Geisinger Health Plan

www.TheHealthPlan.com/federal

Customer Service 844-863-6850

Geisinger Health Plan **2024**

A Health Maintenance Organization (Standard and Basic Options)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details. This plan is accredited. See page 14.

Serving: Northeastern, Central, and South Central Pennsylvania

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 15 for requirements.

Enrollment codes for this Plan:

GG4 Standard Option - Self Only

GG6 Standard Option - Self Plus One

GG5 Standard Option - Self and Family

AJ1 Basic Option – Self Only

AJ3 Basic Option - Self Plus One

AJ2 Basic Option – Self and Family

IMPORTANT

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-849

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

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

Potential Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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

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

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Introduction

This brochure describes the benefits of Geisinger Health Plan under contract (CS 2911) between Geisinger Health Plan and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 844-863-6850 or through our website: www.thehealthplan.com/federal. The address for Geisinger Health Plan is:

Geisinger Health Plan

100 North Academy Avenue

Danville, PA 17822-3220

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized on page 16. Rates are shown at the end of this brochure.

The Plan issues this brochure in accordance with the terms of a Certificate of Authority awarded by the Pennsylvania Departments of Health and Insurance, pursuant to the Pennsylvania Health Maintenance Act of 1972, as amended.

Plain Language

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

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

Stop HealthCare Fraud!

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

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 844-863-6850 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form

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

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage. Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26).
- A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.

Discrimination is Against the Law

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medication and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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

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

Patient Safety Links

For more information on patient safety, please visit:

http://www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
http://www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals

Preventable Healthcare Acquired Conditions ("Never Events")
When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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

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

FEHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
Minimum essential coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage (MEC). Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum value standard	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
Where you can get information about enrolling in the FEHB Program	See www.opm.gov/healthcare-insurance for enrollment information as well as: • Information on the FEHB Program and plans available to you • A health plan comparison tool • A list of agencies that participate in Employee Express • A link to Employee Express • Information on and links to other electronic enrollment systems Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you: • When you may change your enrollment; • How you can cover your family members; • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire; • What happens when your enrollment ends; • When the next Open Season for enrollment begins. We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, disability leave, pensions, etc. you must also contact your employing or retirement office. Once enrolled in your FEHB program plan you should contact your carrier directly for address updates and questions about your benefit coverage.
Enrollment types available for you and your family	Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

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

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance

Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2024 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Temporary Continuation of Coverage (TCC)

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

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

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

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

Converting to individual coverage

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

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

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-223-1282 or visit our website at www.geisinger.org/health-plan/plans/geisinger-marketplace.

Health Insurance Marketplace

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

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan's operations and/or care management meet nationally recognized standards. Geisinger Health Plan holds the following accreditations: Accredited with the National Committee for Quality Assurance. To learn more about this plan's accreditation (s), please visit the following websites: National Committee for Quality Assurance (www.ncqa.org). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

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

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

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

General features of our Options

Geisinger Health Plan's Standard Option and Basic Option are Solutions HMO plans. You select a Primary Care Provider who will coordinate all of your care. Members may self-refer for covered services to a participating provider without the need of a referral from the member's Primary Care Provider. Services include inpatient hospitalization, outpatient surgery, diagnostic testing, rehabilitation therapy, and other services as prescribed by your Primary Care Provider.

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

For the Standard Option, you must satisfy a calendar year deductible of $750 per Self Only or $1,500 per Self and Family. After you have satisfied the annual deductible, you will then be required to pay 20% coinsurance for covered surgical procedures and inpatient hospitalization up to the coinsurance out-of-pocket maximum of $4,250 under Self Only or $8,500 under Self and Family. The annual deductible is in addition to the out-of-pocket maximum.

For the Basic Option, you must satisfy a calendar year deductible of $1,500 per Self Only or $3,000 per Self and Family. After you have satisfied the annual deductible, you will then be required to pay 30% coinsurance for covered surgical procedures and inpatient hospitalization up to the coinsurance out-of-pocket maximum of $7,000 under Self Only or $14,000 under Self and Family. The annual deductible is in addition to the out-of-pocket maximum.

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Your medical and claims records are confidential

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

Your rights and responsibilites

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

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

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at TheHealthPlan.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

If you want more information about us, call 844-863-6850, or write to Geisinger Health Plan, Customer Services, 100 North Academy Avenue, Danville, PA 17822-3229. You may also contact us by fax at 570-271-5871 or visit our website at TheHealthPlan.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at TheHealthPlan.com to obtain a copy of our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Service Area

To enroll in this Plan, you must live or work in our service area. This is where our providers practice.

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

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

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

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

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

Section 2. Changes for 2024

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

Changes to Standard and Basic Options

- **Your share of the non-Postal premium will increase for Self Only or increase for Self and Family.**
- **Congenital Fertility Services** – The Plan is expanding its Infertility Services for Artificial Insemination (AI) and adding intravaginal insemination (IVI). The cost share for AI services to include SCP office visit, initial consultation, evaluation, and lab testing is $35 for Standard option and 30% after the deductible for Basic option. (See page 34)
- **Fertility Services** – The Plan is adding three (3) cycles of in vitro fertilization (IVF) services. Fertility Services will require prior authorization. The cost share for IVF services is 20% after the deductible for Standard option and 30% after the deductible for Basic option. (See Page 35)
- **Fertility Drugs** - The Plan is adding three (3) cycles of in vitro fertilization (IVF) drugs. The cost share for AI and IVF generic Oral and injectable medications is 30% and 50% of the cost for non-preferred brand injectable medications. (See page 35)
- **Gender Affirming Care Services** - The Plan is providing coverage for all gender affirming services deemed medically necessary including facial gender affirming surgeries. The cost share is 20% after the deductible for Standard option and 30% after the deductible for Basic option. (See page 50 & 51)

Section 3. How You Get Care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 844-863-6850 or write to us at Geisinger Health Plan, Customer Services, 100 North Academy Avenue, Danville, PA 17822-3229. You may also request replacement cards through our website at www.thehealthplan.com.

Where you get covered care

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

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

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

This plan recognizes that transgender, non-binary and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

- **Plan facilities**

This plan provides Care Coordinators for complex conditions and can be reached at 844-863-6850 or www.thehealthplan.com for assistance.

What you must do to get covered care

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

- **Primary care**

Your primary care provider can be a general practitioner, family practitioner, internist or pediatrician. Your primary care provider will provide most of your healthcare.

If you want to change primary care provider or if your primary care provider leaves the Plan, call Customer Services at 844-863-6850 and we will help you select a new one.

- **Specialty care**

You can get needed care from a specialty provider without a referral from your primary care provider. You must go to a participating specialty physician to receive covered services.

If you want to know if a specialty care provider is participating call Customer Service at 844-863-6850 and we will help you find one or log onto www.thehealthplan.com.

- The specialty provider may have to get an authorization or approval from us beforehand. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call Customer Services at 844-863-6850 and we will help you select a new one and we will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our Service Area and you enroll in another FEHB plan; you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan. If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 844-863-6850. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

Your primary care provider and specialty care physician can arrange inpatient hospitalizations, the pre-service claim approval process only applies to care shown under *Other services*.

You must get prior approval for certain services. If you do not get prior approval you will be responsible for costs.

- **Inpatient hospital admission**

Prior authorization is approval in advance to get services. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization".

- **Other services**

For certain services, however, your provider must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. Plan providers must obtain prior authorization for services including but not limited to the following:

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

Contact customer services at 844-863-6850 for a complete listing of services that require prior authorization.

How to request prior authorization for an admission or for Other services

First, your physician, your hospital, you, or your representative, must call us at 844-863-6850 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

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

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

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 844-863-6850 . You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 844-863-6850 . If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **Maternity Care**

  Members have direct access to obstetrical and gynecological services. They may select a participating health care provider to obtain maternity and gynecological covered services including medically necessary and appropriate follow-up care for diagnostic testing relating to the maternity and gynecological care. Covered services must be within the scope of practice of the selected participating healthcare provider.

  You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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

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

How to get approval for...

- **Your hospital stay**

Hospital benefits may be provided at a Plan participating hospital on either an inpatient or outpatient basis or at an ambulatory surgical center as authorized in advance by your primary care provider, but a participating specialist, by your obstetrical or gynecological participating healthcare provider (for services within their scope of practice) or by the Plan's designated Behavioral Health Benefit Program. Hospital benefits may also be authorized in advance by the Plan for covered services not available through a participating provider. Inpatient benefits are provided for as long as the hospital stay is determined medically necessary by the Plan and not determined to be custodial, convalescent or domiciliary care.

- **How to precertify an admission**

It is the responsibility of your admitting physician to obtain precertification from the Plan for your inpatient hospital admission.

