Geisinger Health Plan

www.TheHealthPlan.com/federal
Customer Service 800-447-4000

2016

A Health Maintenance Organization (Standard Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See pages 4 and 8 for details.

Serving: Northeastern, Central, and South Central Pennsylvania

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 15
- Summary of benefits: Page 77

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See Page 14 for requirements.

Enrollment codes for this Plan:

GG4 Standard Option - Self Only

GG6 Standard Option - Self Plus One

GG5 Standard Option - Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

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, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

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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. Customer service may be reached at 800-447-4000 or through our website: www.thehealthplan.com/federal. The address for Geisinger Health Plan is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means 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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.

- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-447-4000 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

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

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

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26).
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage or enrolling in the plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your 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 or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. 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/. 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.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. These conditions and errors are called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use Geisinger Health Plan preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
Minimum essential coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage (MEC) and satifies the ACA's individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum value standard	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
Where you can get information about enrolling in the FEHB Program	See www.opm.gov/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 that 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 brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you: • When you may change your enrollment; • How you can cover your family members; • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire; • What happens when your enrollment ends; • When the next Open Season for enrollment begins. We don’t determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.
Types of coverage available for you and your family	Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure .

Children's Equity Act

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

If this law applies to you, you must enroll Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the 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. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 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 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

You may be eligible for spouse equity coverage or 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 additional information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/ .

Temporary Continuation of Coverage (TCC)

If you leave Federal service or Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

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 or Tribal 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.

Health Insurance Marketplace

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a 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 Standard Option

Geisinger Health Plan's Standard 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. Services include inpatient hospitalization, outpatient surgery, diagnostic testing, rehabilitation therapy, and other services as prescribed by your Primary Care Physician.

You must satisfy a calendar year deductible of $750 per Self Only or $1,500 per Self and Family. After you have satisfied the annual deductible, you will then be required to pay 20% coinsurance for covered surgical procedures and inpatient hospitalization up to the out-of-pocket maximum of $4,750 under Self Only or $9,500 under Self and Family. The annual deductible is in addition to the out-of-pocket maximum.

The Standard Option coverage affords you protection from catastrophic illness because there is a limit to your out-of-pocket costs for covered care. After you have met the annual out-of-pocket maximum, the coinsurance will be eliminated for the balance of the benefit year for most covered procedures. Please note that you must still make copayments for covered office visits and prescription drugs.

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 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 website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- **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 17822-3229. You may also contact us by fax at 570-271-5871 or visit our website at 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 or work 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, Fulton, 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 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. Changes for 2016

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.

Program wide changes

- Self Plus One enrollment type has been added effective January 1, 2016.
- We have removed the exclusion for services, drugs, or supplies related to sex transformations. See page 59.

Changes to Standard Option

- Coverage for speech therapy is now a separate benefit from occupational and physical therapy. Speech therapy now has its own 60-visit limit. Occupational and physical therapy will have a combined 60-visit limit. See pages 31 and 32.
- Urgent care visits will require a primary care office visit copayment of $20, rather than a specialist office visit copayment. See page 48.
- Spinal injections for back pain will require cost sharing by the member. See page 31 to confirm the specific amount you will pay.
- Member cost sharing for injectable drugs has increased from $100 to $150. See page 54.

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 website at 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 website 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 website 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 heath and substance abuse covered services without a referral from their Primary Care Physician. Mental health and substance abuse service will require precertification 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.
- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. 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.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain precertification for:

- Inpatient hospital admissions
- Skilled Nursing Facility admissions
- Certain outpatient surgeries
- Bariatric surgery for morbid obesity
- Home health/hospice care
- Durable medical equipment
- Out of network referral requests
- Transplant services
- Non-emergency outpatient radiology testing such as MRI, MRA, CT, PET, nuclear cardiology, echocardiology
- Inpatient and outpatient mental health and substance abuse treatment
- Certain injectable drugs
- Services associated with non-covered procedures
- Inpatient and outpatient physical therapy, occupational therapy and speech therapy
- Injection therapy for back pain

Contact customer services at 800-447-4000 for a complete listing of services that require precertification.

