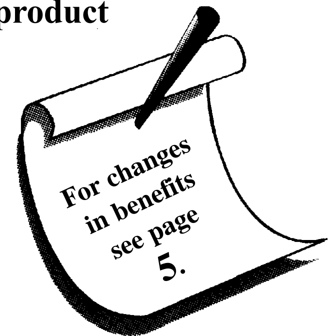
Penn State Geisinger Health Plan 2000

PennState Geisinger Health Plan

A Health Maintenance Organization with a Point of Service product



Serving: Central and Northeastern Pennsylvania

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

Enrollment code:
N91 Self Only
N92 Self and Family

This Plan has full accreditation from the NCQA. See the *2000 Guide* for more information on NCQA.

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
RETIREMENT AND INSURANCE SERVICE

RI 73-303

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Introduction

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

This brochure describes the benefits you can receive from Penn State Geisinger Health Plan under its contract (CS 2231) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 5. Premiums are listed 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. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Penn State Geisinger Health Plan as "this Plan" throughout this brochure even though in other legal documents you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **Health Maintenance Organizations (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.

3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.

4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations.

6. **General exclusions – Things we don't cover.** Look here to see benefits that we will not provide.

7. **Limitations – Rules that affect your benefits.** This section describes limits that can affect your benefits.

8. **FEHB FACTS.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organization

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services or point-of-service benefits (POS) (see page 18 for specific POS benefits) 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

- To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.
- This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.
- If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program (See Section 3., How to get benefits, for more information).
- You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.
- If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- Your share of the non-postal premium will decrease by 3.4% for Self Only and by 3.4% for Self and Family.
- The Plan now provides coverage for certain serious mental illnesses (See page 15).
- The Plan has added mail order prescription drug coverage available at participating mail order pharmacies for up to a 90-day supply of maintenance medication subject to a $16 copay per prescription unit or refill (See page 17).
- The Plan now provides coverage for diabetic supplies. Previously, diabetic supplies, except for insulin and disposable needles and syringes, were excluded from coverage (See page 17).
- The Plan now provides coverage for diabetes-related foot orthotics subject to a member copay of 50% of charges. Previously, all foot orthotics, whether diabetes-related or not, were excluded from coverage (See page 11).
- The Plan now provides coverage for diabetic medical equipment subject to no member copay, up to a calendar year maximum Plan payment of $2,500 per person (See page 12).
- Women may now select a participating provider to obtain all medically necessary obstetric and gynecological care without prior approval from their primary care physician. Previously, women could self-refer, but only for one routine gynecological visit per year (See page 10).
- This Plan’s service area has been expanded in the State of Pennsylvania to include the full counties of Berks, Cameron, Jefferson, and York, and portions (Zip Codes) of Cumberland, Elk, and Perry counties (see page 6).

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, 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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or certain point-of-service benefits (see page 18 for details). We will not pay for any other health care services.

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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for emergency care.

After you pay $741.12 in copayments or coinsurance for one family member, or $1,926.90 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This copayment maximum is separate from the out-of-pocket maximum for the charges you pay when you use POS benefits as described on page 19. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs do not count toward these limits and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us, or you use point-of-service benefits. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Section 3. How to get benefits *continued*

Who provides my health care?

This Plan is a Mixed Model Prepayment (MMP) HMO. Penn State Geisinger Health Plan Clinic doctors and selected independent doctors, who comprise the Penn State Geisinger Health Plan Physician Panel, provide care to Plan members and practice at many locations in Central and Northeastern Pennsylvania. The network includes 1,257 primary care doctors and 2,991 specialty care doctors. Members can also receive care from non-Plan providers at additional costs (see POS Benefits on page 18).

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: women may see their Plan obstetrician/gynecologist, without a referral, for an annual routine examination, as well as medically necessary obstetrical and gynecological visits.

What do I do if my primary care physician leaves the Plan?

Call us or we will notify you and help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care. If a specialist to whom you have been referred recommends hospitalization, be sure to obtain authorization from your primary care physician.

What do I do if I'm in the hospital when I join this Plan?

First, call our Customer Service Team at 800/447-4000. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist.