- **What happens when you do not follow the precertification rules when using non-network facilities**

All covered services must be received by a Plan participating provider or facility. Any service or care received outside of this Plan's network or service area, without precertification from the Plan, except in the case of emergency care, will be the financial responsibility of the member. We will only pay for emergency services. We will not pay for any other healthcare services received outside of our service area or network unless the service has received prior Plan approval.

- **Circumstances beyond our control**

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 844-863-6850.

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

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

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

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

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

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Costs for Covered Services

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

Cost-sharing

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

Copayments

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

Example of the Standard Option plan: When you see your primary care provider you pay a $20 copayment per office visit, or if you see a specialist you pay a $35 copayment per office visit. If you visit an emergency room you will pay a $150 copayment. This copyament is waived if you are admitted to the hospital. You will need to satisfy a deductible for certain services such as inpatient hospital stays before we pay for these services.

Deductible

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

- The calendar year deductible is $750 per person under self only enrollment in our Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $750 under Standard Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,500 under Standard Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,500.
- The calendar year deductible is $1,500 per person under self only enrollment in our Basic Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $1,500 under Basic Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $3,000 under Basic Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $3,000.

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

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

Differences between our Plan allowance and the bill

You should also see Section Important Notice About Surprise Billing-Know Your Rights below that describes your protections against surprise billing under the No Surprises Act

Your catastrophic protection out-of-pocket maximum

For the Standard Option, after your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $5,000 for Self Only, or $10,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

For the Basic Option, after your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $8,550 for Self Only, or $17,100 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceede that amount.

The maximum annual limitation on cost sharing listed under Self Only of $5,000 (Standard Option) and $8,550 (Basic Option) applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.

Example Scenario: Your plan has a $5,000 Self Only maximum out-of-pocket limit and a $10,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $5,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $10,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $10,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

• Expenses for services and supplies that exceed the stated maximum dollar or day limit

• Expenses from utilizing out-of-network providers unless prior approval

• Expenses from obesity surgery

• Expenses from wisdom teeth extraction

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

Carryover

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

When Government facilities bill us

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

Important Notice About Your Surprise Billing-Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:
• emergency care – when you have little or no say in the facility or provider from whom you receive care, or for

• non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for

• air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to Geisinger.org/BalanceBilling or contact the health plan at 844-863-6850.

The Federal Flexible Spending Account Program - FSAFEDS

- **Healthcare FSA (HCFSA)** Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expense, and much more) for you, your tax dependents, and your adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible-out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. Standard and Basic Option Benefits

Section 5. Standard and Basic Option Benefits Overview

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

The Standard and Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at 844-863-6850 or on our website at www.thehealthplan.com.

Each option offers unique features.

- **Standard Option**

Calendar year deductible: $750 per person ($1,500 per person Self Plus One enrollment, or $1,500 per Self and Family enrollment)

PCP/Specialty Office Visit: $20/$35 copay

Coinsurance: 20%

Emergency Room: $150

Rx: 30%/40%/50%/50%

- **Basic Option**

Calendar year deductible: $1,500 per person ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment)

PCP/Specialty Office Visit: 30% coinsurance

Coinsurance: 30%

Emergency Room: $250

Rx: 30%/40%/50%/50%

Section 5(a). Medical Services and Supplies Provided by Physicians and Other HealthCare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- **Standard Plan:** calendar year deductible: $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment).
- **Basic Plan:** calendar year deductible: $1,500 per person ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment).
- The calendar year applies deductible applies to almost all benefits in this section. We added "(No Deductible)" to show when the calendar year deductible does not apply.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i. e., hospital, surgical center, etc.).

Benefit Description	You pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.		
Diagnostic and treatment services	**Standard**	**Basic**
Professional services of providers • In Primary Care Provider Office	$20 per primary care provider (PCP) office visit	30% after deductible
Professional services of providers • In Specialty Care Provider Office	$35 per specialty care provider (SCP) office visit	30% after deductible
Professional services of providers • In an urgent care center	$20 per urgent care visit	30% after deductible
Professional services of providers • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion • At home • Advance care planning	20% after deductible	30% after deductible
Not Covered:	*All charges*	*All charges*

Benefit Description	You pay	
Telehealth services	**Standard**	**Basic**
• Telemonitoring services (Blue tooth scales in members' homes) for members with Heart Failure • Interactive Voice Response (IVR) after hospital discharge for members with targeted conditions to assist with transitions of care management up to 30-45 day period following discharge • E-ICU services when provided by Geisinger Health System only • Telestroke services when provided by Geisinger Health System only	No Charge	No Charge
Teladoc virtual visits with a U.S. board-certified doctor: Teladoc.com or 1-800-Teladoc (835-2362) Telemedicine: Call your doctor or 800-275-6401 to see if telemedicine visits are available.	$5 primary care copay	30% after deductible
Teladoc virtual visits with a U.S. board-certified doctor: Teladoc.com or 1-800-Teladoc (835-2362) Telemedicine: Call your doctor or 800-275-6401 to see if telemedicine visits are available.	$5 behavioral health copay	30% after deductible
Teladoc virtual visits with a U.S. board-certified doctor: Teladoc.com or 1-800-Teladoc (835-2362) Telemedicine: Call your doctor or 800-275-6401 to see if telemedicine visits are available.	$10 specialist copay	30% after deductible
Lab, X-ray and other diagnostic tests	**Standard**	**Basic**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Non-routine mammogram • CT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% after deductible	30% after deductible

Benefit Description	You pay	
Preventive care, adult	**Standard**	**Basic**
Routine physical every 12 months. The following preventive services are covered a the time interval recommended at each of the link below: • Immunizations such as Pneumococcal, influenza, shingles, tetanus/Tdap, and human papillomavirus (HPV). For a complete list of immunizations do to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. • Individual counseling on prevention and reducing health risks • Preventive care benefits for women (including, but not limited to, the Women's Preventive Services Guidelines from the Health Resources and Services Administration) such as Pap smears, gonorrhea, prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder • Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities as recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing	30% after deductible if office visit is required to receive services otherwise Nothing
Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing	30% after deductible if office visit is required to receive services otherwise Nothing
Routine mammogram are covered	Nothing	Nothing
Adult immunizations-endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing	30% after deductible if office visit is required to receive services otherwise Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**Standard**	**Basic**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will subject to the applicable member copayment, coinsurance, and deductible.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing	30% after deductible if office visit is required to receive services otherwise Nothing
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**Standard**	**Basic**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing
Maternity care	**Standard**	**Basic**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression	Nothing for office visits, otherwise 20% after deductible	Nothing for office visits, otherwise 30% after deductible
Breastfeeding support, supplies and counseling for each birth Note: Here are some things to keep in mind:	Nothing	Nothing

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**Standard**	**Basic**
• You do not need to precertify your vaginal delivery; see page 56 for other circumstances such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, nonmatrnity benefits, apply to circumcision • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible	Nothing	Nothing
Childbirth Preparedness Class: • Prepares the mother for the birth of her baby. Limit of $100 per benefit period.	Limit of $100 per benefit period.	Limit of $100 per benefit period.
Family planning	**Standard**	**Basic**
Contraceptive counseling on an annual basis	Nothing	Nothing
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal ligation Note: We cover oral contraceptives under the prescription drug benefit.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing	30% after deductible if office visit is required to receive services otherwise Nothing
Voluntary sterilization (See Surgical Procedures Section 5 (b)	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing	30% after deductible if office visit is required to receive services otherwise Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All charges*

Benefit Description	You pay	
Infertility services	**Standard**	**Basic**
The term **infertility** used in this document, is a person unable to conceive or produce conception after one year of egg-sperm contact when the individual attempting conception is under the age of 35, or after six months egg-sperm contact when the individual attempting conception is 35 years of age or older. Infertility may be due to natural dysfunction (congenital), as a sequelae of another physical condition or disease (secondary), or as a result of surgery, radiation, chemotherapy, gender transition or other medical treatment affecting reproductive organs or processes. Diagnosis and treatment of infertility such as: • Artificial insemination: - intracervical insemination (ICI) - intrauterine insemination (IUI) - Intravaginal insemination (IVI) • Fertility drugs (injectable drugs administered by provider is covered in the medical drug benefit) Note: We cover self injectable and oral fertility drugs under the prescription drug benefit.	$35 per SCP office visit, initial consultation, evaluation and lab testing	30% after deductible per SCP office visit, initial consultation, evaluation and lab testing
Congenital Infertility Services Coverage for members with congenital infertility, undergoing gender transformation, or a treatment that is expected to render them permanently infertile (excluding voluntary sterilization): · Ovarian stimulation, retrieval of eggs (prior to age 45) and fertilization limited to two (2) attempts. · Oocyte cryo-preservation limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP. · Sperm collection (prior to age 45) and storage limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP. · Three cycles of IVF with egg or embryo cryopreservation. In-vitro fertilization is covered only in the case of fertility preservation due to infertility IVI, IUI, and ICI with or without medication is covered for otherwise healthy biological female members. IUI, IVI and ICI is covered for the time period that fertility is naturally expected. Services will no longer be covered for members clinically determined to have less than 5% chance for a live birth (for example: after a member has done and failed to deliver with IVF).	20% after deductible	30% after deductible

