Geisinger Health Plan

(Formerly Penn State Geisinger Health Plan)

http://www.thehealthplan.com

GEISINGER HEALTH PLAN

2001

A Health Maintenance Organization with a point of service product

Serving: Central, Northeastern, and South Central Pennsylvania

Enrollment in this Plan is limited; see page 6 for requirements.

For changes in benefits see page 7.

Commercial HMO/POS Product
This Plan has "Excellent" Accreditation from the NCQA. See the 2001 Guide for more information on NCQA.

Enrollment codes for this Plan:

N91 Self Only
N92 Self and Family

Authorized for distribution by the:

OPM
UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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FEHB
Federal Employees Health Benefits Program

RI 73-303

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Introduction

Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822-3020

This brochure describes the benefits of Geisinger Health Plan under our contract (CS 2231) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Geisinger Health Plan.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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 only pay 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.

We also have Point of Service (POS) benefits:

Our HMO offers Point of Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

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 coinsurance. If you see a non-participating provider for emergency services or under the transitional care benefit (explained on page 9 of Section 3) for a chronic or disabling condition, you will only be responsible for your copayments or coinsurances.

Who provides my health care?

We are a Mixed Model Prepayment (MMP) HMO. Our Clinic doctors and selected independent doctors, who comprise the Geisinger Health Plan Physician Panel, provide care to Plan members and practice at many locations in Central, Northeastern, and South Central Pennsylvania. Our network includes 1,222 primary care doctors and 2,176 specialty care doctors. You can also receive care from non-Plan providers at additional costs (see POS Benefits on page 35).

The most important decision you will make is selecting a primary care physician. Your primary care physician is your source to all other health services, including referrals to specialists. Services of other providers are covered only when you have a referral from your primary care physician or, when you use your point-of-service benefits. The only exception is that women may self-refer to a plan participating obstetrician/gynecologist (OB/GYN) for an annual routine examination and medically necessary care.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. 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.

- Accreditation
- Plan Authorization & Utilization Review Procedure
- Disease Management Programs
- About All Professional Providers
- About Facilities

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

Service Area

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

Our service area is: All of Berks, Blair, Bradford, Cambria, Cameron, Carbon, Centre, Clearfield, Clinton, Columbia, Dauphin, Huntingdon, Jefferson, Juniata, Lackawanna, Lancaster, Lebanon, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming and York counties.

You may also enroll with us if you live in the following places: Portions of Bedford, Cumberland, Elk, Perry and Potter counties as denoted by the following zip codes:

Bedford:	15521, 15554, 16614, 16633, 16650, 16655, 16659, 16664, 16667, 16670, 16672, 16679, 16695
Cumberland:	17007, 17011, 17013, 17025, 17043, 17055, 17065, 17324
Elk:	15821, 15823, 15827, 15831, 15841, 15846, 15860, 15868
Perry:	17020, 17024, 17031, 17037, 17040, 17045, 17053, 17062, 17068, 17074, 17090
Potter:	17729

You must get your care from providers who contract with us. We will not pay for any other healthcare services outside our service area with the exception of emergency care or certain point-of-service benefits (see page 27 for details).

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling our Customer Service Team at 800/447-4000 or by checking our website at www.thehealthplan.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  •• Speak up if you have questions or concerns.
  •• Keep a list of all medicines you take.
  •• Make sure you get the results of any test or procedure.
  •• Talk with your doctor and health care team about your options if you need hospital care.
  •• Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 39.4% for Self Only or 51.6% for Self and Family.
- There are no benefit changes.
- We have changed our name from Penn State Geisinger Health Plan to Geisinger Health Plan.

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 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.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more. You will be responsible for specified coinsurances and deductibles, and you may have to file claims for out-of-network, non-referred services. (See page 35 for details on POS benefits.)

- **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.

- **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.

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 from our provider directory. This decision is important since your primary care physician provides or arranges for most of your health care

- **Primary care**

Your primary care physician can be a 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 us. We will help you select a new one.

- **Specialty care**

For specialty care, you will need prior approval from your primary care physician. However, women may see a Plan obstetrician/gynecologist (OB/GYN) for an annual routine examination, as well as medically necessary obstetrical and gynecological care, without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician

will work with the specialist and the Plan to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval 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 or 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 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 in the hospital when your enrollment in our Plan begins, call our Customer Service Team immediately at 800/447-4000. If you are new to the FEHB Program, we will arrange for you to receive care.