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will 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. 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 and authorization for, the referral.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide 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.

Section 3. How to get benefits *continued*

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice. Services of other providers are covered only when you have been referred by your primary care physician or when you use POS benefits, with the exception of women self-referring to an obstetrician/gynecologist for medically necessary care.

How do you decide if a service is experimental or investigational?

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.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing;
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information.

Section 4. What to do if we deny your claim or request for service *continued*

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at 800/447-4000 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Section 4. What to do if we deny your claim or request for service *continued*

Where should I mail my disputed claim to OPM?

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

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

What laws apply if I file a lawsuit?

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 or supplies.

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Medical and Surgical Benefits

A comprehensive range of preventive, diagnostic and treatment services is provided by this Plan's 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 judgement 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.

What is covered

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well-baby care, periodic check-ups, and women may self-refer to their Plan obstetrician/gynecologist for an annual routine examination, as well as medically necessary obstetrical and gynecological visits
- Mammograms are covered as follows: for women age 35 through age 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 and treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures such as laboratory tests and X-rays
- 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.

Section 5. Benefits *continued*

If enrollment in this Plan is terminated during pregnancy, benefits will be provided after coverage under this 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, and diabetes-related foot orthotics; you pay 50% of charges. No coverage is provided for disposable supplies or dental appliances of any sort.
- 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 and 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, IUDs). **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 affects/adverse events).
- Cardiac rehabilitation
- Nutritional supplements (formulas) for the treatment of aminoacidopathies, such as phenylketonuria (PKU), branched-chain ketonuria, galectosemia, and homocystinuria

Section 5. Benefits *continued*

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 nondental 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 coverage 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. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance. Coverage is provided for breast prostheses and surgical bras, as well as their replacements.

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 of $2,500 per member.

Diabetic medical equipment, such as blood glucose monitors, insulin infusion devices and pumps, injection aids such as needle-free injection devices, bent needle set for insulin pump infusion, and non-needle cannula for insulin infusion are covered at 100%, up to a calendar year maximum Plan payment of $2,500 per member.

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 prosthetic 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

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

Section 5. Benefits *continued*

Hospital/Extended Care Benefits

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:

Hospital care

- 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
- 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 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.

Ambulance service

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

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 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 16 for non-medical 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 a serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become 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.

Section 5. Benefits *continued*

Emergencies within the service area

When an emergency happens, provided that it will not place you at an increased risk of injury, you should make a reasonable effort to contact your primary care physician or our Tel-A-Nurse staff for medical direction. If you are unable to contact your primary care physician or the Tel-A-Nurse staff, you should make a reasonable effort to safely proceed to the nearest participating provider emergency room. If you are not able to contact your primary care physician, Tel-A-Nurse staff, or are unable to safely proceed to a participating provider emergency room, you should proceed to the nearest emergency room.

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, any 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 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.

To be covered by this Plan, any 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.

What is covered

- Emergency care at a doctor's office or urgent care center
- Emergency 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 non-emergency care, including follow-up care that can be provided within the Penn State Geisinger Health Plan system
- 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

Section 5. Benefits *continued*

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 HCFA 1500 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 8.

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.

Serious mental illness

What is covered

Serious mental illness includes:

1. Schizophrenia;
2. Bipolar Disorder;
3. Obsessive Compulsive Disorder;
4. Major Depressive Disorder;
5. Panic Disorder;
6. Anorexia Nervosa;
7. Bulimia Nervosa;
8. Schizo-Affective Disorder; and
9. Delusional Disorder.

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of serious mental illness:

Section 5. Benefits *continued*

Outpatient care

Up to a maximum of 60 outpatient visits (individual and group therapy combined up to 55-minutes each visit) 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.

Inpatient care

Up to a maximum of 30 days of hospitalization each calendar year; **you pay** nothing for hospital care; a $25 copay for each 55-minute visit by a Plan psychiatrist or psychologist while hospitalized for the first 30 days – all charges thereafter.

One (1) inpatient day may be converted to two (2) outpatient visits for up to an additional 60 outpatient visits per calendar year.

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.