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**Standard**	**Basic**
Please note: Some infertility drugs may be covered under medical drug coverage, see Section 5(f) for Infertility drugs coverage. **Member is responsible for the cost once the member's enrollment terminates or reaches the six attempts per year benefit.**	20% after deductible	30% after deductible
Iatrogenic Infertility Covered services for members undergoing radiation, pharmacological treatment, or chemotherapy that is expected to render them permanently infertile: • Ovarian stimulation, retrieval of eggs and fertilization limited to two (2) attempts. • Oocyte cryo-preservation limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP. • Sperm collection and storage limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP. • Artificial insemination: Intravaginal insemination (IVI), Intrauterine insemination (IUI), Intracervical insemination (ICI) • One cycle of IVF with egg or embryo cryopreservation. In-vitro fertilization is covered only in the case of fertility preservation due to iatrogenic infertility Coverage for members undergoing gender transformation or a treatment other than chemotherapy that is expected to render them permanently infertile (excluding voluntary sterilization): **Member is responsible for the cost once the member's enrollment terminates or reaches the $25,000 maximum lifetime benefit.** • Ovarian stimulation, retrieval of eggs and fertilization limited to two (2) attempts. • Oocyte cryo-preservation limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP. • Sperm collection and storage limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP. • One cycle of IVF with egg or embryo cryopreservation. In-vitro fertilization is covered only in the case of fertility preservation due to iatrogenic infertility	20% after deductible	30% after deductible
Not covered: • Reversal of voluntary sterilization	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**Standard**	**Basic**
• Assisted reproductive technology (ART) other than IVF noted above. e.g., Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT). • Cryopreservation of embryos or eggs for fertility preservation purposes other than chemotherapy, gender transformation, or other medical treatments that may render an individual infertile. • Cryopreservation of embryos or eggs for reciprocal IVF • Sperm storage/banking for members requesting this service for convenience or "back-up" for a fresh specimen. • Elective egg/sperm cryopreservation for fertility preservation due to natural aging or menopause. • Storage of cryopreserved sperm, eggs for more than 24 months • Selective fetal reduction • Gender selection • Frozen embryo Transfer • Human zona binding assay (hemizona test) • Serum anti-sperm antibody testing • Sperm acrosome reaction test • Sperm DNA fragmentation assays • Advanced Sperm Selection Techniques (i.e. PICSI, Zeta potential, sorting by X or Y chromosome, magnetic activating cell sorting, etc.) • Sperm hyperactivation processing/techniques • Co-culture of embryos • Embryo toxic factor test (ETFL) or Natural killer cell assay • IVIG (Intravenous Immunoglobulin) • Granulocyte Colony Stimulating Factor (G-CSF) • Intralipid infusion • Ovulation kits • Post-coital testing • Artificial oocyte activation • In vitro maturation of eggs • Direct intraperitoneal insemination (DIPI) • Peritoneal ovum and sperm transfer (POST) • Genetic engineering • Egg harvesting or other infertility treatment performed during an operation not related to surgery, chemotherapy, radiation or pharmacological treatment with a likely side effect of infertility.	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**Standard**	**Basic**
• Endometrial Scratching • Embryo Glue (hyaluronic acid) • human chorionic gonadotropin (hCG) infusion into the uterine cavity • uterine artery vasodilation (i.e. sildenafil) • Ovarian tissue cryopreservation and transplantation procedures • Reimplantation or grafting of human testicular tissue • Donor sperm • Donor egg	*All charges*	*All charges*
Allergy care	**Standard**	**Basic**
• Testing and treatment	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing	30% after dedutible if office visit is required to receive services otherwise Nothing
• Allergy injections • Allergy Serum	Nothing	Nothing
Treatment therapies	**Standard**	**Basic**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 48. • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/ condition is provided for up to36 sessions • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth Hormone Therapy (GHT) Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under You need prior Plan approval for certain services on page 18.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise 20% after deductible	30% after deductible

Benefit Description	You pay	
Implanted Devices (medical and contraceptive)	**Standard**	**Basic**
• Drug delivery	50% per device	50% per device
• Contraceptives	Nothing	Nothing
Physical and occupational therapies	**Standard**	**Basic**
Unlimited visits for the services of each of the following: • Qualified physical therapists • Occupational therapists	$35 per office/outpatient visit Inpatient visits subject to deductible and coinsurance (see Page 50). No additional copayments required for inpatient therapy.	30% after deductible
• Physical therapy for back pain; limited to 2 series of 5 visits each per benefit period	$35 per series	30% after deductible
• Spinal injection for back pain	$20% after deductible	30% after deductible
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.	Nothing	Nothing
Pulmonary rehabilitation up to 36 visits	Nothing	Nothing
APOS Therapy 2-6 Therapy visits as needed. Includes the shoes and fitting.	Nothing	Nothing
Not covered: • *Long-term rehabilitative (maintenance) therapy* • *Exercise programs* • *Biofeedback*	*All charges*	*All charges*
Speech therapy	**Standard**	**Basic**
For the services of a qualified speech therapist (unlimited visits) ABA Therapy can be found in section 5(e)	$35 per office visit/ outpatient visit Inpatient visits subject to deductible and coinsurance (see Page 50). No additional copayments required for inpatient therapy.	30% after deductible

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies)	**Standard**	**Basic**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children*. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For coverage of certain devices, see Section 5(a) *Orthopedic and prosthetic devices*.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise 20% after deductible	30% after deductible
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard**	**Basic**
• Diagnostic vision exams to determine the need for vision correction • Vision testing for children through age 17 (see *Preventive care, children*)	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise Nothing	30% after deductible if office visit is required to receive services otherwise Nothing
• Annual eye refractions to determine the refractive error of the eye	Nothing	Nothing
• Diabetic Eye Exams	Nothing	Nothing
Not covered: • *Eyeglasses, contact lenses, and after age 17, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery.*	*All charges*	*All charges*
Foot care	**Standard**	**Basic**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$20 PCP or $35 SCP copayment if office visit is required to receive services otherwise 20% after deductible	30% after deductible
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*

Benefit Description	You pay	
Orthopedic and prosthetic devices	**Standard**	**Basic**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External Hearing aids and testing to fit them (children only). Refer to page 32- Preventive care, children • External components of cochlear implants and bone anchored hearing aids (BAHA) • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Rigid, gas permeable contact lens coverage for treatment of progressive eye diseases, such as keratoconus. The contact lenses will be coded as a prosthetic, but will not be subject to the "one every 5 year" benefit as most prosthetics are (noted on page 40). Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	Nothing	Nothing
Externally worn breast prostheses and mastectomy bras, including necessary replacements following a mastectomy Note: Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.	Nothing, no maximum limit	Nothing, no maximum limit
• Orthopedic devices, rigid appliances or apparatus used to support, align or correct bone and muscle deformities such as leg braces. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	50% of charges (not subject to deductible or coinsurance maximum)	50% of charges (not subject to deductible or coinsurance maximum)
• Diabetic foot orthotics	20% after deductible	30% after deductible
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics (except for diabetics), heel pads and heel cups*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**Standard**	**Basic**
• *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than five (5) years after the last one we covered for members over age 19* • *Disposable supplies* • *Dental appliances of any sort, including but not limited to, bridges, braces and retainers, except those for non-dental treatment of TMJ* • *Sexual dysfunction devices, male or female* • *Replacement due to neglect* • *Wigs*	*All charges*	*All charges*
Durable medical equipment (DME)	**Standard**	**Basic**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Insulin pumps (not subject to per year maximum) • Semi-electric hospital beds and related equipment • Manual Wheelchairs (not subject to per year maximum) • Crutches, canes and walkers GHP reviews all member DME requests to approve up to an additional $200 toward the cost of equipment such as assisted speaking devices that would significantly improve a member's clinical condition or enhance their ability to perform activities of daily living. Note: Call us at 844-863-6850 as soon as your Plan physician prescribes the equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing	Nothing
Not covered: • *Motorized wheelchairs* • *Deluxe equipment of any sort, or equipment which has been determined by the Plan to be non-standard.* • *Disposable items such as incontinent pads, electrodes, ace bandages, elastic stockings, and dressings* • *Equipment which serves for comfort or convenience functions or is primarily for the convenience of a person caring for a member* • *Air conditioners* • *Humidifiers*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**Standard**	**Basic**
• *Electric air cleaners* • *Exercise or fitness equipment* • *Elevators* • *Hot tubs* • *Hoyer lifts* • *Shower/bath bench* • *Special clothing of any type* • *Hearing devices of any type (except as noted above)* • *Replacement due to neglect* • *Batteries* • *Access ramps* • *Pulse oximeters over age 18*	*All charges*	*All charges*
Home health services	**Standard**	**Basic**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or other healthcare professional. • Services include oxygen therapy and medications, intravenous therapy, physical, occupational and speech therapy and social services.	Nothing	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services provided by any non-home health provider*	*All charges*	*All charges*
Urological Supplies. Urinary supplies, such as urinary catheters, collection devices, insertion trays, are covered for permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three (3) months.	20% after deductible	30% after deductible
Chiropractic	**Standard**	**Basic**
• Direct access to participating providers for medically necessary chiropractic services to include new patient exams, adjunctive therapy, X-rays and clinical laboratory tests. • Maximum 15 visits per benefit year.	$20 per office visit	30% after deductible
• Chiropractic appliances	$50 maximum Plan allowance	$50 maximum Plan allowance