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.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

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

We call this review and approval process precertification. Your physician must obtain precertification for the following services: Inpatient hospital admissions, follow-up care recommended by a non-Plan provider, Magnetic Resonance Imaging (MRI) of the lumbar spine, penile implants, and skilled nursing care.

Precertification is also required when you use your Point of Service benefits for all non-emergency out-of-network inpatient admissions, and designated outpatient procedures are reviewed and approved by the Plan, prior to the provision of services. The purpose of precertification review is to determine medical necessity and appropriate length of stay. Non-emergency out-of-network inpatient admissions and designated outpatient procedures normally covered under the Point of Service provision that have not been precertified will be covered, but you will be subject to a maximum penalty of $500. You must call 800/447-4000 to obtain an authorized number and authorization form in order to receive coverage for non-emergency out-of-network inpatient admissions and designated outpatient procedures.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

  A copayment is a fixed amount of money you pay to the provider when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **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. We do not have a deductible for our in-network benefits, but there is a deductible when you use your POS benefits (see page 35 for details).

  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 negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible under the POS program. We have coinsurance on some in-network and all out-of-network (POS) benefits (see page 35 for details).

  Example: In our Plan, in-network, you pay 20% of charges per prescription unit or refill for human growth hormone therapy, and 50% of charges for Norplant and Intrauterine devices (IUDs), and for orthopedic devices. Under POS, you pay 20% of all covered charges after you have met your calendar year deductible.

Your out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total $741.12 per person or $1,926.90 per family enrollment in any calendar year, you do not have to pay any more for covered services. This out-of-pocket maximum is separate from the out-of-pocket maximum for the charges you pay when you use POS benefits as described on page 35. However, copayments and coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Prescription Drugs

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits – OVERVIEW

(See page 7 for how our benefits changed this year and page 51 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800/447-4000 or at our website at www.thehealthplan.com.

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

IMPORTANT

Here are some important things to 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.
- We have no calendar year deductible.
- 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.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing
At home	$10 per visit

Diagnostic and treatment services *(Continued)*	**You pay**
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	**You pay**
Routine screenings, such as: • Blood lead level • Cholesterol Test • Colorectal Cancer Screening, including •• Fecal occult blood test	$10 per visit
•• Sigmoidoscopy	$10 per visit
Prostate Specific Antigen (PSA test)	$10 per visit
Routine pap test	$10 per visit
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • At age 40 and older one every year	$10 per visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines for high risk adults	$10 per visit
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per visit

• Examinations, such as: ••Eye exams through age 17 to determine the need for vision correction. ••Ear exams through age 17 to determine the need for hearing correction • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per visit
Maternity care	**You pay**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for first prenatal visit only; nothing thereafter.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	**You pay**
• Voluntary sterilization • Injectable contraceptive drugs	$10 per visit
• Surgically implanted contraceptives • Intrauterine devices (IUDs)	50% of charges; office visit copayment is waived
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••intracervical insemination (ICI) ••intrauterine insemination (IUI)	$10 per visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Fertility drugs* • *Cost of donor sperm*	*All charges.*
Allergy care	**You pay**
Testing and treatment Allergy injection	$10 per visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	**You pay**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Nutritional supplements (formulas) for the treatment of aminoacidopathies, such as phenylketonuria (PKU), branched-chain ketonuria, galectosemia, and homocystinuria	$10 per visit
• Growth hormone therapy (GHT) NOTE: GHT is covered under Prescription drug benefits	20% of charges per prescription unit or refill

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy -- • 45 dates of service per condition for the services of each of the following, but no less than two consecutive months per condition if significant improvement can be expected within two months: ••qualified physical therapists; ••speech therapists – limited to certain speech impairments of organic origin; and ••occupational therapists – limited to services that assist the member to achieve and maintain self-care and improved functioning in activities of daily living. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.	$10 per visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*

Hearing services (testing, treatment, and supplies)	You pay
• Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$10 per visit
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthoptics* • *Eye refractions and eyeglasses and external lenses following cataract removal*	*All charges.*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per visit

Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	**You pay**
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, penile implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. (Members age 19 or older are limited to the initial prosthesis and replacement of an existing device every five years. For members 18 years or younger, the benefit includes replacement or modification of devices required due to the member's growth, in addition to the initial device.)	Nothing up to maximum Plan payment of $5,000 per member per calendar year for prosthetic devices; all charges over this maximum.
• Orthopedic devices include rigid appliances or apparatus used to support, align or correct bone and muscle deformities such as braces and diabetic-related foot orthotics. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	50% of charges
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics, except for diabetic-related foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 5 years after the last one we covered (for members age 19 and older)* • *disposable supplies* • *dental appliances of any sort, including but not limited to, bridges, braces, and retainers, except those for non-dental treatment of TMJ*	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen (see below) and dialysis equipment. Under this benefit, we also cover: • hospital beds and related equipment (bed rails, mattresses, trapezes) • standard wheelchairs • crutches • canes • walkers • commodes (elevated seats, portable bedside commodes) • oxygen equipment and breathing apparatus, positive and intermittent positive pressure breathing machines • suction machine and therapeutic equipment (infusion equipment, I.V. stands and equipment) • apnea monitors • diabetic medical equipment, such as blood glucose monitors, insulin infusion devices and pumps, and injection aids, such as needle-free injection devices, bent needle set for insulin infusion pump, and non-needle cannula for insulin infusion. Note: Call us at 800/447-4000 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing up to maximum Plan payment of $2,500 per member per calendar year; all charges over this maximum.
Not covered: • *Motorized wheelchairs* • *Deluxe equipment of any sort, or equipment which has been otherwise determined by the Plan to be non-standard*	*All charges.*
Home health services	**You pay**
• 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 home health aide • Services include intravenous fluids and medications.	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Alternative treatments	**You pay**
No benefit	No benefit

Not covered: • *chiropractic services* • *accupuncture* • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	**You pay**
Coverage is limited to: • Tobacco Cessation - You must use a Plan certified counselor or tobacco cessation program and attend at least 4 of 6 sessions. You pay the full cost of each session and any prescription items associated with the program. Reimbursement is made when the course is completed. • No office visit copayment for tobacco cessation counseling sessions • Lifetime limit of 3 programs (with 6 months between programs) • Reimbursements for Tobacco Cessation pharmco-therapies are limited to prescription items only. • Receipts for reimbursement of prescription drugs and sessions should be sent to: Geisinger Health Plan, Pharmacy Department, 100 North Academy Avenue, Danville, PA 17822-3045.	$22 per program session, and $8 copay per prescription drug item
• Diabetes self-management	$10 per visit

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

IMPORTANT

Here are some important things to 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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility (i.e., hospital, surgical center, etc.).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards and when medical criteria is met. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns	$10 per visit in physician's office; nothing if done in hospital
• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a).	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.* • *Removal of Norplant within one year, except when medically necessary, i.e., side effects/adverse events.*	*All charges.*

Reconstructive surgery	You pay

• 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; webbed fingers; and webbed toes.
	$10 per visit

• All stages of breast reconstruction surgery following a mastectomy, such as:
  •• surgery to produce a symmetrical appearance on the other breast;
  •• treatment of any physical complications, such as lymphedemas;
  •• breast prostheses and surgical 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.
	See above.

Not covered: • *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	**You pay**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of congenital defects such as cleft lip and cleft palate • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Extraction of partially or totally bony impacted wisdom teeth. • Surgery to correct TMJ is covered upon radiological determination of pathology	$10 per visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges.*
Anesthesia	**You pay**
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
• Office	$10 per visit

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

IMPORTANT

Here are some important things to remember 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.
- 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 covered in Section 5(a) or (b).

