Geisinger Quality Options
PPO Premier $6,000 Plan
Summary of Benefits

	Preferred Provider	Non-Preferred Provider
Deductible	$6,000 single $12,000 family	$6,500 single $13,000 family
Deductible must be satisfied every coverage period before coinsurance applies.		
Copayments do not apply to the deductible.		
Coinsurance	0%	30%
Coinsurance Maximum	$0 single $0 family	$6,000 single $12,000 family
Deductible does not apply to coinsurance maximum.		
Maximum Out of Pocket	$8,550 single $17,100 family	$0 single $0 family
Lifetime Benefit	Unlimited	Unlimited

SERVICES covered when medically necessary	Preferred Provider You Pay	Non-Preferred Provider You Pay *
Outpatient Services		
PCP office visits.	$20	30% after deductible
Specialist office visit.	$40	30% after deductible
Periodic health assessments/routine physicals.	$0	30% after deductible
Outpatient surgery.	0% after deductible	30% after deductible
Preventive Services. For a Full list of preventive services refer to: https://www.healthcare.gov/what-are-my- preventive- care-benefits. All PPACA Preventive Services including but not limited to:		
Mammograms.	$0	30% after deductible
Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel.	$0	30% after deductible
Pap smears.	$0	30% after deductible
Chlamydia screening for females ages 16-25.	$0	30% after deductible
Dexa scan.	$0	30% after deductible
Fecal occult blood testing.	$0	30% after deductible
Cholesterol screening.	$0	30% after deductible
Diabetes care including HbA1c testing, LDL-C screening and nephropathy screening.	$0	30% after deductible
Lipid panel.	$0	30% after deductible
Newborn screening: one hematocrit and hemoglobin screening for infants under 24 months.	$0	30% after deductible
Colorectal Cancer Screening		
Colorectal cancer screening, limited to flexible sigmoidoscopy, colonoscopy and related services covered 100%. Note: preparation medication is not covered under the medical benefit. However, preparation medication may be covered under your pharmacy benefit, which will be subject to your normal pharmacy benefit cost-sharing.	$0	30% after deductible
Well-Child Services		
Well-child office visits (age 0-21)	$0	30% after deductible
Testing Services		
X-rays, laboratory and other diagnostic tests.	0% after deductible	30% after deductible

Computed Axial Tomography (CAT Scan), Magnetic Resonance Imaging (MRI), and Position Emission Tomography (PET Scan), Magnetic Resonance Angiography (MRA) and nuclear cardiology.	0% after deductible	30% after deductible
All Other Diagnostic Services		
Ostomy supplies.	0% after deductible	Not Covered
Medically necessary urological supplies.	0% after deductible	Not Covered
Other diagnostic services.	0% after deductible	30% after deductible
Well-Woman Care		
Annual gynecological examination.	$0	30% after deductible
Maternity Care		
Maternity Hospitalization. Limit: 90 inpatient days per benefit year when services are performed by a non-preferred provider.	0% after deductible	30% after deductible
Maternity care by your physician before and after the birth of your baby. No referral required for In-Network benefits.	$0	30% after deductible
Hospitalization		
Care in a semi-private room at a participating facility. Includes intensive care, cardiac care unit services, obstetrical care, newborn care, transplant services, medications and diagnostic tests. Limit: 90 inpatient days per benefit year when services are performed by a non-preferred provider.	0% after deductible	30% after deductible
Medical and surgical specialist care, including anesthesia.	0% after deductible	30% after deductible
Surgery for Correction of Obesity		
Facility charges.	$2,000 (does not apply to out-of-pocket maximum)	Not covered
Professional charges.	0% after deductible	Not covered
Emergency Services		
Emergency care.	$150 (waived if admitted to hospital)	$150 (waived if admitted to hospital)
Ambulance service to and from hospital.	$0	$0
Critical response air transport.	$0	$0
Urgent care.	$20	$20
Rehabilitation Services..		
Physical therapy for back pain, limited to 2 series of 5 visits each, per benefit period.	$40 per series	Not covered
Spinal injections for back pain	30% coinsurance	Not covered
Physical, Occupational and Speech Therapy	$40	30% after deductible
Cardiac rehabilitation, outpatient, up to 36 sessions/benefit year.	$0	30% after deductible
Pulmonary rehabilitation benefit, outpatient, limit to 36 sessions per benefit year	$0	30% after deductible
Diabetes Services and Supplies[1]		
Diabetic eye examination.	$0	30% after deductible
Prescription/supply coverage: Lifescan test strips (One-Touch, One-Touch Ultra, Surestep and FastTake) and lancets are covered. The following may be limited to specific vendors: insulin, syringes and needles for the administration of insulin only, oral agents used to control blood sugar (1 copayment/34 day supply) and Glucagon emergency kit (two per copayment). Mail order discount does not apply.	Tier 1: $25 for 34-day supply Tier 2: $50 for 34-day supply Tier 3: $70 for 34-day supply	Not Covered
Diabetic foot orthotics.	0% after deductible	Not covered
Home blood glucose monitors: Lifescan brand diabetic supplies only. Must be purchased at a participating pharmacy.	$0	Not covered
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	$0	Not covered
[1]*The Plan reserves the right to restrict vendors and apply quantity limitations.*		
Skilled Nursing/Home Health Services.		
Short-term, non-custodial medical care in a licensed, skilled nursing facility, as approved by a Plan physician and the Plan, for up to 60 days.	0% after deductible	30% after deductible
Home health care	$0	30% after deductible
Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.	$0	30% after deductible
Implanted Devices (medical and contraceptive)		
Drug delivery.	50%	
Contraceptives	$0	50% plus 30% coinsurance