Chiropractic - continued on next page

Benefit Description	You pay	
Chiropractic (cont.)	**Standard**	**Basic**
• Contact Geisinger Health Plan Customer Service by calling 844-863-6850 or logging onto thehealthplan.com for network information.	$50 maximum Plan allowance	$50 maximum Plan allowance
Not covered: • Services for exams or treatment for conditions other than those related to neuromusculoskeletal disorders • Acupuncture • Biofeedback • Services received by providers not part of the Geisinger Health Plan network • Hypnotherapy, thermography, behavior training • Sleep therapy and weight programs • MRI, CT scans, bone scans, nuclear radiology, diagnostic radiology • DME, Prescription drugs and hospitalization	*All Charges*	*All Charges*
Alternative treatments	**Standard**	**Basic**
No benefit	*All charges*	*All charges*
Medical Foods	**Standard**	**Basic**
Oral or tube delivered nutrition products or supplements used for the treatment of members with an established diagnosis of inborn error of metabolism (eg, phenylketonuria (PKU), homocystinuria, branch chain ketonuria, galactosemia, etc) with documentation of failure of conservative dietary interventions are covered as mandated by Act 191. Prescription medical foods (formulas) administered orally or via a tube into the alimentary canal for members diagnosed with a rare genetic (inherited) inborn errors of metabolism (IEM), such as phenylketonuria (PKU), homocystinuria, branched-chain ketonuria, and galactosemia are covered for individuals of all ages who need administration of a formula that is manufactured for the therapeutic treatment and dietary management of individuals with IEMs and is administered under the direction of a physician. **The Following Indications Requires Prior Authorization by a Plan Medical Director or designee:** **Oral Nutritional Products:** Oral nutritional products are not covered unless mandated by law **(see Exclusions)**	Nothing	Nothing

Medical Foods - continued on next page

Benefit Description	You pay	
Medical Foods (cont.)	**Standard**	**Basic**
Enteral nutrition (including administration, supplies and formula) may be considered medically necessary in members with: - Requirement of a feeding tube; and a) Central nervous system injury or disease that results in partial or total inability to take nutrients orally and with functional gastrointestinal tract of sufficient absorptive capacity; or b) Disease or injury (permanent or temporary) that requires the use of a feeding tube in insured individuals: i. Who are malnourished or are at risk of becoming malnourished; and ii. Who have inadequate or anticipated inadequate oral intake for at least 7 days; and iii. In whom the tube feeding provides the primary source of nutrition **Amino acid-based Elemental formula** may be considered to be medically necessary in members age 5 years and younger when all of the following criteria are met: • Medical record documentation of a laboratory or diagnostic test supported diagnosis of one or more of the following: a. Short gut syndrome b. IgE mediated allergies to food proteins c. Food protein induced enterocolitis syndrome d. Eosinophilic esophagitis (EE) e. Eosinophilic gastroenteritis (EG) f. Eosinophilic colitis g. Amino acid, organic acid and fatty acid metabolic and malabsorption disorder h. Cystic fibrosis **and** • Documentation of at least two failed formula alternatives **EXCLUSIONS:** Oral nutrition products and/or supplements **NOT** used to treat inborn errors of metabolism are **NOT COVERED** including, but not limited to: • Formula or Supplements to treat a deficient diet or to provide an alternative source of nutrition in conditions such as, but not limited to, allergies, obesity, hypo- or hyper-glycemia and gastrointestinal disorders; or • Lactose-free foods; or • Banked breast milk; or • Standardized or specialized infant formulas (including over-the-counter infant formulas (such as Similac, Enfamil, etc.)	Nothing	Nothing

Medical Foods - continued on next page

Benefit Description	You pay	
Medical Foods (cont.)	**Standard**	**Basic**
Grocery items and food additives as defined under section V. Additional Definitions or medical food products are **NOT COVERED.** Enteral products for the diagnosis of "failure to thrive" are **NOT COVERED.** Enteral products for the purpose of augmenting normal dietary sources of nutrition are **NOT COVERED.** Digestive enzyme cartridges (e.g. Relizorb) used in conjunction with enteral nutrition therapy is considered to be of unproven benefit and therefore not medically necessary and **NOT COVERED.** **NOTE:** May be considered on a per-case basis through the Program Exception process for Medicaid Business segment members ages 5 years and older with exocrine pancreatic insufficiency who are partially or completely unable to hydrolyze fats in enteral formula. Low-protein modified food products are **NOT COVERED** for inherited errors of metabolism because they do not meet the policy definition of medical foods or nutritional formulas. This information is in accordance with the state mandate. Pennsylvania Mandate does not require coverage for low-protein modified food products such as breads, pasta, pastry shells, and rice pizza shells that can be purchased commercially without a prescription and are used in the dietary management of rare hereditary genetic metabolic disorders such as PKU, branched chain-ketonuria, galactosemia, and homocystinuria.	Nothing	Nothing

Benefit Description	You Pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section.		
Educational classes and programs	**Standard**	**Basic**
Geisinger Health Plan offers case management and health management programs to members with complex medical conditions and chronic health conditions. A specially-trained nurse (Case Manager/ Health Manager) contacts members with targeted health conditions (for example heart failure and pneumonia) after a hospital, rehabilitation, or skilled nursing home admission. Members are also contacted by a case manager/health manager if they have a history of increased inpatient, outpatient, and emergency department utilization. The purpose of all case manager/health manager contacts is to assess and identify areas of impact – including the use of community/social services, medication management, and/or coordination of care with primary and/or specialty provider services.	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You Pay	
Educational classes and programs (cont.)	**Standard**	**Basic**
Diabetes Care Program: Members in the Diabetes Care Program work with a case manager/health manager who provides education on topics such as diet, exercise, medications, routine foot care and ways to improve blood sugar control. They also coordinate treatment changes with the member's primary care provider and facilitate services such as eye exams and kidney screenings to assist members in taking control of diabetes. **Adult and Pediatric Asthma Care Program**: Education is a key factor in the Asthma Care Program. Members learn about medications, proper use and cleaning of inhalers, spacers and nebulizers, and peak flow monitoring. Case managers/health managers help members and their families understand and manage asthma triggers and symptoms with a goal of decreasing acute exacerbations that interfere with normal activities. **Heart Failure (HF) Program:** An ongoing combination of education and follow-up by a case manager teaches members the importance of medications, diet and healthy lifestyle habits, as well as other important ways to improve the management of heart failure. Case managers work with members and their health care team to design an individualized plan of care that manages symptoms and reduces risk for hospitalization. **Chronic Obstructive Pulmonary Disease (COPD) Program:** This program helps members better manage their chronic lung disease (also known as emphysema). GHP nurses focus on medication management, including taking the right medications and using inhalers properly. Other information about exercising, monitoring your condition, and stopping tobacco is stressed. **HeartWise Program:** Managing risk factors and promoting proper medication management is the focus of the HeartWise Program for members with heart disease. Cholesterol and blood pressure management are key aspects of the program. Case managers/health managers provide education about diet and exercise, and coordinate recommended therapies with providers. **Hypertension Program:** Case managers/health managers assist members in learning what they can do to control blood pressure and reduce the risk of developing other health problems that can result from poorly controlled blood pressure.	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You Pay	
Educational classes and programs (cont.)	**Standard**	**Basic**
Osteoporosis Program: Osteoporosis affects both women and men and can have devastating effects. Knowing the impact of diet and exercise, as well as monitoring bone density are important components of this program. A nurse case manager/health manager works with the member and their health care provider to monitor bone density and find the right medications, if needed.	Nothing	Nothing
Tobacco Cessation: including individual/group/ telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. OTC drugs require a physician prescription. **Multicomponent, Family Centered Programs:** focused on childhood obesity that are part of intensive behavioral interventions (behavior change counseling for healthy diet and physical activity)	Nothing for counseling for up to four sessions per quit attempt and up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to four sessions per quit attempt and up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other HealthCare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- **Standard Plan:** calendar year deductible: $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment).
- **Basic Plan:** calendar year deductible: $1,500 per person ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment).
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification .

Benefit Description	You pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.		
Surgical procedures	**Standard**	**Basic**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery)	20% after deductible	30% after deductible

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**Standard**	**Basic**
• Surgical treatment of severe obesity (bariatric surgery) Note: We cover medically necessary bariatric surgery if you are age 18 and over. We limit the covered bariatric procedures to laparoscopic band gastroplasty or roux-en-y gastric bypass (Roux-en-Y). Surgery for morbid obesity must be performed in a participating institution designated by either the American Society of Bariatric Surgery (ASBS) or American College of Surgeons (ACS) as a level 1 Bariatric Surgery Center of Excellence. You must satisfy all medical criteria. Please contact Plan for the complete medical policy. • Insertion of internal prosthetic devices. See 5(a)-Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Ostomy supplies; supplies are covered only for members who have had a surgical procedure which resulted in the creation of a stoma (artificial opening in the body which remains after surgery is completed). Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	20% after deductible	30% after deductible
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot, see Foot Care*	*All charges*	*All Charges*
Reconstructive surgery	**Standard**	**Basic**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas;	20% after deductible	30% after deductible

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**Standard**	**Basic**
- breast prostheses and mastectomy bras and replacements (see *Prosthetic devices*) Gender Affirming services will be covered as long as they are deemed medically necessary, including facial gender affirming surgeries. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Gender Affirming Procedures includes but not limited to the following: - Male to Female: Penectomy, Orchiectomy - Female to Male: Mastectomy (subcutaneous mastectomy or simple/total mastectomy), Nipple/areola reconstruction related to mastectomy, Salpingo-oophorectomy, Vaginectomy, Colpectomy, Hysterectomy Medically necessary Gender Affirming services to improve or correct physiologic function are covered.	20% after deductible	30% after deductible
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Reversal of genital surgery* • *Reversal of surgery to revise secondary sex characteristics*	*All Charges*	*All Charges*
Oral and maxillofacial surgery	**Standard**	**Basic**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Surgery to correct TMJ is covered upon radiological determination of pathology • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	20% after deductible	30% after deductible
• Extraction of partially or totally bony impacted wisdom teeth (third molars).	Nothing	Nothing

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**Standard**	**Basic**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Orthognathic or prognatic surgery only to improve the appearance of a functioning structure*	*All Charges*	*All charges*
Organ/tissue transplants	**Standard**	**Basic**
These **solid organ transplants** are covered. These **solid organ transplants** are subject to medically necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Kidney • Kidney-pancreas • Liver • Lung (single/bilateral) - The Plan would consider lung and lobar transplant medically necessary for the appropriate indications • Pancreas* • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas *We limit coverage for pancreas (only) transplants to members who have had a previous successful kidney transplant	20% after deductible	30% after deductible
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated)	20% after deductible	30% after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard**	**Basic**
- Recurrent germ cell tumors (including testicular cancer)	20% after deductible	30% after deductible
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Hematopoietic Stem Cell Transplant - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g.,Wiskott-Aldrich syndrome)	20% after deductible	30% after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard**	**Basic**
- Stem cell transplant would be considered medically necessary for several inherited disorders of phagocytosis such as (but not limited to) chronic granulomatous disease and hemophagocytic lymphistiocytosis - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	20% after deductible	30% after deductible
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia	20% after deductible	30% after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard**	**Basic**
- Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	20% after deductible	30% after deductible
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma	20% after deductible	30% after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard**	**Basic**
- Advanced non-Hodgkin's lymphoma	20% after deductible	30% after deductible
- Chronic inflammatory demyelination polyneuropathy (CIDP)		
- Multiple myeloma		
- Multiple sclerosis		
- Sickle Cell anemia (would need to be in a clinical trial)		
• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for		
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
- Advanced Hodgkin's lymphoma		
- Advanced non-Hodgkin's lymphoma		
- Breast cancer		
- Chronic lymphocytic leukemia		
- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
- Chronic myelogenous leukemia		
- Colon cancer		
- Multiple myeloma		
- Multiple sclerosis		
- Myelodysplasia/Myelodysplastic Syndromes		
- Non-small cell lung cancer		
- Ovarian cancer		
- Prostate cancer		
- Renal cell carcinoma		
- Sarcomas		
- Sickle cell anemia		
• Autologous Transplants for		
- Advanced childhood kidney cancers		
- Advanced Ewing sarcoma		
- Advanced Hodgkin's lymphoma		
- Advanced non-Hodgkin's lymphoma		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard**	**Basic**
- Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	20% after deductible	30% after deductible
National Transplant Program (NTP)- Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplant services must be ordered by a plan specialist physician and approved by our medical director in advance of the transplant services. The transplant must be performed in Centers of Excellence specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sone discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipients includes coverage for the medical and surgical expenses of a live donor; to the extent that these services are not covered by another plan or program. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We will reimburse travel, meals and lodging expenses for the member and organ donor up to a combined maximum of $5000 per transplant procedure in accordance with Plan guidelines. Daily limit for lodging and meal reimbursements is $200. For information on submitting receipts and the Plan's specific guidelines for reimbursement, contact the Customer Service Team at 844-863-6850. Note: *We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.*	20% after deductible	30% after deductible
Not covered:	*All Charges*	*All Charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard**	**Basic**
• *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*	*All Charges*
Anesthesia	**Standard**	**Basic**
Professional services provided in - • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	20% after deductible	30% after deductible
• Office visit	$20 per PCP office visit	30% after deductible
• Office visit	$35 per SCP office visit	30% after deductible

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)"when it applies. The calendar year deductible is for the Standard Plan: $750 per person ($1500 per Self Plus One enrollment, or $1500 per Self and Family enrollment). The calendar year deductible is for the Basic Plan: $1500 per person ($3000 per Self Plus One enrollment, or $3000 per Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.		
Inpatient hospital	**Standard**	**Basic**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% after deductible	30% after deductible
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood, blood plasma, and other biologicals • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items	20% after deductible	30% after deductible

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**Standard**	**Basic**
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	20% after deductible	30% after deductible
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Blood and blood plasma*	*All Charges*	*All Charges*
Outpatient hospital or ambulatory surgical center	**Standard**	**Basic**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	20% after deductible	30% after deductible
Not covered: • *Blood and blood plasma*	*All Charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**Standard**	**Basic**
Extended care benefit: • Room and board • General nursing care	20% after deductible	30% after deductible
Skilled nursing facility (SNF): A comprehensive range of benefits for short-term stays in a Plan participating skilled nursing facility for up to sixty (60) days per period of confinement when medically necessary. Readmission within six (6) months from discharge for the same condition is considered a continuation of the prior period of confinement.	20% after deductible	30% after deductible
Not covered: Custodial, domiciliary or convalescent care	*All Charges*	*All Charges*

Benefit Description	You pay	
Hospice care	**Standard**	**Basic**
You are eligible for supportive and palliative care. Services include inpatient and outpatient care, family counseling and medical social services. Services are provided under the direction of your primary care doctor who certifies the terminal stage of illness with a life expectancy of six (6) months or less.	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All Charges*	*All Charges*
End of life care	**Standard**	**Basic**
Hospice/palliative care • Members are eligible for supportive and palliative care. Services include inpatient and outpatient care, family counseling and medical social services. Services are provided under the direction of the member's primary care provider who certifies the terminal stage of illness with a life expectancy of six (6) months or less. (member pays nothing) • Advance care planning is also provided at no charge by GHP's Case Management team including advanced directives, living wills, and POLST. Case Managers are available to coordinate services between Primary Care, specialty care, palliative care and hospice to support the Member and family.	Nothing	Nothing
Ambulance and Ancillary PCP	**Standard**	**Basic**
Local professional urgent/emergent ambulance service when medically necessary. Inpatient ancillary PCP	Nothing	Nothing

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Standard Plan:** calendar year deductible: $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment).
- **Basic Plan:** calendar year deductible: $1,500 per person ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area

In an emergency situation, you should call an emergency information center or safely proceed immediately to the nearest Emergency Services Health Care Provider. Emergency services do not require preauthorization or a referral from your PCP. If the emergency service results in hospitalization, the Emergency Services Health Care Provider is responsible to notify the Plan within 48 hours or the next business day. Medically necessary follow up care with a participating provider must be authorized in advance by your PCP for it to be covered by us. Medically necessary follow up care by non-participating providers must be authorized in advance by the Health Plan. For your PCP's phone number, please refer to the front of your ID card or contact our Customer Service Team at 1-844-863-6850 (TDD 1-800-447-2833).

