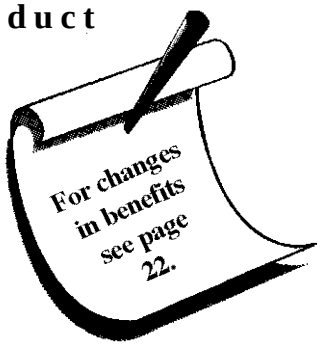
# Penn State Geisinger Health Plan 1999

**A Health Maintenance Organization with a Point of Service pro d u c t**




**This plan has full accreditation from the NCQA. See the FEHB Guide formore information on NCQA.**

**Serving:** Central and Northeastern Pennsylvania

Enrollment in this Plan is limited; see page 8 for requirements.

**Enrollment code:**

**N91 Self Only**

**N92 Self and Family**

**Visit the OPM website at http://www.opm.gov/insure**
**and**
**this Plan's website at http://www.psghs.edu**

**Authorized for distribution by the:**

**United States Office of Personnel Management**

**Federal Employees Health Benefits Program**

**RI 73-303**

# Penn State Geisinger Health Plan

Penn State Geisinger Health Plan, 100 North Academy Avenue, Danville, PA 17822-3020, has entered into a contract (CS 2231) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Penn State Geisinger Health Plan, or the Plan.

This brochure is the official statement of benefits on which you can rely. Aperson enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 22 of this brochure.

# Table of Contents

# Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation — sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-800/447-4000 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

**THE HEALTH CARE FRAUD HOTLINE**
**202/418-3300**

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

# General Information

## Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

## If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 14, or when you self-refer for point of service, or POS, benefits as described on pages 18-19.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

## If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

## Your responsibility

**It is your responsibility to be informed about your health benefits.** Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

## Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency or POS benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSAat 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

## Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

### Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

### Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

**Notification and election requirements:**

**Separating employees** — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

**Children** — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

# General Information *continued*

**Former spouses** — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. Aformer spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

### Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. Afamily member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

### Certificate of creditable coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans may have been enrolled in, may reduce or eliminate the length of time a preexisiting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

# Facts about this Plan

This Plan is a health maintenance organization (HMO) that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. **Within the Plan's network you are required to select a personal doctorwho will provide or arrange for your care and you will pay minimal amounts for comprehensive benefits.** There are no claim forms when Plan doctors are used. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See pages 18-19 for more information.

Your decision to join an HMO should be based on your preference for the plan’s benefits and delivery system, not because a particular provider is in the plan’s network. You cannot change plan’s because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

## Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 800/447-4000 or you may write the Carrier at Penn State Geisinger Health Plan, 100 North Academy Avenue, Danville, PA 17822-3020. You may also contact the Carrier by fax at 717/271-5871, at its website at http://www.psghs.edu of by e-mail at khockenbrough@psghs.edu.

Information that must be made available to you includes:

- Disrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

The following information is also available upon request:

- Plan authorization and utilization review procedures;
- Use of clinical protocols, practice guidleines, and utilization review standards pertinent to patient's clinical circumstances;
- Special disease management programs or programs for persons with disabilities;
- Formulary drug list and patient-specific waiver procedure consideration;
- Qualifications of reviewers at the initial decision and reconsideration under the FEHB disputed claims process.

## Who provides care to Plan members?

The Plan is a Mixed Model Prepayment (MMP) HMO. Care is provided to Plan members by Penn State Geisinger Health Plan Clinic doctors and selected independent doctors who comprise the Penn State Geisinger Health Plan Physician Panel and practice at many locations in central and northeastern Pennsylvania. This includes 854 primary care doctors and 1,684 specialty care doctors. Members can also receive care from non-Plan providers at additional costs (see POS Benefits on pages 18-19).

Each family member may select from the Plan's Provider List the doctor from whom he or she wishes to receive primary care. Changes in primary care site selection must be made by providing the Plan with a completed Primary Care Source Change Form. Each family member may also choose to receive primary care from a non-Plan provider.

## Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this source that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when you have been referred by your primary care doctor or when you use POS benefits, with the following exception: a woman may see her Plan obstetrician/gynecologist for her annual routine examination without referral.