IMPORTANT

Benefit Description	You pay
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.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
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 and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	**You pay**
• 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 • Blood and blood plasma, if donated or replaced • 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. The need for anesthesia, by itself, is not such a condition. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges.*

Extended care benefits/skilled nursing care facility benefits	You pay
Extended care and skilled nursing facility (SNF): We provide a comprehensive range of benefits for short-term stays of up to 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. This includes: • Bed, board, and general nursing • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: • *custodial care, rest cures, domiciliary, or convalescent care.*	*All charges.*
Hospice care	**You pay**
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility up to a lifetime maximum of $10,000 per member. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing, up to a lifetime Plan maximum of $10,000 per member.
Not covered: Independent nursing, homemaker services	*All charges.*
Ambulance	**You pay**
• Local professional ambulance service when medically appropriate, including air transport (LifeFlight)	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- 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.

IMPORTANT

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 or outside our service area: In an emergency, you should make a reasonable effort to contact your primary care physician or our Tel-A-Nurse staff for medical direction, provided this will not place you at an increased risk of injury. If you are unable to contact your primary care physician or our Tel-A-Nurse staff, you should make every reasonable effort to proceed to the nearest participating provider emergency room. If you cannot contact your primary care physician, Tel-A-Nurse staff, or are unable to safely proceed to a participating provider emergency room, proceed to the nearest emergency room.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to you.

If you need to be hospitalized in a non-Plan facility, you or a family member should notify us within 24 hours or the first working day following your admission, unless it is not reasonably possible to do so. If your emergency does result in a hospital admission, your copayment is waived. If you are hospitalized in a non-Plan facility and a Plan doctor believes your care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Your primary care physician or the Plan's Medical Director must authorize any follow-up care recommended by a non-Plan provider, except as covered under your Point-of-Service (POS) benefits.

Emergencies outside our service area: Same coverage as within our service area, except that benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$10 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit; waived if admitted
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	**You pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per visit $10 per visit $25 per visit; waived if admitted
Not covered: • *Elective care or non-emergency care, including follow-up care that can be provided by the Plan* • *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	**You pay**
Professional ambulance service when medically appropriate, including air transport (LifeFlight) See 5(c) for non-emergency service.	Nothing

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

All mental health or substance abuse services require prior approval from the Plan as well as a referral from your primary care physician.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.

IMPORTANT

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

- **Who can write your prescription.** A participating Plan physician or referral doctor must write your prescription.
- **Where you can obtain them.** Prescriptions can be filled at a Plan participating pharmacy and dispensed for up to a 34-day supply. Prescriptions for outpatient maintenance drugs can be obtained at a participating mail order pharmacy for a minimum of, and not more than, a 90-day supply.
- **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 combination of input from practicing physicians and pharmacists. Medications in each therapeutic class have been reviewed for effectiveness, safety and cost.

- **These are the dispensing limitations.**
- Prescription drugs prescribed by a Plan or referral doctor will be dispensed at $8 per prescription unit or refill for up to a 34-day supply. We can fill more than one month of your prescription at a time, but we will not exceed the maximum of 3 months (102 days) at one time.
- Outpatient maintenance prescription drugs prescribed by a Plan or referral doctor may be obtained at a participating mail order pharmacy. Drugs will be dispensed for a minimum, and not more than, a 90-day supply. You pay $16 (2 times the regular $8 prescription copayment). Certain drugs are not available through our mail order program, including some prepackaged medications and medications with quantity limitations. These types of prescriptions should be obtained as described above.
- **When you 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 and send us your receipt, including your Member Insurance ID Number (displayed on your Identification Card) 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.

Prescription drug benefits begin on the next page.

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:	$8 copay per prescription unit or refill $16 copay (2 times the regular prescription drug copay of $8) per prescription unit or refill from a participating mail order pharmacy
• Drugs and medicines that by State or Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Diabetic supplies, including oral pharmacological agents for controlling blood sugar • Insulin • Oral and injectable contraceptive drugs; contraceptive diaphragms • Drugs obtained for out-of-area emergencies	
LIMITED BENEFITS	
• Human Growth Hormones	20% of charges per prescription unit or refill
• Disposable needles and syringes for insulin or administration of covered medications (limit 100 per copayment)	$8
• Lancets (limit 200 per copayment)	$8
• Glucose test strips (50 per copayment)	$8
• Drugs for sexual dysfunction are subject to dosage limits set by the Plan. Contact the Plan for details	

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • 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, in addition to the $8 copayment. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800/988-4861. You can also address questions or concerns regarding prescription drugs and mail order medications to our Pharmacy Department by writing to: Geisinger Health Plan Pharmacy Department, 100 North Academy Avenue, Danville PA 17822-3045.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Nonprescription medicines and medical supplies, such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Fertility Drugs* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies. We have national availability of pharmacies through the Perx Select network of Express Scripts.* • *Ketone (urine) test strips*	*All Charges.*

Section 5 (g). Special Features

Feature	Description
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-877/543-5061 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	We have an access line for deaf or hearing impaired members. Simply dial 570/271-5677 and a Customer Service Team member will be happy to help you.
Centers of excellence for transplants	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 require.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to 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.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; 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.

