Geisinger Funding Alternative Premier PPO Summary of Benefits PPO \$8000 Plan C

Preferred Provider

Non-Preferred

Provider

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Coinsurance Maximum So single \$0 single \$12,000 single \$10,000 si	Deductible must be satisfied every coverage period before coinsurance applies. Copayments do not apply to the deductible.		
Deductible does not apply to coinsurance maximum. Maximum Out of Pocket Services covered when medically necessary Preferred Provider You Pay* Outpatient Physician Services Primary care office visits (PCP). \$40 30% after deductible Preductible visits (PCP). \$40 30% after deductible Specialist office visit. \$75 30% after deductible Financy care physician Specialist physician \$50 \$60 \$60 \$60 \$60 \$60 \$60 \$60	Coinsurance	0%	30%
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Preventive Services: For a Full list of preventive services refer to healthcare.gov/coverage/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. Pap smears. \$0 30% after deductible	Critical response air transport.	\$0	\$0
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Pap smears. \$0 30% after deductible	Mammograms.	\$0	30% after deductible
	Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel.	\$0	30% after deductible
Chlamydia screening ages 16-25. \$0 30% after deductible	Pap smears.	\$0	30% after deductible
	Chlamydia screening ages 16-25.	\$0	30% after deductible
Dexa scan. \$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
Well-Child Services		
Well-child office visits (age 0-21)	\$0	30% after deductible
Well-Woman Care		
Annual gynecological examination, including pelvic examination and routine pap smears. Includes appropriate follow-up care and referrals for diagnostic testing and treatment services relating to gynecological care.	\$0	30% after deductible
Outpatient Services.		
Outpatient surgery.	0% after deductible	30% after deductible
X-rays, laboratory, and 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
Ostomy supplies.	0% after deductible	Services limited to preferred providers
Urological supplies.	0% after deductible	Services limited to preferred providers
Other diagnostic services.	0% after deductible	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
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 (cost sharing does not apply to maximum out-of-pocket)		
Facility charges.	\$2,000	Services limited to preferred