## Choosing your doctor

The Plan's provider directory lists primary care doctors (family practitioners, pediatricians and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Team at 1-800/447-4000; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **Important note: When you enroll in this Plan, services (except for emergency or POS benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, orother provider cannot be guaranteed.**

If you enroll, you will be asked to complete a Primary Care Site Selection Form and send it directly to the Plan, indicating the primary care doctor you select for yourself and each member of your family. Members may change their doctor selection by providing a Primary Care Source Change Form to the Plan 30 days in advance.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

## Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, or when you choose to use the Plan's POS benefits, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct acccess visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

## For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only call to explain that you are now a Plan member and ask that you be referred for your next appointment.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

## Hospital care

If you require hospitalization, your primary care doctor will make the necessary arrangements and continue to supervise your care. If a specialist to whom you have been referred recommends hospitalization, be sure to obtain authorization from your primary care doctor.

## Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $741.12 per Self Only enrollment or $1,926.90 per Self and Family enrollment. This copayment maximum does not include charges for prescription drugs. This copayment maximum is separate from the out-of-pocket maximum for the charges you pay when you use POS benefits, as described on pages 18-19.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

## Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

## Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

# Facts about this Plan *continued*

## Experimental/ investigational determinations

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

## Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

## The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described below. You must live in the service area to enroll in this Plan.

The service area for this plan includes the following area:

All of Blair, Bradford, Cambria, Carbon, Centre, Clearfield, Clinton, Columbia, Dauphin, Huntingdon, Juniata, Lackawanna, Lancaster, Lebanon, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming Counties and portions of Bedford and Potter Counties as denoted by the following zip codes:

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

Potter 17729

Benefits for care outside the service area are limited to emergency services, as described on page 14, (and to services covered under Point Of Service Benefits, as described on pages 18-19).

If you or a covered family member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

# General Limitations

## Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is the official statement of benefits on which you can rely.

## Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

## Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

# General Limitations *continued*

**Medicare**

If you or a covered family member is enrolled in this Plan and Medicare Part Aand/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers or the services are covered under this Plan's POS benefits. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

**Group health insurance and automobile insurance**

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (l) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

**CHAMPUS**

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

**Medicaid**

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

**Workers' compensation**

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

**DVA facilities, DoD facilities, and Indian Health Service**

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

**Other Government agencies**

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

**Liability insurance and third party actions**

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

# General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see *Emergency Benefits*) or eligible self-referred services obtained under Point Of Service Benefits;
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs, and supplies related to sex transformations; and
- Procedures, services, drugs, and 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.

# Medical and Surgical Benefits

## What is covered

Acomprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 copay for office visits but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; **you pay** a $10 copay for a doctor's house call and nothing for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care, periodic check-ups and self-referral for one routine gynecological visit per year
- Mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women age 40 and up, one mammogram every year. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures such as laboratory tests and Xrays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The $10 copay is waived after the first visit for maternity care. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.

- Cornea, heart, heart-lung, kidney, liver, lung (single and double), and pancreas-kidney transplants; 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. Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be limited to clinical trials, based on recommendations by the National Cancer Institute, as determined by the Plan's Medical Director. Transplants are covered when approved by the Plan's Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices (rigid appliances or apparatus used to support, align, or correct bone and muscle deformities), such as braces are covered, except for disposable supplies, foot orthotics, or dental appliances of any sort. **You pay** 50% of charges.
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers
- Surgical placement of devices for the purpose of drug delivery and/or contraception (i.e., Norplant). **You pay** 50% of charges for the device. The office visit copay is waived. There is no coverage for removal within one year, except when medically necessary (i.e., side effects/adverse events).
- Cardiac rehabilitation
- Nutritional supplements (formulas) for the treatment of aminoacidopathies, such as phenylketonuria (PKU), branched-chain ketonuria, galectosemia, and homocystinuria

## Limited benefits

**Oral and maxillofacial surgery** is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, extraction of partially or totally bony impacted wisdom teeth, treatment of fractures, excision of tumors and cysts of the jaw bone and non-dental treatment required due to accidental or traumatic injury. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.. Surgery for correction of temporomandibular joint (TMJ) dysfunction is covered upon radiologic determination of pathology.