How to request precertification for an admission or for Other services

First, your physician, your hospital, you, or your representative, must call us at 800-447-4000 before admission or services requiring precertification are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have precertification. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-447-4000. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-447-4000. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **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.

- **If your treatment needs to be extended**

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

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, but 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 precertification from the Plan for your inpatient hospital admission.

- **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 precertification 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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

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

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

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

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

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your costs for covered services

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

Cost-sharing

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

Copayments

A copayment (or copay) is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive 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 copyament 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 $750 per person under self only enrollment in our Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $750 under Standard Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,500 under Standard Option. Under a Self and 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.

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 does not begin until you have met your calendar year deductible.

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

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $4,750 for Self Only, or $9,500 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $4,750 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $4,750 Self Only maximum out-of-pocket limit and a $9,500 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $4,750 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $9,500, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $9,500 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers unless prior approval
- Expenses from obesity surgery
- Expenses from wisdom teeth extraction

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Standard Option Benefits

See page 15 for how our benefits changed this year. Page 77 is a benefits summary

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Section 5. Standard Option Benefits Overview

This Plan offers a Standard Option. Benefits are described in Section 5.

Section 5 is divided into subsections. Please read *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 filing advice, or more information about Standard Option benefits, contact us at 800-447-4000 or on our website at www.thehealthplan.com.

The Standard Option offers the following unique features:

$20 office visit copayment; $35 specialist visit copayment; $100 emergency room visit copayment; Annual deductible of $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment) 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 ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). 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
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.	
Diagnostic and treatment services	
Professional services of physicians • 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
• Injection or infusion of select injectible drugs that are part of the medical benefit. Note: A list of these drugs can be provided through the Customer Services Department at 800-447-4000	$150 copay per injection or infusion up to $1,500 OOP Maximum per calendar year.
Professional services of physicians • During a hospital stay • In a skilled nursing facility	20% after deductible
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Pathology • X-rays • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% after deductible

Benefit Description	You pay
Preventive care, adult	
Routine physical every 12 months which includes routine screenings such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - Colonoscopy screening • Pulmonary Function Test	$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 visit is required to receive services, otherwise Nothing
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing
Routine mammogram (with or without clinical breast examination) – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year	Nothing
Routine immunizations, limited to: • 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
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/ .	
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	All charges

Benefit Description	You pay
Preventive care, children	
• 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
• Well-child care charges for routine examinations, immunizations and care (up to age 21) • Examinations, such as: - Vision screenings through age 17 to determine the need for vision correction - Hearing screenings through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 21)	$0 PCP. If additional services, such as lab work or diagnostic tests are provided during the visit, or if a specific medical condition is treated, these services may incur an office visit copayment.
Hearing aid devices through age 17 every three years limited to $2,000 per benefit period	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise 20% after deductible.
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online athttp://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. No cost sharing. • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 44 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 Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.	Nothing for office visits, otherwise 20% after deductible

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	
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.)	Nothing for office visits, otherwise 20% after deductible
Breastfeeding support, supplies and counseling for each birth	Nothing
Childbirth Preparedness Class: • Prepares the mother for the birth of her baby. Limit of $100 per benefit period.	Up to $100 per member per benefit period
Family planning	
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Injectable contraceptive drugs (injection only) • Intrauterine devices (IUD) insertion • Diaphragm fitting Note: We cover oral contraceptives under the prescription drug benefit.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	All charges
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs (oral and self injectable pharmacy, all other medical)	$35 per SCP office visit, initial consultation,evaluation and lab testing
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *intravaginal insemination (IVI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	All charges