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 unit) 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 Penn State Geisinger Health Plan or a representative.

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

Section 5. Benefits *continued*

Mail order pharmacy benefits

Only outpatient maintenance prescription drugs prescribed by a Plan or referral doctor may be obtained at a participating mail order pharmacy. The drugs will be dispensed for up to a minimum, and not less than, a 90-day supply; **you pay** a $16 copay (2 times the regular prescription drug copay of $8) per prescription unit or refill. Some drugs are not available through the mail order program and must be obtained as described above.

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, Intrauterine Devices); **you pay** 50% of the cost of the implanted contraceptive device and nothing for the implantation. The office copay is waived. There is no coverage for removal within one year, except when medically necessary (i.e., side effects/adverse events). (Norplant and IUDs are covered under Medical and Surgical Benefits)
- Insulin
- Diabetic supplies, including oral pharmacological agents for controlling blood sugar, insulin syringes and needles, and blood glucose monitor supplies, such as lancets, and glucose test strips
- Disposable needles and syringes needed to inject covered prescribed medication

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

Limited benefits

- Human growth hormones; **you pay** 20% of charges 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 programs, with an interim of 6 months between programs.
- 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 completed. You are responsible for the $8 copay 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
- Fertility drugs

Section 5. Benefits *continued*

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). **You pay** nothing.

What is not covered

- Other dental services not shown as covered

Medicare+Choice

"Penn State Geisinger Health Plan Gold" is a comprehensive benefits package especially for Medicare beneficiaries. Under the "Gold" plan, coverage is provided for routine office visits, physical exams, immunizations, diagnostic testing and X-rays, as well as hospitalization.

To be a member of the "Gold" plan, you must maintain your Medicare Part A and Part B insurance, and care must be provided by your Primary Care Physician, including arrangements for specialty care. As an enrollee in both the Penn State Geisinger Health Plan under the Federal Employees Health Benefits (FEHB) Program, and "Penn State Geisinger Health Plan Gold," any applicable coinsurances or deductibles are waived for services covered by the health plans.
For more information on "Penn State Geisinger Health Plan Gold," when you are also enrolled in the Penn State Geisinger Health Plan under the FEHB Program, contact our Customer Service Team at 1-800/631-1656.

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 or 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 admissions 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 authorized number and authorization form in order to receive coverage from non-emergency out-of-network inpatient admission and designated outpatient procedures.

Section 5. Benefits *continued*

Deductible

Deductible means 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 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 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 an out-of-pocket maximum 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 a 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.

What is not covered

- $500 penalty for failure to precertify non-emergency out-of-network inpatient admissions and designated 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

Section 5. Benefits *continued*

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, PA 17822-3026
Attention: Claims Department

You must sign Section A of the claim form 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 a covered expense, 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.

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 or condition.**

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services (see Point of Service benefits);
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations –Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.
If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.
If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.
If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.
If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.
For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 18.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.
When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.
If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. 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.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. 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 determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Section 7. Limitations –Rules that affect your benefits *continued*

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8. FEBH FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 800/447-4000, or write to Penn State Geisinger Health Plan, 100 North Academy Avenue, Danville, PA 17822-3020. You may also contact us by fax at 570/271-5871, or visit our website at www.psghs.edu.

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

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 January 1.

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Section 8. FEBH FACTS *continued*

Are my medical and claims records 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for 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.

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.

When you lose benefits *continued*

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get 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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.
If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

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 or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Penn State Geisinger Health Plan – 2000

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. There is also coverage for Serious Mental Illness	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	16
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.	10-11
	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. There is also coverage for Serious Mental Illness	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	16
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	13-14
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** an $8 copay per prescription unit or refill	16-17
Dental care		Accidental injury benefit; **you pay** nothing	18

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.......18-20
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.......6

2000 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. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	**N91**	**$49.01**	**$16.33**	**$106.18**	**$35.39**	**$57.99**	**$7.35**	**$57.99**	**$7.35**
Self and Family	**N92**	**$149.48**	**$49.83**	**$323.88**	**$107.96**	**$176.89**	**$22.42**	**$176.89**	**$22.42**