**Reconstructive surgery** will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

**Short-term rehabilitative therapy** (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to 45 dates of service, but no less than two consecutive months per condition if significant improvement can be expected within two months; **you pay** nothing. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

**Durable medical equipment**, such as standard wheelchairs and hospital beds, are covered at 100% of the cost of rental or purchase up to a calendar year maximum Plan payment per member of $2,500.

# Medical and Surgical Benefits *continued*

**Prosthetic devices**, such as artificial limbs, are covered subject to a maximum Plan payment of $5,000 per member per calendar year. Members age 19 and older are limited to the initial prosthesis and replacement of an existing prosthesis every five (5) years. For members through 18 years, this benefit includes the replacement or modification of devices required due to the member's growth, in addition to the initial device. **You pay** nothing.

**Diagnosis and treatment of infertility** is covered; **you pay** a $10 office visit copay. The following types of artificial insemination are covered: intracervical insemination (ICI) and intrauterine insemination (IUI). **You pay** a $10 office visit copay; cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

## What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Homemaker services
- Hearing aids
- Transplants not listed as covered
- Long-term rehabilitative therapy
- Foot orthotics
- Chiropractic services
- Blood and blood derivatives not replaced by the member
- Eye refractions and eyeglasses and external lenses following cataract removal

# Hospital/Extended Care Benefits

## What is covered

### Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** nothing. **All necessary services are covered**, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

### Extended care

The Plan provides a comprehensive range of benefits for short-term stays of up to 60 days per episode 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. **You pay** nothing. **All necessary services are covered**, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

### Hospice Care

Supportive and palliative care for a teminally 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.

### Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. Life Lion® is included.

# Hospital/Extended Care Benefits *continued*

## Limited benefits

### Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

### Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 15 for nonmedical substance abuse benefits.

## What is not covered

- Personal comfort items, such as telephone and television
- Blood and blood derivatives not replaced by the member
- Custodial care, rest cures, domiciliary or convalescent care

# Emergency Benefits

## 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 the Plan may determine are medical emergencies - what they all have in common is the need for quick action.

## Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 24 hours. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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 your condition.

To be covered by this Plan, and follow-up care recommended by non-Plan providers must be authorized in advance by a member's primary care doctor or the Medical Director except as covered under POS benefits.

### Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

### You pay...

$25 per hospital emergency room visit or $10 per urgent care center visit or doctor's office visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

## Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 24 hours or on the first day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctors believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, and follow-up care recommended by non-Plan providers must be authorized in advance by a member's primary care doctor or the Medical Director except as covered under POS benefits.

# Emergency Benefits *continued*

**Plan pays...**

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

**You pay...**

$25 per hospital emergency room visit or $10 per urgent care center visit or doctor's office visit for e m e rgency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

**What is covered**

- E m e rgency care at a doctor's office or urgent care center
- E m e rgency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

**What is not covered**

- Elective care or nonemergency care, including follow-up care that can be provided within the Penn State Geisinger Health Plan system
- E m e rgency 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

**Filing claims for non-Plan providers**

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 20.

# Mental Conditions/Substance Abuse Benefits

## Mental conditions

**What is covered**

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

**Outpatient care**

Up to 30 outpatient visits 55 minutes in length to a Plan psychiatrist or psychologist each calendar year; **you pay** a $25 copay for each covered individual therapy visit and a $10 copay for each covered group therapy visit -- all charges thereafter.

**Inpatient care**

Up to 30 days of hospitalization each calendar year; **you pay** nothing for hospital care; a $25 copay for each day of psychiatric care while hospitalized for the first 30 days -- all charges thereafter.

Partial hospitalization is provided for up to 60 days each calendar year. Two days of partial hospitalization count as one day toward the 30-day inpatient limit.

**What is not covered**

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

## Substance abuse

**What is covered**

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

# Mental Conditions/Substance Abuse Benefits *continued*

**Outpatient care**

Up to 30 outpatient visits to Plan providers for treatment each calendar year; **you pay** nothing for the first 30 visits--50% of charges for all subsequent courses of treatment.

**Inpatient care**

Up to 30 days per calendar year in a substance abuse rehabilitation (intermediate care) program in an alcohol or drug detoxification or rehabilitation center approved by the Plan; **you pay** nothing during the benefit period -- 50% of charges for all subsequent courses of treatment.

**"Swing days"**

Up to 30 outpatient visits per calendar year may be exchanged on a two-for-one basis for up to 15 additional inpatient days of rehabilitation with certification by a Plan doctor.