Benefit Description	You pay
Allergy care	
• Testing and treatment	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise nothing
• Allergy injections • Allergy Serum	Nothing
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 39. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth Hormone Therapy (GHT) Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Section 5(f), page 54, for additional information.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise 20% after deductible
Implanted Devices (medical and contraceptive)	
• Drug delivery • Contraceptives	50% per device $0
Physical and occupational therapies	
60 visits per condition per benefit year (combined limit PT/OT) for the services of each of the following: • qualified physical therapists and • occupational therapists	$35 per office/outpatient visit Inpatient visits subject to deductible and coinsurance (see Page 46). No additional copayments required for inpatient therapy.
• Physical therapy for back pain; limited to 2 series of 5 visits each per benefit period (visits apply to combined PT/OT limit) • Spinal injection for back pain	$35 per series 20% after deductible
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions. • Pulmonary rehabilitation up to 36 visits	Nothing Nothing
Not covered:	All charges

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	
• *Long-term rehabilitative (maintenance) therapy* • *Exercise programs* • *Biofeedback*	All charges
Speech therapy	
60 visits per benefit year for the services of a qualified speech therapist.	$35 per office visit/outpatient visit Inpatient visits subject to deductible and coinsurance (see Page 46). No additional copayments required for inpatient therapy.
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For coverage of certain devices, see Section 5(a) *Orthopedic and prosthetic devices.*	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise 20% after deductible
Not covered: • Hearing services that are not shown as covered	*All charges.*
Vision services (testing, treatment, and supplies)	
• Diagnostic vision exams to determine the need for vision correction • Vision testing for children through age 17 (see *Preventive care, children*)	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing
Annual eye refractions to determine the refractive error of the eye	Nothing
• Diabetic Eye Exams	Nothing
Not covered: • 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.	*All charges*

Benefit Description	You pay
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise 20% after deductible
Not covered: • Routine nail trimming • Treatment of bunions (except capsular or bone surgery), corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain (except for diabetic conditions).	All charges
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Hearing aid and testing to fit them (children only). Refer to page 27- Preventive care, children • External components of cochlear implants and bone anchored hearing aids (BAHA) • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	Nothing
Externally worn breast prostheses and mastectomy bras, including necessary replacements following a mastectomy Note: Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. 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.	$0, no maximum limit
• Orthopedic devices, rigid appliances or apparatus used to support, align or correct bone and muscle deformities such as leg braces.	50% of charges (not subject to deductible or coinsurance maximum)

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	50% of charges (not subject to deductible or coinsurance maximum)
• Diabetic foot orthotics	20% after deductible
Not covered: • Orthopedic and corrective shoes, arch supports, foot orthotics (except for diabetics), heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements provided less than five (5) years after the last one we covered for members over age 19 • Disposable supplies • Dental appliances of any sort, including but not limited to, bridges, braces and retainers, except those for non-dental treatment of TMJ • Sexual dysfunction devices, male or female • Replacement due to neglect • Wigs	All charges
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Insulin pumps (not subject to per year maximum) • Semi-electric hospital beds and related equipment • Manual Wheelchairs (not subject to per year maximum) • Crutches, canes and walkers (not subject to per year maximum) • Portable bedside commodes • Apnea monitors GHP reviews all member DME requests to approve up to an additional $200 toward the cost of equipment such as assistive speaking devices that would significantly improve a member's clinical condition or enhance their ability to perform activities of daily living. 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.	Nothing

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
Not covered: • 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, 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 • Pulse oximeters over age 18	All charges
Home health services	
• 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.	Nothing
Services include intravenous therapy and medications, physical, occupational and speech therapy and social services.	Nothing for other participating professionals
Not covered: • 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	All charges

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	
Urological Supplies. Urinary supplies, such as urinary catheters, collection devices, insertion trays, are covered for permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three (3) months.	20% after deductible
Chiropractic	
• 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
• Chiropractic appliances • Contact American Specialty Health Network at 800-972-4226 for network information or log onto thehealthplan.com.	$50 maximum Plan allowance
Not covered: • 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 • *MRI, CAT scans, bone scans, nuclear radiology, diagnostic radiology* • *DME, Prescription drugs and hospitalization*	All Charges
Alternative treatments	
No benefit	All charges