IMPORTANT

Accidental injury benefit	**You pay**
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).	Nothing

Dental benefits

We have no other dental benefits.

Section 5 (i). Point of service benefits

IMPORTANT

Here are some important things to remember 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.
- 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.
- All out-of-network services are subject to applicable deductibles, coinsurances and lifetime maximums as listed in this section.
- All non-emergency out-of-network inpatient admissions and designated outpatient procedures require precertification.
- You will be subject to a maximum penalty of $500 for all non-emergency out-of-network services received without precertification from us.
- Emergency care is covered as an "in-network" benefit; see page 27 for details.

IMPORTANT

Point of Service (POS) Benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

All out-of-network services, except those excluded below, are covered. Out-of-network services means those services received from a participating or non-participating provider without a referral. All such services will be subject to applicable deductibles, coinsurance and the lifetime maximum benefit listed below. All non-emergency out-of-network inpatient admissions and designated outpatient procedures require precertification (see Section 3).

Precertification

Precertification is the process whereby all non-emergency out-of-network inpatient admissions and designated outpatient procedures are reviewed and approved by the Plan, prior to the provision of services, in order to determine medical necessity and appropriate length of stay. Refer to Section 3 for further details on precertification.

Deductible

A specified dollar amount for out-of-network services that must be incurred and paid by you before the Plan will assume any liability for all or part of the remaining covered services. The deductible must be met every calendar year. For a Self Only enrollment the calendar year deductible is $250; for a Self and Family enrollment the calendar year deductible is $250 per person up to a maximum of $750.

Coinsurance

A specified portion of the Plan's usual, customary, and reasonable (UCR) allowance you are required to pay. After your deductible is met, we pay 80% of the UCR allowance and you pay 20% of the UCR allowance until you reach the annual out-of-pocket amount, exclusive of your deductible and amounts in excess of the UCR allowance.

Maximum benefit

There is an out-of-pocket maximum of $2,500 for a Self Only enrollment; for a Self and Family enrollment the out-of-pocket maximum is $2,500 per person up to a maximum of $7,500. This will be the maximum dollar amount, excluding deductibles and amounts in excess of the Plan's UCR allowance, which you are required to pay toward out-of-network services each calendar year. Any amounts you pay in excess of the Plan's UCR allowance will not be counted toward satisfying the maximum out-of-pocket amounts. This maximum out-of-pocket amount is in addition to the in-network annual maximum out-of-pocket (copayment and coinsurance) amount.

The lifetime maximum benefit is $1,000,000. This is the maximum amount of benefits we will cover under this point of service provision. Once you reach the maximum out-of-pocket amount, we will pay 100% of the Plan's UCR allowance until the lifetime maximum of $1,000,000 is reached. There is no in-network lifetime maximum.

Hospital/extended care benefits

Non-emergency out-of-network inpatient hospital admissions require precertification as described above. They will be covered subject to deductible, coinsurance and maximum benefit limits, also listed above. The hospital charge, sometimes called a facility charge, does not cover any charges for doctors' services.

Emergency benefits

Emergency benefits are not covered under this benefit; all emergency care is covered as an in-network service.