**What is not covered**

- Treatment not authorized by a Plan doctor

# Prescription Drug Benefits

**What is covered**

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply. **You pay** an $8 copay per prescription unit or refill for up to a 34-day supply.

In lieu of name brand drugs, generic drugs will be dispensed when an approved generic is available. If a name brand drug is dispensed when a generic is available, you pay the difference in cost between the generic and the name brand drug in addition to the $8 copayment. When there is a documented therapeutic failure using a generic drug, Penn State Geisinger Health Plan will authorize the member to obtain a name brand product for the $8 copayment. In such cases, the doctor is required to provide evidence from the patient's chart for review by the System T h e r a p e u t i c s Committee or representative.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral and injectable contraceptive drugs; contraceptive diaphragms
- Implanted devices for the purpose of drug delivery and/or contraception (i.e., Norplant); you pay 50% of the cost of the implanted contraceptive device and nothing for implantation. The off i c e copay is waived. There is no coverage for removal within one year, except when medically necessary (i.e., side effects/adverse events). (Norplant is covered under Medical and Surg i c a l Benefits)
- Insulin
- Disposable needles and syringes needed to inject covered prescribed medication, including insulin

Intravenous medication for home use, implantable drugs, and some injectable drugs, are covered under Medical and Surgical Benefits.

**Limited benefits**

- Human growth hormones; **you pay** 20% per prescription unit or refill
- Sexual dysfunction drugs are subject to dosage limits set by the Plan. Contact the Plan for details.
- Tobacco Cessation:

  Reimbursement for Tobacco Cessation pharmaco-therapies are limited to prescription items only in the following circumstances:

- Members must use a Plan certified counselor or tobacco cessation program and attend at least 4 of 6 sessions.
- You pay $22 per program session. No office visit copay for tobacco cessation counseling sessions.
- Lifetime limit of 3 counseling programs, with an interim of 6 months between programs.

# Prescription Drug Benefits *continued*

- Initially, each member must pay full cost of each session as well as the cost of any prescription item associated with the program. Reimbursement is made when the course is complete. You are responsible for the $8 copayment for each prescription item. Send receipts for prescription drugs and sessions to: Penn State Geisinger Health Plan, Pharmacy Department, 100 North Academy Avenue, Danville, PA 17822-3045.

**What is not covered**

- Drugs available without a prescription or for which there is a non-prescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies. (The Plan now has national availability of Pharmacies through the Perx Select network of Express Scripts Inc.)
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Contraceptive devices such as IUDs (except diaphragms)
- Fertility drugs
- Diabetic supplies (test strips and lancets), except for syringes and needles

# Other Benefits

## Dental care

### What is covered

**Accidental injury benefit**

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) while the member is covered under the FEHB Program. **You pay** nothing.

**What is not covered**

- Other dental services not shown as covered

# 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 Benefits 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 as listed below. All non-emergency out-of-network inpatient admission and designated outpatient procedures require pre-certification.

### 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. 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 1-800/447-4000 to obtain an authorization number and authorization form in order to receive coverage for non-emergency out-of-network inpatient admissions and designated outpatient procedures.

### Deductible

Deductible means a specified dollar amount or 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 Self Only the amount is $250, for Self and Family the amount is $750.

### Coinsurance

Coinsurance means the specified portion of the usual, customary and reasonable (UCR) allowance that you are required to pay. After the deductible is met, the Plan will 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 deductible and amounts in excess of the UCR allowance. The UCR allowance means the allowance for covered services determined, from time to time by the Plan, to be reasonable considering the degree of professional and technical involvement necessary to perform the service. This UCR allowance shall not exceed the amount customarily charged by providers in the same geographical location where the procedure is performed. The UCR allowance may either exceed or be less than actual charges. The UCR allowance will be determined on the basis of when care is provided, not when payment is made. The UCR allowance is set at the 90th percentile of Medicode UCR allowances.

### Maximum benefit

There will be a maximum out-of-pocket of $2,500 per Self Only and $7,500 per Self and Family enrollment. This will be the maximum dollar amount, excluding deductible and amounts in excess of the UCR allowance, that you are required to pay toward out-of-network services in a given calendar year. Any amounts paid by you in excess of the 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 copayment amount (out-of-pocket).