Benefit Description	You Pay
Note: The calendar year deductible applies to certain Standard Option benefits in this Section.	
Educational classes and programs	
Geisinger Health Plan offers case management and health management programs to members with complex medical conditions and chronic health conditions. A specially-trained nurse (Case Manager/ Health Manager) contacts members with targeted health conditions (for example heart failure and pneumonia) after a hospital, rehabilitation, or skilled nursing home admission. Members are also contacted by a case manager/health manager if they have a history of increased inpatient, outpatient, and emergency department utilization. The purpose of all case manager/health manager contacts is to assess and identify areas of impact – including the use of community/social services, medication management, and/or coordination of care with primary and/or specialty provider services. **Diabetes Care Program**: Members in the Diabetes Care Program work with a case manager/health manager who provides education on topics such as diet, exercise, medications, routine foot care and ways to improve blood sugar control. They also coordinate treatment changes with the member's primary care provide and facilitate services such as eye exams and kidney screenings to assist members in taking control of diabetes. **Adult and Pediatric Asthma Care Program**: Education is a key factor in the Asthma Care Program. Members learn about medications, proper use and cleaning of inhalers, spacers and nebulizers, and peak flow monitoring. Case managers/health managers help members and their families understand and manage asthma triggers and symptoms with a goal of decreasing acute exacerbations that interfere with normal activities. **Heart Failure (HF) Program:** An ongoing combination of education and follow-up by a case manager teaches members the importance of medications, diet and healthy lifestyle habits, as well as other important ways to improve the management of heart failure. Case managers work with members and their health care team to design an individualized plan of care that manages symptoms and reduces risk for hospitalization.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You Pay
Educational classes and programs (cont.)	
Chronic Obstructive Pulmonary Disease (COPD) Program: This program helps members better manage their chronic lung disease (also known as emphysema). GHP nurses focus on medication management, including taking the right medications and using inhalers properly. Other information about exercising, monitoring your condition, and stopping tobacco is stressed. **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/health managers provide education about diet and exercise, and coordinate recommended therapies with providers. **Hypertension Program:** Case managers/health 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. **Osteoporosis Program:** Osteoporosis affects both women and men and can have devastating effects. Knowing the impact of diet and exercise, as well as monitoring bone density are important components of this program. A nurse case manager/health manager works with the member and their health care provider to monitor bone density and find the right medications, if needed.	Nothing
Tobacco cessation programs: including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. OTC drugs require a physician prescription.	Nothing for counseling for up to four sessions per quit attempt and up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.

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 ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **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.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*)	20% after deductible
• 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.	20% after deductible

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* 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). 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.	20% after deductible
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	All Charges
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. 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: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and mastectomy bras and replacements (see *Prosthetic devices*) 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.	20% after deductible
Not covered:	All Charges

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
• *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* • *Surgeries related to sex transformation*	All Charges
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • 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	20% after deductible
Extraction of partially or totally bony impacted wisdom teeth (third molars).	Nothing
Not covered: • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) • Orthognathic or prognatic surgery only to improve the appearance of a functioning structure	All charges
Organ/tissue transplants	
These **solid organ transplants** are covered. These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung (single/bilateral) • Pancreas* • Intestinal transplants	20% after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas - Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis *We limit coverage for pancreas (only) transplants to members who have had a previous successful kidney transplant	20% after deductible
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	20% after deductible
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, pure red cell aplasia) - Hemoglobinopathies - Severe combined immunodeficiency - Severe or very severe aplastic anemia	20% after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria - Myelodysplasia/Myelodysplastic Syndromes - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Advanced Myeloproliferative Disorders (MPDs) • Autologous transplants for - Acute lymphocytic leukemia - Acute myleogeneous leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Neuroblastoma - Amyloidosis **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members over 60 years of age with a diagnosis listed above are subject to medical necessity review by the Plan.	20% after deductible
Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency disease (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	20% after deductible
Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials. • Autologous transplants for: - Breast cancer - Epithelial ovarian cancer - Childhood rhabdomyosarcoma - Advanced Ewing sarcoma - Advanced Childhood kidney cancers - Mantle Cell (Non-Hodgkin's lymphoma) - Agressive Non-Hodgkin's Lymphoma	20% after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
National Transplant Program (NTP)- Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplant services must be ordered by a plan specialist physician and approved by our medical director in advance of the transplant services. The transplant must be performed in Centers of Excellence specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sone discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipients includes coverage for the medical and surgical expenses of a live donor; to the extent that these services are not covered by another plan or program. 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 800-447-4000.	20% after deductible
Note: *We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members*	
Not covered: • Donor screening tests and donor search expenses, except as shown above • Implants of artificial organs • Transplants not listed as covered	All Charges
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	20% after deductible
• 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 ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). 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.	
Inpatient hospital	
Room and board, such as • 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.	20% after deductible
Other hospital services and supplies, such as: • 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	20% after deductible
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	20% after deductible

