\$60 (non-preferred brand) copayment up to a 34-day supply per prescription or refill</p> <p>From a participating mail order pharmacy: \$10(generic)/\$70(preferred brand)/\$120 (non-preferred brand) copayment for a 90 day supply per prescription or refill</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<ul style="list-style-type: none"> • Human Growth Hormone 	<p>20% of charges per prescription unit or refill</p>	<p>20% of charges per prescription unit or refill</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Experimental and investigational drugs not approved by the FDA</i> • <i>Prescription drugs for weight loss</i> • <i>Smoking cessation aids, including but not limited to nicotine replacement drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Dietary supplements, Vitamins (except prescription prenatal), fluoride supplements/rinses, anabolic steroids, blood plasma product, irrigation solutions, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Fertility drugs (covered in Section 5(a) as a medical benefit)</i> • <i>Supplies such as dressings and antiseptics</i> 	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>

Section 5(g) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Contact Plan for access to these covered services.
- **Under Standard Option**, the calendar year deductible is \$750 per person (\$2,250 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- **Under High Option**, the calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
<p>Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies. There is no calendar year deductible for the High Option plan.</p>		
Accidental injury benefit	High Option	Standard Option
<p>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury (not chewing or biting).</p>	<p>Nothing after deductible</p>	<p>20% after deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Dental benefits

We have no other dental benefits.

Section 5(h) Special features

Feature	Description
24 hour nurse line	<p>For any of your health concerns, you can call Tel-A-Nurse 24 hours a day, 7 days a week at the number set forth on your Member Identification Card. You will talk with a registered nurse who will discuss treatment options and answer your health questions. Tel-A-Nurse is not an authorized agent for the determination of benefits or appointment scheduling.</p> <p>Tel-A-Nurse also provides Members access to an audio library of over 200 medical topics of interest. You can access this service using the same toll free number.</p>
Services for deaf and hearing impaired	<p>Geisinger Health Plan has an access line for deaf and hearing-impaired Members. This toll free number is set forth on the back of your Member Identification Card.</p>
Centers of excellence	<p>Our provider directory lists all Plan participating providers and facilities, including transplant centers outside of our service area. Your primary care physician will arrange any necessary transplant procedures you may need.</p>
Travel benefit/services overseas	<p>Twenty-four hour emergency coverage worldwide.</p>

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Accessories Program:

As a Geisinger Health Plan member, you have access to excellent health care at an affordable cost, a growing network of health care providers and a variety of wellness and care coordination programs. Even better, you're also eligible for money-saving discounts on a host of health-related products and services.

Our Accessories Program is only available to Geisinger Health Plan members and their dependents. To access the discounted services under this program, all you need is your Geisinger Health Plan membership card. You do not need a referral from your primary care physician for the Accessories Program services.

Member discounts are available for fitness center memberships, chiropractic services, massage therapy and acupuncture. It also offers discounts for health products, eyewear, eye exams, mail order contact lenses and laser vision correction.

Your health plan may already cover some of these services for which a discount is available through the Accessories program. You should exhaust your covered benefits first before taking advantage of the Accessories Program. Contact our Customer Service Team at 1-800-447-4000 for questions on the wonderful benefits of our Accessories Program.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition (see specifics regarding transplants).**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 800-447-4000.

When you must file a claim – such as for services you receive outside the Plan’s service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Geisinger Health Plan
Claims Department
P.O. Box 8200
Danville, PA 17821-8200

Prescription drugs

Submit your claims to:

Geisinger Health Plan
Claims Department
P.O. Box 8200
Danville, PA 17821-8200

Other supplies or services

Submit your claims to:

Geisinger Health Plan
Claims Department
P.O. Box 8200
Danville, PA 17821-8200

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: Geisinger Health Plan, Appeals Department, 100 North Academy Avenue, Danville, PA 17822-3020; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-447-4000 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

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

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

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

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-447-4000 or see our Web site at www.thehealthplan.com.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in one of our Medicare Advantage plans and also remain enrolled in our FEHB plan. You must maintain your Medicare Part A and B insurance to remain in our Medicare Advantage plan. We will not waive any of our copayments, coinsurance or deductibles.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial Care	Services to assist individuals in the activities of daily living not requiring continuing attention of skilled, trained medical or paramedical personnel.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12
Experimental or investigational service	Services we determine, at our sole discretion, to be experimental, investigational or unproven and the associated covered services related to them. The fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if it is considered experimental, investigational or unproven.
Group health coverage	The employer, union or trust through which the member is enrolled.
Medical necessity	Medical Necessity or Medically Necessary means covered services rendered by a health care provider that we determine to be appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury in accordance with current standards of medical practice and not primarily for the convenience of the Member or Member's health care provider.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:
Us/We	Us and We refer to Geisinger Health Plan
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

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

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Children's Equity Act

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

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care/or health care expenses. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary BEFORE taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

Dependent Care FSA (DCFSA) – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

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

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

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

Additional Information

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

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It’s important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Summary of benefits for the High Option of Geisinger Health Plan - 2009

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the \$500 per person (\$1,500 per family) calendar year deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 PCP, \$35 SCP	17
Services provided by a hospital:		
• Inpatient	Nothing after deductible	33
• Outpatient	Nothing after deductible	34
Emergency benefits:		
• In-area	\$100 per visit; waived if admitted	36
• Out-of-area	\$100 per visit, waived if admitted	37
Mental health and substance abuse treatment:	Regular cost sharing	38
Prescription drugs:		
• Retail pharmacy	\$5/\$35/\$60	41
• Mail Order	\$10/\$70/\$120	41
Dental care	Nothing after deductible	42
Vision care: Refraction	\$0	22
Special Features	24-hour nurse hotline, services for deaf and hearing impaired, centers of excellence, travel benefit/services overseas	43
Protection against catastrophic costs (out-of-pocket maximum):	None	

Summary of benefits for the Standard Option of Geisinger Health Plan - 2009

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the \$750 per person (\$2,250 per family) calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 PCP, \$35 SCP	17
Services provided by a hospital:		
• Inpatient	20% after deductible	33
• Outpatient	20% after deductible	34
Emergency benefits:		
• In-area	\$100 per visit; waived if admitted	36
• Out-of-area	\$100 per visit; waived if admitted	37
Mental health and substance abuse treatment:		
	Regular cost sharing	38
Prescription drugs:		
• Retail pharmacy	\$5/\$35/\$60	41
• Mail order	\$10/\$70/\$120	41
Dental care		
	20% after deductible	42
Vision care: Refractions		
	\$0	22
Special features		
	24-hour nurse hotline, services for deaf and hearing impaired, centers of excellence, travel benefit/services overseas	43
Protection against catastrophic costs (out-of-pocket maximum):		
	None	

2009 Rate Information for Geisinger Health Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the *Guide to Benefits for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Service Nurses* (RI 70-2NU).

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	GG1	\$155.66	\$77.46	\$337.26	\$167.83	\$179.45	\$53.67
High Option Self and Family	GG2	\$352.56	\$183.61	\$763.88	\$397.82	\$406.42	\$129.75
Standard Option Self Only	GG4	\$153.42	\$51.14	\$332.41	\$110.80	\$176.94	\$27.62
Standard Option Self and Family	GG5	\$352.56	\$117.94	\$763.88	\$255.54	\$406.42	\$64.08