Geisinger

Service, Copayments, Limits	Children	Adults
Primary Care Provider (PCP)	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	No	No
Specialist (physician)	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	Yes	Yes
Certified Registered Nurse Practitioner (CRNP)	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	No	No
Family Planning Clinic	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	No	No
Federally Qualified Health Center/Rural Health Center (FQHC/RHC)	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	No	No

Independent Clinic	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	**Referral needed**	**Referral needed**
Maternity – (physician, certified nurse midwives, birth centers)	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	No	No
Urgent Care or Convenience Care Centers (within GHP Family network)	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	No	No
Ambulance (emergency)	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	No	No
Ambulance (non-emergency medical transport)	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	**Prior authorization needed**	**Prior authorization needed**

Chiropractic Services	Covered	Covered
Copayment	$0	$1.00
Limits	None	None
Prior authorization/referral needed	None	None
Dental Services (routine)	Covered	Covered
Copayment	$0	$0
Limits	**2 per calendar year (every 6 months. More if medically necessary)**	**2 per calendar year (every 6 months. More if medically necessary)**
Prior authorization/referral needed	None	None
Optometrist Services	Covered	Covered
Copayment	$0	$0
Limits	None	**2 visits (exams) per benefit year**
Prior authorization/referral needed	No	No
Eyeglass Lenses	Yes	Yes
Copayment	$0	$0
Limits	**4 lenses per calendar year (more if medically necessary)**	**4 lenses per calendar year (more if medically necessary)**
Prior authorization/referral needed	No	No
Eyeglass Frames	Yes	Yes
Copayment	$0	$0
Limits	**2 frames per calendar year (more if medically necessary)**	**2 frames per calendar year (more if medically necessary)**

Prior authorization/referral needed	No	No
Contact Lenses	Yes	Yes
Copayment	$0	$0
Limits	**4 lenses per calendar year (instead of glasses)**	**4 lenses per calendar year (instead of glasses)**
Prior authorization/referral needed	No	No
Podiatry Services	Covered	Covered
Copayment	$0	$0
Limits	Nail trimming is covered only if medically necessary. **Not Covered**- Routine foot care including the cutting or removal of corns, callouses, and other routine hygienic care.	Nail trimming is covered only if medically necessary. **Not Covered**- Routine foot care including the cutting or removal of corns, callouses, and other routine hygienic care.
Prior authorization/referral needed	**Referral needed**	**Referral needed**
Laboratory Services	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	No	No
X-ray	Covered	Covered
Copayment	$0	**$1.00 per service**
Limits	None	None
Prior authorization/referral needed	No	No
Diagnostic Radiology:	Covered	Covered

(CT) Computed Axial Tomography (MRA) Magnetic Resonance Angiography (MRI) Magnetic Resonance Imaging (PET) Positron Emission Tomography Nuclear Cardiology Studies Virtual Colonoscopy		
Copayment	$0	**$1.00 per service**
Limits	None	None
Prior authorization/referral needed	**Prior authorization needed for some services.**	**Prior authorization needed for some services.**
Renal Dialysis	Covered	Covered
Copayment	$0	$0
Limits	None	**- Initial training for home dialysis is limited to 24 sessions per patient per calendar year.** **- Backup visits to the facility limited to no more than 75 per calendar year**
Prior authorization/referral needed	No	No
Therapy (Physical, occupational, speech) Rehabilitative or Habilitative	Covered	**Covered, only when provided by a hospital, outpatient clinic, or home health provider**
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	**Prior authorization needed**	**Prior authorization needed**
Outpatient Hospital Clinic	Covered	Covered
Copayment	$0	$0

Limits	None	None
Prior authorization/referral needed	**Referral needed**	**Referral needed**
Outpatient Hospital Short Procedure Unit (SPU)	Covered	Covered
Copayment	$0	**$3.00**
Limits	None	None
Prior authorization/referral needed	No	No
Outpatient Ambulatory Surgical Center (ASC)	Covered	Covered
Copayment	$0	**$3.00**
Limits	None	None
Prior authorization/referral needed	No	No
Emergency Room	Covered	Covered
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	No	No
Inpatient Acute Hospital	Covered	Covered
Copayment	$0	**$3 per day, $21 maximum per admission**
Limits	None	None
Prior authorization/referral needed	**Prior authorization needed**	**Prior authorization needed**
Inpatient Rehab Hospital	Covered	Covered
Copayment	$0	**$3 per day, $21 maximum per admission**
Limits	None	None

Prior authorization/referral needed	**Prior authorization needed**	**Prior authorization needed**
Intermediate Care Facilities (for individuals with an intellectual disability or other related condition)	Covered	Covered, requires an institutional level of care
Copayment	$0	$0
Limits	None	None
Prior authorization/referral needed	**Prior authorization needed**	**Prior authorization needed**
Skilled Nursing Facility (SNF)	Covered	Covered
Copayment	$0	$0
Limits	30 consecutive days are covered then Fee-for-Service program provides coverage, no longer covered by GHP Family.	30 consecutive days are covered then Fee-for-Service program provides coverage, no longer covered by GHP Family.
Prior authorization/referral needed	**Prior authorization needed**	**Prior authorization needed**
Home Healthcare (including nursing aide and therapy services)	Covered	Covered
Copayment	$0	$0
Limits	None	**Unlimited for first 28 days; limited to 15 days every month thereafter**
Prior authorization/referral needed	**Prior authorization needed for certain services.**	**Prior authorization needed for certain services.**
Hospice Care	Covered	Covered
Copayment	$0	$0
Limits	None	**Limitation on Respite Care, may not exceed a total of 5 days in a 60-day certification period.**
Prior authorization/referral needed	**None**	**None**
Durable Medical Equipment (DME)	Covered	Covered

Copayment	$0	$2
Limits	None	None
Prior authorization/referral needed	**Prior authorization needed for some services.**	**Prior authorization needed for some services.**