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
Not covered: • *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* • *Blood and blood plasma*	All Charges
Outpatient hospital or ambulatory surgical center	
• 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 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.	20% after deductible
Not covered: Blood and blood plasma	All charges
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: • Room and board • General nursing care	20% after deductible
Skilled nursing facility (SNF): 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.	20% after deductible
Not covered: Custodial, domiciliary or convalescent care	All Charges

Benefit Description	You pay
Hospice care	
You are eligible for supportive and palliative care. Services include inpatient and outpatient care, family counseling and medical social services. Services are provided 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.	Nothing
Not covered: Independent nursing, homemaker services	All Charges
Ambulance	
Local professional urgent/emergent ambulance service when medically necessary	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 ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). 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 800-447-4000 (TDD 1-800-447-2833).

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.	
Emergency within our service area	
• Emergency care at a doctor's office	$20 per PCP office visit $35 per SCP office visit
• Emergency care at an urgent care center	$20 per visit
• 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. ER copay is not waived if you are placed in observation status.	$100 per visit (If referred to ER by PCP, $20 copayment applies) – deductible applies to authorized admission
Not covered: • Elective care or non-emergency care	All Charges

Emergency within our service area - continued on next page

Benefit Description	You pay
Emergency within our service area (cont.)	
• 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.	All Charges
Emergency outside our service area	
• 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	Same as for Emergency care within our service area
Not covered: • *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* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	All Charges
Ambulance	
Professional ambulance service when medically necessary, including air transport (LifeFlight) Note: See 5(c) for non-emergency service.	Nothing

Section 5(e). Mental health and substance abuse 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.
- 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.
- 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.
- **Under Standard Option**, the calendar year deductible is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). 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.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
  - 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.
  - 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.
  - 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 and follow-up care. We may limit your benefits if you do not obtain a treatment plan. We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefits Description	You Pay
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.	
Professional services	
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:	$20 group therapy session $20 individual therapy visit

Professional services - continued on next page

Benefits Description	You Pay
Professional services (cont.)	
• Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 group therapy session $20 individual therapy visit
• Facility-based intensive outpatient treatment	$20 per session
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	20% after deductible
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	20% after deductible
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization	20% after deductible

Benefits Description	You Pay
Not Covered	
• Services that are not part of a preauthorized approved treatment plan	All charges
Limitations	
We may limit your benefits if you do not obtain a treatment plan.	
Autism Spectrum Disorder*	
Care provided for members under 21 years of age for the treatment of autism spectrum disorders (as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and Pervasive Development Disorder not otherwise specified.), which includes pharmacy, psychiatric and psychological, rehabilitative and therapeutic care. **For psychiatric, psychological and rehabilitative care, services must be provided by facilities participating with the Plan's behavioral health manager. Call 888-839-7972 for more information. Pre-authorization is required for all services except routine outpatient visits.*	
Pharmacy care	Copayment per outpatient prescription drug (See Section 5(f))
Psychiatric and Psychological care: direct or consultative services provided by a psychiatrist or psychologist.	$20 individual therapy session/$20 group therapy session
Habilitative/Rehabilitative Care: Professional services and treatment programs, including applied behavioral analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.	$35 per day
Therapeutic Care: Includes services provided by speech pathologists, occupational therapists or physical therapists.	$35 per day