Emergencies outside our service area

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

Benefit Description	You pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.		
Emergency within our service area	**Standard**	**Basic**
• Emergency care at a primary care doctor's office	$20 per PCP office visit	30% after deductible for doctor's office
• Emergency care at a doctor's office	$35 per SCP office visit	30% after deductible for doctor's office
• Emergency care at an urgent care center	$20 urgent care visit	30% after deductible for urgent care
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital directly from the emergency room. ER copay is not waived if you are placed in observation status.	$150 ER copay	$250 ER copay

Emergency within our service area - continued on next page

Benefit Description	You pay	
Emergency within our service area (cont.)	**Standard**	**Basic**
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
• Follow-up care recommended by plan providers that has not been authorized in advance by members PCP or by non-plan providers that has not been approved by the Health Plan.	*All Charges*	*All Charges*
Emergency outside our service area	**Standard**	**Basic**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital directly from the emergency room. ER copay is not waived if you are placed in observation status.	Same as for Emergency care within our service area	Same as for Emergency care within our service area
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges*	*All Charges*
Ambulance	**Standard**	**Basic**
Professional ambulance service when medically necessary, including air transport (LifeFlight) Note: See 5(c) for non-emergency service.	Nothing	Nothing

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **Standard Plan:** calendar year deductible: $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section.We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Basic Plan:** calendar year deductible: $1,500 per person ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment).
- The calendar year deductible applies to almost all benefits in this Section.We added "(No deductible)" to show when the calendar year deductible does not apply.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefits Description	You Pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.		
Professional services	**Standard**	**Basic**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	$20 group therapy session/$20 individual therapy visit	30% after deductible

Professional services - continued on next page

Benefits Description	You Pay	
Professional services (cont.)	**Standard**	**Basic**
• Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 group therapy session/$20 individual therapy visit	30% after deductible
• Facility-based intensive outpatient treatment	$20 per session	30% after deductible
Diagnostics	**Standard**	**Basic**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	20% after deductible	30% after deductible
Inpatient hospital or other covered facility	**Standard**	**Basic**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	20% after deductible	30% after deductible
Outpatient hospital or other covered facility	**Standard**	**Basic**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment.	20% after deductible	30% after deductible
Autism Spectrum Disorder	**Standard**	**Basic**
Care provided to members for the treatment of autism spectrum disorders (as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and Pervasive Development Disorder not otherwise specified.), which includes pharmacy, psychiatric and psychological, rehabilitative and therapeutic care. *EXCLUSIONS.* *Psychiatric Care Services, Psychological Care Services and Rehabilitative Care Services obtained from Providers who do not participate in the Plan's Designated Behavioral Health Program are* Not Covered.	20% after deductible	30% after deductible

Autism Spectrum Disorder - continued on next page

Benefits Description	You Pay	
Autism Spectrum Disorder (cont.)	**Standard**	**Basic**
Pharmacy Care Services obtained from non–Participating Pharmacy Providers are Not Covered. *Therapeutic Care Services obtained from a Non-Participating Provider are* Not Covered.	20% after deductible	30% after deductible
Pharmacy care	Copayment per outpatient prescription drug (See Section 5(f))	Copayment per outpatient prescription drug (See Section 5(f))
Psychiatric and Psychological care: direct or consultative services provided by a psychiatrist or psychologist.	$20 individual therapy session/ $20 group therapy session	30% after deductible
Habilitative/Rehabilitative Care: Professional services and treatment programs, including applied behavioral analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.	$35 per day	30% after deductible
Therapeutic Care: Includes services provided by speech pathologists, occupational therapists or physical therapists.	$35 per day	30% after deductible

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- There is no calendar year deductible for Prescription drug benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Covered medications and supplies: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit. (See page 40).

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice, must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a plan participating pharmacy, or for maintenance medications by mail using a participating mail order pharmacy.
- **We use a formulary.** The purpose of our formulary is to optimize patient care through appropriate selection and use of drugs that ensure quality, cost-effective prescribing. Our formulary is a collaboration of input from practicing physicians and pharmacists. Medications in all therapeutic classes have been reviewed for effectiveness, safety and cost. Our formulary is based on a three-tier structure:
  - Tier One: Includes most generic drugs and these medications generally do not require preauthorization to be covered.
  - Tier Two: Includes certain formulary brand name drugs that do not have a generic equivalent. Preauthorization may be required for certain drugs in Tier Two in order to be covered.
  - Tier Three: Includes certain formulary brand name drugs with a generic equivalent and non-formulary brand name drugs. Preauthorization is required for certain drugs in Tier Three in order to be covered.
  - Tier Four: Includes certain high cost/specialty medications. Preauthorization is required for certain drugs in Tier Four in order to be covered. Call customer service at 844-863-6850 for a list of these medications.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan participating or referral physician and obtained at a Plan participating pharmacy will be dispensed for up to a 34-day supply per prescription or refill. Prescribed maintenance medication can be ordered using our mail order participating pharmacy. You get a 90-day supply for two times the copayment plus the convenience of having the medications delivered right to your home.
- The Health Plan has developed a **Specialty Vendor Medication Program** which is utilized to help manage certain high-cost and/or limited-access pharmaceuticals, such as injectable and biologic products. Typically, these agents require precertification and must be filled through our contracted Specialty Pharmacy network. Quantity limits often apply. For a complete list of products, please contact the Pharmacy Services Department at 1-800-988-4861.
- Geisinger Health Plan implemented a **Site of Care** program for select injectable drugs when obtained through home infusion. There will be no cost share to members receiving select injectable drugs when obtained through home infusion. For 1/1/21, the list of select injectable drugs has expanded. Patients receiving Intravenous immunoglobulin (IVIG), Actemra, Benlysta, Entyvio, Orencia, Simponi Aria, Prolia, and Xgeva for infusion at hospital-owned infusion sites will be transitioned to home-based or provider office based infusions at their next authorization.

- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA approved generic drug is available, and your physician has not specified Dispensed as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs are the chemical equivalent of a corresponding brand name drug and is less expensive cost which may reduce your out-of-pocket prescription drugs costs.
- **When you do have to file a claim.** Normally, you won't have to submit a claim to us for prescriptions. In the event you are required to make a payment in excess of your required prescription copayment at the time your prescription is filled, we will reimburse you by check. Simply request a claim form from our Customer Service Team at 844-863-6850. Send us your receipt, including your Member ID Number as soon as possible. You must submit claims by December 31 in the year following the year in which the prescription was filled. Refer to *Section 7. Filing a claim for covered services.*

Benefit Description	You pay	
Covered medications and supplies	**Standard**	**Basic**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Plan approved diabetic supplies and pharmacological agents, or devices used to assist in insulin injection (injection aids) including insulin syringes and needles, lancets, and blood glucose test strips (members will now pay one copay based on days' supply regardless of the number of strips, quantity limit for blood glucose test strips is 6.67 per day) • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • With prior authorization opoid doses greater than or equal to 120mg morphine equivalent daily dose. • Nasal Naloxone without quantity limits. • Oral forms of suboxone, buprenorphine, and buprenorphine/naloxone no longer require prior authorization. Note: The Health Plan has developed a Specialty Vendor Medication Program which is utilized to help manage certain high-cost and/or limited-access pharmaceuticals, such as injectable and biologic products. Typically these agents require precertification and must be filled through our contracted Specialty Pharmacy network. Quantity limits often apply. For a complete list of products, please contact the Pharmacy Services Department at 800-988-4861.	At a participating retail pharmacy for up to a 34-day supply per prescription or refill: • 30% of the cost for generic (minimum $5, maximum $15) • 40% of the cost for preferred brand (minimum $40, maximum $120) • 50% of the cost for non-preferred brand (minimum $60, maximum $180) • 50% of the cost for certain high cost/specialty drugs (minimum $85, maximum $250) From a participating mail order pharmacy for a 90-day supply per prescription or refill: • 30% of the cost for generic (minimum $10, maximum $30) • 40% of the cost for preferred brand (minimum $80, maximum $240) • 50% of the cost for non-preferred brand (minimum $120, maximum $360)	At a participating retail pharmacy for up to a 34-day supply per prescription or refill: • 30% of the cost for generic (minimum $5, maximum $15) • 40% of the cost for preferred brand (minimum $40, maximum $120) • 50% of the cost for non-preferred brand (minimum $60, maximum $180) • 50% of the cost for certain high cost/specialty drugs (minimum $85, maximum $250) From a participating mail order pharmacy for a 90-day supply per prescription or refill: • 30% of the cost for generic (minimum $10, maximum $30) • 40% of the cost for preferred brand (minimum $80, maximum $240) • 50% of the cost for non-preferred brand (minimum $120, maximum $360)