The lifetime maximum benefit is the maximum amount of benefits this Plan will cover under this point of service provision. Once you reach the maximum out-of-pocket amount, the Plan will pay 100% of the 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 facility charge, does not cover any charges for doctors' services.

### Emergency benefits

Are not covered under this benefit as all emergency care is covered as in-network services.

# Point of Service Benefits *continued*

**What is not covered**

- $500 penalty for failure to precertify non-emergency out-of-network inpatient admissions and designated outpatient procedures
- Durable medical equipment
- Prosthetics
- Orthotics
- Inpatient mental health care
- Outpatient prescription drugs
- Substance abuse, outpatient mental health care and emergency care will be covered only as defined under in-network benefits
- Any service for which a claim 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 for all out-of-network services. To receive a claim form, you should call the Plan 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:

Penn State Geisinger Health Plan
100 North Academy Avenue
Danville, PA17822-3026
Attention: Claims Department

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

# How to Obtain Benefits

## Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Team at 1-800/447-4000, or you may write to the Plan at Penn State Geisinger Health Plan, 100 North Academy Avenue, Danville, PA 17822-3020. You may also contact the Plan by fax at 717/271-5871, at its website at http://www.psghp.edu or by e-mail at khockenbrough@psghs.edu.

## Disputed claims review
## Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

## OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

**Privacy Act statement** — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

# Notes

# How Penn State Geisinger Health Plan Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

## Program-wide changes

- Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.
- If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals (See page 8 for details).
- A medical emergency is defined as the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury of disability, and requires immediate medical or surgical care (See page 14).
- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any cost for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 30 outpatient Mental Conditions visit limit.
- Coverage of drugs for sexual dysfunction are shown under the Prescription Drug Benefit (See page 16).

## Changes to this Plan

- The Plan's service area has been expanded in the State of Pennsylvania to include the counties of Dauphin, Lancaster, Lebanon, and Pike. (See page 9).

# Summary of Benefits for Penn State Geisinger Health Plan - 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, AND SERVICES AVAILABLE AS POS BENEFITS, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

| | Benefits | Plan pays/provides | Page |
|---|---|---|---|
| **Inpatient Care** | **Hospital** | Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing | 13 |
| | **Extended care** | All necessary services, with no dollar limit for short-term stays of up to 60 days. **You pay** nothing | 13 |
| | **Mental conditions** | Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing for hospital care; a $25 copay per day for inpatient psychiatric care | 15 |
| | **Substance abuse** | Up to 30 days per year in a substance abuse treatment program. **You pay** nothing for the first 30 days and 50% of charges for all subsequent courses of treatment | 15 |
| **Outpatient care** | | Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit; the $10 copay is waived after the first visit for maternity care; $10 per house call by a doctor | 11 |
| | **Home health care** | All necessary visits by nurses and health aides. **You pay** nothing | 11 |
| | **Mental conditions** | Up to 30 outpatient visits per year. **You pay** a $25 copay per individual therapy visit; $10 copay per group therapy visit | 15 |
| | **Substance abuse** | Up to 30 outpatient visits per year. **You pay** nothing for the first 30 visits and 50% of charges for all subsequent courses of treatment | 15 |
| **Emergency care** | | Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $25 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan | 14 |
| **Prescription drugs** | | Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** an $8 copay per prescription unit or refill | 16 |
| **Dental care** | | Accidental injury benefit; **you pay** nothing | 17 |
| **Vision care** | | No current benefit | |
| **Point of Service Benefits** | | Services of non-Plan doctors and hospitals. Not all benefits are covered. **You pay** deductibles and coinsurance and a maximum benefit applies | 18-19 |
| **Out-of-pocket maximum** | | Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $741.12 per Self Only or $1,926.90 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for: prescription drugs. This out-of-pocket maximum does not apply to the charges you pay when you use POS benefits; rather, a separate out-of-pocket maximum applies to the charges you pay when you use POS benefits | 8 |

# 1999 Rate Information for 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 most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

| | | 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 | $50.74 | $16.91 | $109.94 | $36.64 | $60.04 | $7.61 |
| Self and Family | N92 | $154.75 | $51.58 | $335.29 | $111.76 | $183.12 | $23.21 |