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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- 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 licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **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 preauthorization to be covered.
  - Tier Two: Includes certain formulary brand name drugs that do not have a generic equivalent. Preauthorization 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. Preauthorization is required for certain drugs in Tier Three in order to be covered.
  - Tier Four: Includes certain high cost/specialty medications. Preauthorization is required for certain drugs in Tier Four in order to be covered. Call customer service at 800-447-4000 for a list of these medications.
- **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 precertification 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.
- Select injectible drugs will incur a $150 copayment with a $1,500 annual out of pocket maximum (medical and prescription benefit).
- **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	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • 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 (copay per box of 100 test strips at retail or mail order pharmacy) and lancets • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction 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 precertification 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 800-988-4861. • Select injectible drugs (medical)	At a participating retail pharmacy for up to a 34-day supply per prescription or refill: • 30% of the cost for generic (minimum $5, maximum $15) • 40% of the cost for preferred brand (minimum $40, maximum $120) • 50% of the cost for non-preferred brand (minimum $60, maximum $180) • 50% of the cost for certain high cost/specialty drugs (minimum $85, maximum $250) From a participating mail order pharmacy for a 90 day supply per prescription or refill: • 30% of the cost for generic (minimum $10, maximum $30) • 40% of the cost for preferred brand (minimum $80, maximum $240) • 50% of the cost for non-preferred brand (minimum $120, maximum $360) • 50% of the cost for certain high cost/specialty drugs (minimum $170, maximum $500) Note: If there is no generic equivalent available, you will still have to pay the brand name copay. $150 copayment ($1,500 annual maximum)
• Women's contraceptive drugs and devices (such as depo provera, diaphragms, and contraceptive rings) Note: The "morning after pill" is an over-the-counter (OTC) emergency contraceptive drug. It's considered a preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy.	$0 for generic and brands with no generic equivalent; all others follow normal prescription copays
• Human Growth Hormone	20% of charges per prescription unit or refill
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Experimental and investigational drugs not approved by the FDA* • *Prescription drugs for weight loss*	

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Dietary supplements, Vitamins (except prescription prenatal and Vitamin D for adults 65 and older as required by the Affordable Care Act), anabolic steroids, blood plasma product, irrigation solutions, nutrients and food supplements even if a physician prescribes or administers them* • *OTC medicines (except prescription medications due to health care reform). Contact the Plan at 800-447-4000 for a list.* • *Fertility drugs (covered in Section 5(a) as a medical benefit).*	
Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the tobacco cessation benefit. (See page 39).	

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Contact Plan for access to these covered services.
- The calendar year deductible is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). 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
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.	
Accidental injury benefit	
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).	20% after deductible
Not covered: • Implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth	All charges

Dental benefits

We have no other dental benefits.

Section 5(h). Special features

Feature	Description
24 hour nurse line	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. 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.
Services for deaf and hearing impaired	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.
Centers of excellence	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.
Travel benefit/services overseas	Twenty-four hour emergency coverage worldwide.

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.

Domestic Partner and Family Dependent Coverage is available with some restrictions. Contact the Plan for details.

Healthy Rewards

A new reimbursement program that helps members pay for fitness activities and rewards those already leading an active life.

- Reimbursement up to $100/single and $200/family
- Activities considered include:
  - Fitness center memberships
  - Exercise classes
  - Race fees
  - School athletic fees
  - Swimming lessons
  - Gymnastics
  - Sports camps
  - Sports fees
  - Karate and more!

Members must complete an online Health Risk Assessment (HRA) to be eligible

Section 6. General Exclusions - services, drugs and supplies we do not cover

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

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.
- Surgery related to sex transformation
- 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.
- Extra care costs and research costs for clinical trials are not covered.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. 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, contact us at 800-447-4000 or at our website at thehealthplan.com.