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**Standard**	**Basic**
	• 50% of the cost for certain high cost/specialty drugs (minimum $170, maximum $500) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	• 50% of the cost for certain high cost/specialty drugs (minimum $170, maximum $500) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
• Select injectible drugs (medical)	$150 copay ($1,500 annual maximum)	$150 copay ($1,500 annual maximum)
Infertility Drug Coverage -Clomiphene citrate (Clomid or Serophene) (Oral) - Human chorionic gonadotropin(hCG), Novarel, Ovidrel, chorionic gonadotropin 10000 unit Intramuscular Solution (Injectable) - Follicle-stimulating hormone (FSH), Follistim, and Gonal-F (Injectable) - Human menopausal gonadotropin (hMG), Menopur (Injectable) - Gonadotropin-releasing hormone agonist (GnRH agonist) leuprolide acetate (Injectable) - Gonadotropin-releasing hormone antagonist (GnRH antagonist) cetrorelix acetate (Injectable) **Please note: There is no maximum lifetime benefit associated for Artificial Insemination (AI) drugs. In vitro fertilization (IVF) related infertility drugs are limited to three (3) cycles per year.** **Please note: Prescription drugs must be prescribed by a Plan participating or referral physician and obtained at a Plan participating pharmacy.**	At a participating retail pharmacy for up to a 34-day supply per prescription or refill: • 30% of the cost for generic (minimum $5, maximum $15) • 40% of the cost for preferred brand (minimum $40, maximum $120) • 50% of the cost for non-preferred brand (minimum $60, maximum $180) • 50% of the cost for certain high cost/specialty drugs (minimum $85, maximum $250) From a participating mail order pharmacy for a 90-day supply per prescription or refill: • 30% of the cost for generic (minimum $10, maximum $30) • 40% of the cost for preferred brand (minimum $80, maximum $240) • 50% of the cost for non-preferred brand (minimum $120, maximum $360)	At a participating retail pharmacy for up to a 34-day supply per prescription or refill: • 30% of the cost for generic (minimum $5, maximum $15) • 40% of the cost for preferred brand (minimum $40, maximum $120) • 50% of the cost for non-preferred brand (minimum $60, maximum $180) • 50% of the cost for certain high cost/specialty drugs (minimum $85, maximum $250) From a participating mail order pharmacy for a 90-day supply per prescription or refill: • 30% of the cost for generic (minimum $10, maximum $30) • 40% of the cost for preferred brand (minimum $80, maximum $240) • 50% of the cost for non-preferred brand (minimum $120, maximum $360)

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**Standard**	**Basic**
	• 50% of the cost for certain high cost/specialty drugs (minimum $170, maximum $500) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	• 50% of the cost for certain high cost/specialty drugs (minimum $170, maximum $500) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Site of Care program: Patients receiving Intravenous immunoglobulin (IVIG), Actemra, Benlysta, Entyvio, Orencia, Simponi Aria, Prolia, Xgeva Aldurazyme, Cerezyme, Fabrazyme, Lumizyme, Naglazyme, Cimzia, Ilaris, Ilumya, Stelara(J3357, SQ Injection), Vyepti IV CGRP (Migraine) for infusion at hospital-owned infusion sites will be transitioned to home-based or provider office based infusions at their next authorization. There will be no cost share to members receiving these select injectable drugs when obtained through home infusion.	Nothing when receiving these select injectable drugs through home infusion.	Nothing when receiving these select injectable drugs through home infusion.
Contraceptive drugs and devices as listed in the ACA/ HRSA site. Contraceptive Coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. (such as Depo Provera, diaphragms, and contraceptive rings) • All Food and Drug Administration (FDA) approved contraceptives are covered as part of the benefit. • Reimbursement for over-the-counter contraceptives can be submitted by filling the contraceptive at an in-network pharmacy with a prescription from your physician. Reimbursement for over-the-counter contraceptives obtained without a prescription is available by completing and submitting the Pharmacy Claims Reimbursement Form available from geisinger.org/ health-plan. Note: The "morning after pill" is an over-the-counter (OTC) emergency contraceptive drug. It's considered a preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy.	$0 for generic and brands with no generic equivalent; all others follow normal prescription copays	$0 for generic and brands with no generic equivalent; all others follow normal prescription copays
• Human Growth Hormone	20% of charges per prescription unit or refill	20% of charges per prescription unit or refill

Benefit Description	You pay	
Preventive care medications	**Standard**	**Basic**
The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 • Liquid iron supplements for children age 0-1year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 Note: To receive this benefit, a prescription from a doctor must be presented to pharmacy.	Nothing	Nothing
Not covered: • Drugs and supplies for cosmetic purposes • Drugs to enhance athletic performance • Experimental and investigational drugs not approved by the FDA • Prescription drugs for weight loss • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Dietary supplements not listed as a covered benefit, Vitamins (except prescription prenatal and Vitamin D for adults 65 and older as required by the Affordable Care Act), anabolic steroids, blood plasma product, irrigation solutions, nutrients and food supplements even if a physician prescribes or administers them • OTC medications (except prescription medications due to healthcare reform). Contact the Plan at 844-863-6850 for a list. • Fertility drugs (covered in Section 5(a) as a medical benefit). • Nonprescription medications	Not covered	Not Covered

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Contact Plan for access to these covered services.
- The Standard Option calendar year deductible is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). The Basic Option calendar year deductible is $1,500 per person ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment). The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Note: The calendar year deductible applies to certain Standard Option benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.		
Accidental injury benefit	**Standard**	**Basic**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury (not chewing or biting).	20% after deductible	30% after deductible
Not covered: • *Implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth*	*All charges*	*All charges*

Dental benefits

We have no other dental benefits.

Section 5(h). Wellness and Other Special Features

Feature	Description
24 hour nurse line	For any of your health concerns, you can call Tel-A-Nurse 24 hours a day, 7 days a week at the number set forth on your Member Identification Card. You will talk with a registered nurse who will discuss treatment options and answer your health questions. Tel-A-Nurse is not an authorized agent for the determination of benefits or appointment scheduling. Tel-A-Nurse also provides Members access to an audio library of over 200 medical topics of interest. You can access this service using the same toll free number.
Services for deaf and hearing impaired	Geisinger Health Plan has an access line for deaf and hearing-impaired Members. This toll free number is set forth on the back of your Member Identification Card.
Centers of excellence	Our provider directory lists all Plan participating providers and facilities, including transplant centers outside of our service area. Your primary care provider will arrange any necessary transplant procedures you may need.
Travel benefit/services overseas	Twenty-four hour emergency coverage worldwide.
Health Coaching	Work with a Geisinger health coach to set individualized health and wellness goals that fit your lifestyle. The benefits of health coaching are provided at no additional cost. You have access to unlimited health coaching sessions to monitor your progress and to stay accountable and motivated. Enroll today and gain the support and encouragement you need to reach your goals. To learn more or to schedule an appointment, contact Geisinger Health and Wellness at 866-415-7138.

Non-FEHB benefits available to Plan members

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

Accessories Program:

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

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

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

Your health plan may already cover some of these services for which a discount is available through the Accessories program. You should exhaust your covered benefits first before taking advantage of the Accessories Program. Contact our Customer Service Team at 844-863-6850 for questions on the wonderful benefits of our Accessories Program or visit www.thehealthplan.com.

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

Section 6. General Exclusions - Services, Drugs and Supplies We Do Not Cover

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs and research costs for clinical trials are not covered.
- Surrogate Services. Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments and pre-natal/delivery/post-natal services are NOT COVERED.
- Private nursing
- Cosmetic surgery. Restorative or reconstructive surgery performed for cosmetic purposes which is not expected to result in significantly improved physiological function (not psychological) as determined by the plan.
- Psychiatric Care Services, Psychological Care Services Rehabilitative Care Services obtained from providers who do not participate in the Plan's Designated Behavioral Health Program are NOT COVERED.
- Pharmacy Care Services obtained from a non-participating Plan provider are NOT COVERED.
- Therapeutic Care Services obtained from a non-participating Plan provider are NOT COVERED.
- Services or supplies we are prohibited from covering under the Federal Law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 844-863-6850 or at our website at www.thehealthplan.com.