Specialty Drugs		
For select high-cost specialty drugs. $1,500 maximum out-of-pocket per benefit year.	$150 copay per injection/infusion	30% after deductible
Durable Medical Equipment		
Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.	$0	Not covered
Prosthetic Devices		
Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.	$0	Not covered
Orthotic Devices		
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	50% coinsurance	Not covered
Impacted Wisdom Teeth Extraction		
Oral surgery by participating provider for extraction of partially or totally bony impacted third molars. Service covered in the physician's office. Hospital and ambulatory surgical center services are not covered.	$0	Not covered
Alcohol and Drug Abuse Treatment..[2]		
Inpatient detoxification. Limit: 90 inpatient days per benefit year when services are performed by a non-preferred provider.	0% after deductible	30% after deductible
Non-hospital residential inpatient rehabilitation. Limit: 90 inpatient days per benefit year when services are performed by a non-preferred provider.	0% after deductible	30% after deductible
Outpatient rehabilitation at an alcoholism/drug abuse facility.	$20 individual therapy session /$20 group therapy session	30% after deductible
[2]No PCP referral required. Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839- 7972 for more information. Pre-authorization is required for all services except routine outpatient visits.		
Outpatient Opioid Detoxification Treatment...[3]		
Subutex and Suboxone are covered as part of this treatment if the member has a GHP drug rider. If the member does not have a GHP drug rider, the detox sessions are covered but Subutex or Suboxone are not covered.	0% after deductible	30% after deductible
[3]No PCP referral required. Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839- 7972 for more information. Pre-authorization is required for all services except routine outpatient visits.		
Mental Health...[4]		
Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional.	$20 individual therapy session /$20 group therapy session	30% after deductible
[4]Services must be provided by facilities participating with the Plan's behavioral health manager. Call(888) 839-7972 for more information. Pre-authorization is required for all services except routine outpatient visits.		
Serious Mental Illness (SMI) Rider...[5]		
Care provided for the following serious mental illnesses: schizoprenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. Care for these conditions by a participating provider facility.	0% after deductible/inpatient facility 0% after deductible/inpatient professional visit 0% after deductible/partial hospitalization day	30% after deductible
[5]Services must be provided by facilities participating with the Plan's behavioral health manager. Call(888) 839-7972 for more information. Pre-authorization is required for all services except routine outpatient visits.		
Non-Serious Mental Illness Rider...		
Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulemia nervosa, schizo-affective disorder and delusional disorder. Care for acute short-term psychiatric conditions in a participating provider facility: No PCP referral required. Services must be provided by facilities participating with the Plan's behavioral health manager. You must receive pre-authorization by calling(888) 839-7972.	0% after deductible/ inpatient facility 0% after deductible/inpatient professional visit 0% after deductible/partial hospitalization per day	30% after deductible
[*]Covered services provided by a non-preferred provider will be based on the PPO's "non-preferred provider fee schedule." This may subject the member to significant out-of-pocket expenses for services received from a non-preferred provider. Emergency care or covered services not available from a preferred provider and approved by the Health Plan are NOT subject to this fee schedule.		