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, date of birth, address, phone number 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 payor– such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

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.

Post-service claims procedures

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

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

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

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

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

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit thehealthplan.com.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to Geisinger Health Plan, 100 North Academy Avenue, Danville, PA 17822 or calling 800-447-4000.

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

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Geisinger Health Plan, Appeals Department, 100 North Academy Avenue, Danville, PA 17822-3220; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or

c) Ask you or your provider for more information

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

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

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

3

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 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.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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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 file a lawsuit, 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 file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-447-4000. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

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

When we are the secondary payor, 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.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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 or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. This plan covers these costs.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older;

- Some people with disabilities under 65 years of age;
- 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 (1-800-633-4227), (TTY:1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We 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. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY:1-800-325-0778).

- **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 (TTY: 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

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

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-447-4000 or see our website at www.thehealthplan.com.

We waive some costs if the Original Medicare Plan is your primary payor. We will waive some out-of-pocket costs as follows:

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

When Medicare Part A is primary, we will waive our:

- Inpatient hospital deductible and coinsurance

When Medicare Part B is primary, we will waive our:

- Calendar year deductible;
- Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient);
- Copayments for office visits

Note: We do not waive benefit limitations, such as the 60 visit limit for Physical, Occupational and Speech therapy. In addition, we do not waive any coinsurance or copayments for prescription drugs.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$750	$0
Out of Pocket Maximum	$4,750 self only/$9,500 family	$4,750 self only/$9,500 family
Primary Care Physician	$20	$0
Specialist	$35	$0
Inpatient Hospital	20% after deductable	$0
Outpatient Hospital	20% after deductable	$0
Rx	Tier 1 -30% Tier 2 - 40% Tier 3 - 50% Tier 4 – Specialty (30 day supply) 50%	Tier 1 -30% Tier 2 - 40% Tier 3 - 50% Tier 4 – Specialty (30 day supply) 50%
Rx – Mail Order (90 day supply)	2x retail copay	2x retail copay

- **Tell us about your Medicare coverage**

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

- **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) (TTY: 1-877-486-2048) or at www.medicare.gov.

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

This Plan and 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). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in 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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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

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

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.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 23.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 21.

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 23.

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.

Health care professional

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

Maximum out-of-pocket

The maximum out-of-pocket is the annual limit that a member or family unit will be required to pay for covered services. This limit includes deductible, coinsurance and copayments (medical and prescription). Non-covered services are not included in this limit.

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:
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Us/We	Us and We refer to Geisinger Health Plan
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve pre-service claims and not post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 800- 447-4000. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
You	You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

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

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care/or health care expenses. The result can be a discount of 30% 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 $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person or $5,000 per household.

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

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

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 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 Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was 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 for enrollment.

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

Dental Insurance

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

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

Vision Insurance

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

Additional Information

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

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 877-888-3337 (TTY: 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 pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 800-843-3557) or visit www.ltcfeds.com .

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Summary of benefits for the Standard Option of Geisinger Health Plan - 2016

- **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 ($1,500 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	27
Services provided by a hospital:		
• **Inpatient**	20% after deductible	45
• **Outpatient**	20% after deductible	46
Emergency benefits:		
• **In-area**	$100 per visit; waived if admitted	46
• **Out-of-area**	$100 per visit; waived if admitted	48
Mental health and substance abuse treatment:	Regular cost-sharing	50
Prescription drugs:		
• Retail pharmacy	30%/40%/50%/50% $5/40/60/85 minimum; $15/120/180/250 maximum	54
• Mail order	30%/40%/50%/50% $10/80/120/170 minimum; $30/240/360/500 maximum	54
Dental care	20% after deductible	56
Vision care: Refractions	$0	33
Special features	24-hour nurse hotline, services for deaf and hearing impaired, centers of excellence, travel benefit/services overseas	57
Protection against catastrophic costs (maximum out-of-pocket):	$4,750 Self Only/$9,500 Self Plus One or Self and Family	22

2016 Rate Information for Geisinger Health Plan

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.