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

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

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

Submit your claims to:

Geisinger Health Plan

Claims Department

P.O. Box 853910

Richardson, TX 75085-3910

Prescription drugs

Submit your claims to:

Geisinger Health Plan

Claims Department

P.O. Box 853910

Richardson, TX 75085-3910

Other supplies or services

Submit your claims to:

Geisinger Health Plan

Claims Department

P.O. Box 853910

	Richardson, TX 75085-3910
Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the following year after you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The Disputed Claims Process

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

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

To help you prepare your appeal, you may contact us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to Geisinger Health Plan, 100 North Academy Avenue, Danville, PA 17822 or calling 844-863-6850.

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: 1. Write to us within 6 months from the date of our decision; and 2. Send your request to us at: Geisinger Health Plan, Appeals Department, 100 North Academy Avenue, Danville, PA 17822-3220; and 3. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and 4. Include a copy of your insurance ID card, copies of documents that support your claim, such as a copy of your plans first appeal denial letter, physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. 5. Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or

c) Ask you or your provider for more information

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

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

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

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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

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

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 844-863-6850 . We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website www.TheHealthPlan.com.

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

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

When FEHB plans pay secondary Coordination of Benefits (COB) claims, including those with Medicare, they pay the lesser of their allowance less paid by the primary plan or primary plan allowance less paid by the primary plan. FEHB will not pay more than the FEHB allowance. You may continue to charge the member copayments or coinsurance on secondary COB claims. If your benefit design includes coinsurance, it must be based on the remaining charge, not on your allowance.

TRICARE and CHAMPVA

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

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

Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP) the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

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

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

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

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. Your provider will then need to submit an explanation of Medicare payment to the plan and we will provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 844-863-6850 or see our website at www.thehealthplan.com.

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

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

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

- Inpatient hospital deductible and coinsurance

If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

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

- Calendar year deductible;
- Coinsurance for services and supplies provided by physicians and other covered healthcare professionals (inpatient and outpatient);

- Copayments for office visits

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. Your provider will then need to submit an explanation of Medicare payment to the plan and we will provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 844-863-6850 or see our website at www.thehealthplan.com.

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

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment. **When Medicare Part A is primary**, we will waive our:

- Inpatient hospital deductible and coinsurance

If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

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

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

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

Benefit Description: Deductible
High Option You pay **without** Medicare: $750
High Option You **with** Medicare Part B: $0

Benefit Description: Out-of-Pocket Maximum
High Option You pay **without** Medicare: $5,000 Self Only/$10,000 Family
High Option You **with** Medicare Part B: $5,000 Self Only/$10,000 Family

Benefit Description: Part B Premium Reimbursement Offered
High Option You pay **without** Medicare: N/A
High Option You **with** Medicare Part B: Up to $120

Benefit Description: Primary Care Provider
High Option You pay **without** Medicare: $20
High Option You **with** Medicare Part B: Up to $0

Benefit Description: Specialist
High Option You pay **without** Medicare: $35
High Option You **with** Medicare Part B: Up to $0

Benefit Description: Inpatient Hospital
High Option You pay **without** Medicare: 20% after deductible
High Option You **with** Medicare Part B: Up to $0

Benefit Description: Outpatient Hospital
High Option You pay **without** Medicare: 20% after deductible
High Option You **with** Medicare Part B: Up to $0

Benefit Description: Incentives Offered
High Option You pay **without** Medicare: N/A
High Option You **with** Medicare Part B: N/A

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) or at www.medicare.gov.

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

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

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

	Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.
• **Medicare prescription drug coverage (Part D)**	When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

·Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.

·OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

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

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

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

Coinsurance

See section 4 page 23.

Copayment

See Section 4, page 23.

Covered services

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

Custodial Care

Services to assist individuals in the activities of daily living not requiring continuing attention of skilled, trained medical or paramedical personnel.

Deductible

See Section 4, page 23.

Experimental or investigational service

Services we determine, at our sole discretion, to be experimental, investigational or unproven and the associated covered services related to them. The fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if it is considered experimental, investigational or unproven.

Group health coverage

The employer, union or trust through which the member is enrolled.

Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Infertility	The term **infertility** used in this document, is a person unable to conceive or produce conception after one year of egg-sperm contact when the individual attempting conception is under the age of 35, or after six months egg-sperm contact when the individual attempting conception is 35 years of age or older. Infertility may be due to natural dysfunction (congenital), as a sequelae of another physical condition or disease (secondary), or as a result of surgery, radiation, chemotherapy, gender transition or other medical treatment affecting reproductive organs or processes.
Maximum out-of-pocket	The maximum out-of-pocket is the annual limit that a member or family unit will be required to pay for covered services. This limit includes deductible, coinsurance and copayments (medical and prescription). Non-covered services are not included in this limit.
Medical necessity	Medical Necessity or Medically Necessary means covered services rendered by a healthcare provider that we determine to be appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury in accordance with current standards of medical practice and not primarily for the convenience of the Member or Member's healthcare provider.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise Bill	An unexpected bill you receive for • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.

Us/We	Us and We refer to Geisinger Health Plan
You	You refers to the enrollee and each covered family member.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve pre-service claims and not post-service claims. We will evaluate whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 844-863-6850. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits for the Standard Option of Geisinger Health Plan - 2024

- **Do not rely on this chart alone.** This is a summary. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.TheHealthPlan.com/federal.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $750 per person ($1,500 per family) calendar year deductible for the Standard Option.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $20 PCP, $35 SCP	29
Services provided by a hospital: Inpatient	20% after deductible	53
Services provided by a hospital: Outpatient	20% after deductible	54
Emergency benefits: In-area	$150 per visit; waived if admitted	56
Emergency benefits: Out-of-area	$150 per visit; waived if admitted	57
Mental health and substance use disorder treatment:	Regular cost-sharing	58
Prescription drugs: Retail pharmacy (At a participating retail pharmacy for up to a 34- day supply per prescription or refill)	30%/40%/50%/50% $5/$40/$60/$85 minimum; $15/$120/$180/$250 maximum	61
Prescription drugs: Mail order (From a participating mail order pharmacy for a 90-day supply per prescription or refill)	30%/40%/50%/50% $10/$80/$120/$170 minimum; $30/$240/$360/$500 maximum	61
Dental care	20% after deductible	65
Vision care: Refractions	$0	36
Wellness and Other Special features	24-hour nurse hotline, telemedicine, services for deaf and hearing impaired, centers of excellence, travel benefit/services overseas, health coaching	66
Protection against catastrophic costs (maximum out-of-pocket):	$5,000 Self Only/$10,000 Self Plus One or Self and Family	23-24

Summary of Benefits for the Basic Option of Geisinger Health Plan - 2024

- **Do not rely on this chart alone.** This is a summary. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.TheHealthPlan.com/federal.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $1,500 per person ($3,000 per family) calendar year deductible for the Basic Option.

Basic Option Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	30% after deductible	29
Services provided by a hospital: Inpatient	30% after deductible	53
Services provided by a hospital: Outpatient	30% after deductible	54
Emergency benefits: In-area	$250 per visit; waived if admitted	56
Emergency benefits: Out-of-area	$250 per visit; waived if admitted	57
Mental health and substance use disorder treatment:	Regular cost-sharing	58
Prescription drugs: Retail pharmacy (At a participating retail pharmacy for up to a 34-day supply per prescription or refill)	30%/40%/50%/50% $5/$40/$60/$85 minimum; $15/$120/$180/$250 maximum	61
Prescription drugs: Mail order (From a participating mail order pharmacy for a 90-day supply per prescription or refill)	30%/40%/50%/50% $10/$80/$120/$170 minimum; $30/$240/$360/$500 maximum	61
Dental care	30% after deductible	65
Vision care: Refractions	$0	36
Wellness and Other Special features	24-hour nurse hotline, telemedicine, services for deaf and hearing impaired, centers of excellence, travel benefit/services overseas, health coaching	66
Protection against catastrophic costs (maximum out-of-pocket):	$8,550 Self Only/ $17,100 Self Plus One of Self and Family	23- 24

2024 Rate Information for Geisinger Health Plan

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Pennsylvania					
Standard Option Self Only	GG4	$271.43	$158.88	$588.10	$344.24
Standard Option Self Plus One	GG6	$586.50	$343.28	$1,270.75	$743.77
Standard Option Self and Family	GG5	$646.18	$339.02	$1,400.06	$734.54
Pennsylvania					
Basic Option Self Only	AJ1	$271.43	$117.79	$588.10	$255.21
Basic Option Self Plus One	AJ3	$586.50	$254.49	$1,270.75	$551.40
Basic Option Self and Family	AJ2	$646.18	$244.94	$1,400.06	$530.70