Additional Services	Preferred Provider You Pay	Non-Preferred Provider You Pay *
Autism Spectrum Disorder Rider[6]		
Care provided for members under 21 years of age for the treatment of autism spectrum disorders (as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental disorders (DSM), or its successor including autistic disorder, Asperger's disorder and Pervasive Development Disorder not otherwise specified.) which includes, pharmacy, psychiatric and psychological, rehabilitative and therapeutic care.		
Pharmacy care	Copayment per outpatient prescription drug rider or 50% coinsurance for members with no prescription drug benefit	Not Covered
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
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.	$40 per day	30% after deductible
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	$40 per day	30% after deductible
[6] For psychiatric, psychological and rehabilitative care, services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839-7972 for more information. Pre-authorization is required for all services except routine outpatient visits.		
Triple Choice Option for Outpatient Prescription Drugs[7]		
34-day supply per copayment for outpatient prescription drugs from a participating pharmacy. Most covered drugs are listed on the formulary, a continually updated list of commonly covered drugs. Each drug assigned to a tier. Tier 1: most generic drugs; prior authorization is generally not required. Tier 2: certain generic drugs and formulary brand name drugs with no generic equivalent; prior authorization may be required. Tier 3: some formulary brand name drugs with generic equivalents and other brand name drugs, including some not listed on the formulary; it may include certain generic drugs; prior authorization may be required. Provider must request prior authorization. For information call Pharmacy Services at (800) 988-4861.	Tier 1: $25 for 34-day supply Tier 2: $50 for 34-day supply Tier 3: $70 for 34-day supply	Not Covered
Contraceptives; includes diaphragms.	Copayment amount depends on tier for 30-day supply	Not covered
Mail Order Pharmacy. Prescriptions can be received through the mail by using the PPO's mail order pharmacy program. A doctor's prescription, copayment and completed form is required.	2 flat copay amount(s) depending on tier/90-day supply	Not covered
[7]The Plan reserves the right to restrict vendors and apply quantity limitations.		
Select Free Generic Drug Program		
Members will pay a $0 copay for certain generic drugs as part of Tier 1. All other Tier 1 drugs will have applicable copay applied. Deductible applies first, if applicable.	$0	Not covered
Manipulative Treatment Services Rider		
Direct access to participating providers for chiropractic services which may include patient exams, manipulation, adjunctive therapy and X-rays. Chiropractic appliances covered up to $50 per benefit year when prescribed by a participating provider. Maximum: 15 visits/benefit year.	$20	Not covered
Eye Exams		
One eye exam per year to determine the refractive error of the eye. No PCP referral required.	$0	Not covered
Telehealth Services		
Telehealth (virtual visit) • Primary care physician • Specialist physician • Behavior health and substance abuse therapy	• $5 • $10 • $5	30% after deductible
Please review individual rider documents for limitations and exclusions.		
**Covered services provided by a non-preferred provider will be based on the PPO's "non-preferred provider fee schedule." This may subject the member to significant out-of-pocket expenses for services received from a non-preferred provider. Emergency care or covered services not available from a preferred provider and approved by the Health Plan are NOT subject to this fee schedule.*		

Additional discounts

Through our Accessories Program, you have access to money-saving discounts on a host of health-related products and services, with no referral necessary.

- Acupuncture
- Chiropractic care
- Eyewear and eye exams
- Fitness centers memberships
- LASIK vision correction
- Mail order contact lenses
- Massage therapy
- Safe Beginnings ®
- Weight Watchers ®

Member Information

We want our members to be well informed. The following information is available by contacting our Customer Care Team at (800) 504-0443.

- Geisinger Health Plan Board of Directors
- Description of process for Formulary exception
- Provider credentialing process
- Summary of provider reimbursement methodologies
- Procedures for covering experimental drugs/procedures
- Summary of quality assurance program
- Provider List and/or monthly Provider List Updates
- Pharmacy formulary
- Provider privileges at contracted hospitals

Important information, definitions, and limitations

Case Management: a service where PPO nurses assist members with serious conditions to obtain appropriate support and services so that members can achieve their optimal level of health.

Confidentiality: the PPO's confidentiality policy protects members' privacy of their personal health information including medical records, claims, benefits and other administrative data in all settings. The policy also prohibits sharing personal health information with employers including fully insured employers. However, as a member you always have access to your medical records. Upon enrollment, members sign routine consent forms which allow the PPO to use your information to conduct its business like paying claims and for measurement of data where members identifiers are removed to assure confidentiality. For release of any other personal information, except when required by law, you will be asked to sign a special consent form. A complete copy of the confidentiality policy is available by contacting the Customer Care Team.

Medical Necessity or Medically Necessary: covered services rendered by a health care provider that the insurer determines are: a) appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury; b) provided for the diagnosis, or the direct care and treatment of the member's condition, illness, disease or injury; c) in accordance with current standards of medical practice; d) not primarily for the convenience of the member, or the member's health care provider; and e) the most appropriate source or level of service that can safely be provided to the member. When applied to hospitalization, this further means that the member requires acute care as an inpatient due to the nature of the services rendered or the member's condition, and the member cannot receive safe or adequate care as an outpatient.

Precertification: the process of calling the PPO to receive authorization for whereby all non-emergency inpatient hospital admissions and designated procedures and services listed in the Subscription Certificate are reviewed and approved for coverage determination by the PPO, prior to the prevision of services.

PCP: primary care physician.

Retrospective review: the PPO will complete a post-clinical review when necessary to determine whether or not the treatment met coverage guidelines. Based on this review, claims associated with treatment will be approved or denied.

This document is intended as an easy-to-read summary. Benefits, limitations and exclusions are provided in accordance with the Subscription Certificate and applicable riders under which a member is enrolled. This managed care plan may not cover all your health care expenses. Read your Subscription Certificate and riders carefully to determine which health care services are covered.