What is not covered

- Durable medical equipment
- Prosthetics
- Orthotics
- Inpatient and outpatient mental health care
- Substance abuse
- Emergency care
- Outpatient prescription drugs
- $500 penalty for failure to precertify non-emergency out-of-network inpatient admission and designated procedures
- Any service for which a claim form has not been properly submitted
- Any service that exceeds lifetime maximum benefit

How to obtain benefits

To receive coverage, you will be required to file a claim form for all out-of-network services. To receive a claim form, you should call us at 1-800/447-4000. You should keep a record of out-of-network services incurred by yourself and each family dependent. If, during a calendar year, charges for out-of-network services exceed the deductible, you must complete a claim form and submit it, together with itemized bills, to the following address:

Geisinger Health Plan
Attention: Claims Department
100 North Academy Avenue
Danville, PA 17822-3029

You must sign Section A of the claim form before we will issue payment to a provider or reimburse you for out-of-network services under this provision. If the claim qualifies as a covered expense, you or the provider will receive reimbursement from us. Claims for services must be submitted to us no later than twelve months after the end of the calendar year in which covered services are provided. If you are not satisfied with our adjudication of a claim, you may utilize our established grievance procedure.

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition a**nd we agree, as discussed under *What Services Require Our Prior Approval* on page 10.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits); or eligible self-referred services (see Point of Service benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are 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;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or fill 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, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800/447-4000.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to:

Attention: Claims Department
Geisinger Health Plan
100 North Academy Avenue
Danville, PA 17822-3029

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

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, Grievance and Appeals Department, 100 North Academy Avenue, Danville PA 17822-3029; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, D.C. 20044-0436.

Send OPM the following information:

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

Note: If you want OPM to review different claims, 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 provide a copy of your specific written consent with the review request.

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

5 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.

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800/447-4000 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payer, we may be entitled to receive payment from your primary plan. We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

●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 two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare managed care plan is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

●The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required.

We will not waive any of our copayments, or coinsurance.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or……	……..✓	
b) The position is not excluded from FEHB…….	……..	……✓
Ask your employing office which of these applies to you.		
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or……	…….✓	
b) Are an active employee……	……..	……✓

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

Claims process – You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800/447-4000.

• Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we waive any of our copayments, coinsurance, or deductibles for your FEHB coverage. You must maintain your Medicare Part A and Part B insurance to remain in our Medicare managed care plan.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

• Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Covered services

Care we provide benefits for, as described in this brochure.

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 11.

Experimental or investigational services

Our Technology Assessment Committee meets quarterly and makes decisions on whether new or presently non-covered medical procedures, equipment or treatments are considered experimental or investigational. Determination of experimental or investigational is not only based on the procedures, but also on an individual's diagnosis. The Committee also looks at whether a drug, service, device or procedure is accepted as standard medical treatment for the condition being treated, and whether any such drug, service, device or procedure requires Federal and/or governmental agency approval which has been granted at the time it was dispensed or received.

Medical necessity

Medical treatment to be appropriate according to generally accepted standards of medical practice.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows: when a provider is contracted with us, we pay the rate specified in the contract for the billed services. When a provider is not contracted with us, we pay the usual, customary, and reasonable rate for the billed services.

Us/We

Us and we refer to Geisinger Health Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

•TCC

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

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

•Enrolling in TCC

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

•Converting to individual coverage

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

•• Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;

•• You decided not to receive coverage under TCC or the spouse equity law; or

•• You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/447-4000 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

NOTES:

Summary of benefits for Geisinger Health Plan - 2001

- **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.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	13
Services provided by a hospital: • Inpatient ..... • Outpatient	 Nothing Nothing	24 25
Emergency benefits: • In-area ..... • Out-of-area	 $25 per emergency room visit $25 per emergency room visit	28 28
Mental health and substance abuse treatment	Regular cost sharing	29
Prescription drugs ..... Up to a 34-day supply per prescription unit or refill from retail pharmacy; and up to a minimum, but not more than, a 90-day supply per prescription unit or refill from mail order.	$8 copay from retail pharmacy $16 copay from mail order	31
Dental Care ..... Accidental injury benefit only	Nothing	34
Vision Care	No benefit.	17
Special features: 24 hour nurse line; Services for deaf and hearing impaired; Centers of excellence for transplants		34
Point of Service benefits – Yes		35
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $741.12/Self Only or $1,926.90/Family enrollment per year Some costs do not count toward this protection	11

2001 Rate Information for
Geisinger Health Plan
(formerly Penn State Geisinger Health Plan)

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	N91	$68.30	$22.77	$147.99	$49.33	$80.82	$10.25
Self and Family	N92	$195.82	$75.55	$424.28	$163.69	$231.17	$40.20