		providers
Professional charges.	0% after deductible	Services limited to preferred providers
Eye Exams		
One eye exam per year to determine the refractive error of the eye.	\$0	Services limited to preferred providers
Rehabilitation Services		
Physical therapy for back pain, limited to 2 series of 5 visits each, per benefit period.	\$75 per series	Services limited to preferred providers
Spinal injections for back pain	0% after deductible, if coinsurance is 0% then 30% coinsurance applies	Services limited to preferred providers
Physical, Occupational and Speech Therapy	\$75	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 (OneTouch, OneTouch Ultra, and OneTouch Verio) 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).	\$0 single \$0 family deductible which must be met first then Tier 1: \$15 for 34-day supply Tier 2: \$45 for 34-day supply Tier 3: \$70 for 34-day supply	Services limited to a preferred pharmacy
Diabetic foot orthotics.	0% after deductible	Services limited to preferred providers
Home blood glucose monitors: LifeScan brand diabetic supplies only. Must be purchased at a participating pharmacy.	\$0	Services limited to a preferred pharmacy
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	\$0	Services limited to preferred providers
¹ The Plan reserves the right to restrict vendors and apply quantity limita	tions.	
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%	50% plus 30% coinsurance
Contraceptives	\$0	50% plus 30% coinsurance
Specialty Drugs		
For select high-cost specialty drugs. \$1,500 maximum out-of-pocket per benefit year. (cost sharing for drugs obtained from a specialty	\$150 copay per injection/infusion	30% after deductible
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Durable Medical Equipment Equipment which can stand repeated use, such as wheelchairs, nospital beds and oxygen equipment. Standard equipment is covered interpretation of a participating proteider. Proceeding the presented by a participating proteider, proteined from a alrahopatiny vendur. The Plan reserves the right to restrict vendor. Prossibility a participating proteider, proteined from a participating vendur. The Plan reserves the right to restrict vendor. Prossibility devidures. The Plan reserves the right to restrict vendor. Prossibility devidures a strainfail limbs. Must be prescribed by participating providers. Bright appliance used to support, slight or correct bone and muscle electromities. Must be prescribed by participating providers. Drithotic Devices Rigid appliance used to support, slight or correct bone and muscle electromities. Must be prescribed by participating providers. Drithotic Devices Rigid appliance used to support, slight or correct bone and muscle electromities. Must be prescribed by participating provider for extraction of partialty or totally comprehend providers. Drithotic Devices Rigid appliance used to support, slight or correct bone and muscle electromities. Survival application of partialty or totally comprehend providers. Drithotic Devices Rigid appliance used to support, slight or correct bone and muscle electromities. Must be prescribed by participating provider for extraction of partialty or totally comprehend providers. Drithotic Devices Alcohol and Drug Abuse Treatment Impatient detoxification. Limit: 90 inpatient days per benefit year when services are performed by a non-preferred provider. Doutpatient renabilitation at an alcoholismidrug abuse facility. Submitted to preferred provider and partial provider and providers. Drithotic provider devices and providers and providers and providers. Drithotic providers and providers and providers and providers and providers. Drithotic providers and providers and providers and providers and providers. Drithot			
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Outpatient Opioid Detoxification Treatment Buprenorphine and buprenorphine/naloxone are covered as part of this treatment if the member has a GHP drug rider and are subject to the cost sharing set forth in that rider. If the member has a GHP drug rider and are subject to the cost sharing set forth in that rider. If the member does not have a GHP drug rider, the detox sessions are covered but buprenorphine or buprenorphine/naloxone are not covered. Mental Health Mental Health care by psychiatrist, licensed clinical psychologist or obtate licensed behavioral health professional. Serious Mental Illness (SMI) Services Care provided for the following serious mental illnesses: schizophrenia, opiolar disorder, obsessive-compulsive disorder, major depressive disorder, and cisorder, and cisorder, and cisorder, and cisorder, and cisorder, and cisorder, and cisorder and delusional disorder. Non-Serious Mental Illness Services Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, and delusional disorder. O% after deductible/inpatient professional visit ow 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
Buprenorphine and buprenorphine/naloxone are covered as part of this treatment if the member has a GHP drug rider and are subject to the cost sharing set forth in that rider. If the member does not have a GHP drug rider, the detox sessions are covered but buprenorphine or buprenorphine/naloxone are not covered. Mental Health Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional. Serious Mental Illness (SMI) Services Care provided for the following serious mental illnesses: schizophrenia, bipolar disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. Non-Serious Mental Illness Services Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, anorexia nervo	Outpatient rehabilitation at an alcoholism/drug abuse facility.		30% after deductible
treatment if the member has a GHP drug rider and are subject to the cost sharing set forth in that rider. If the member does not have a GHP drug rider, the detox sessions are covered but buprenorphine or puprenorphine/naloxone are not covered. Mental Health Mental Health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional. Serious Mental Illness (SMI) Services Care provided for the following serious mental illnesses: schizophrenia, bipolar disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. Non-Serious Mental Illness Services Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, anorexia nervosa, sch	Outpatient Opioid Detoxification Treatment		
Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional. Serious Mental Illness (SMI) Services Care provided for the following serious mental illnesses: schizophrenia, object disorder, obsessive-compulsive disorder, major depressive affective disorder and delusional disorder. Non-Serious Mental Illness Services Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, obsessive-disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, anorexia nervosa, bulimia nervosa, schizo-affective	Buprenorphine and buprenorphine/naloxone are covered as part of this treatment if the member has a GHP drug rider and are subject to the cost sharing set forth in that rider. If the member does not have a GHP drug rider, the detox sessions are covered but buprenorphine or buprenorphine/naloxone are not covered.	0% after deductible	30% after deductible
Serious Mental Illness (SMI) Services Care provided for the following serious mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder and delusional disorder. Non-Serious Mental Illness Services Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, obsessive-compulsive disorder, major depressive disorder, obsessive-compulsive disorder, major depressive disorder, daric deductible/partial hospitalization day O% after deductible/inpatient facility o% after deductible/partial hospitalization day O% after deductible/inpatient facility o% after deductible/inpatient facility o% after deductible/inpatient professional visit o% after deductible/inpatient professional visit o% after deductible/inpatient professional visit o% after deductible/partial hospitalization per day Autism Spectrum Disorder Rider	Mental Health		
Care provided for the following serious mental illnesses: schizophrenia, pipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. Non-Serious Mental Illness Services Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. O% after deductible/inpatient facility o% after deductible/ inpatient facility o% after deductible/inpatient professional visit o% after deductible/inpatient professional visit o% after deductible/partial hospitalization per day Autism Spectrum Disorder Rider	Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional.		30% after deductible
obipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. Non-Serious Mental Illness Services Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. O% after deductible/inpatient facility O% after deductible/inpatient professional visit O% after deductible/partial hospitalization per day Autism Spectrum Disorder Rider	Serious Mental Illness (SMI) Services		
Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. O% after deductible/inpatient facility O% after deductible/inpatient professional visit O% after deductible/partial hospitalization per day Autism Spectrum Disorder Rider	Care provided for the following serious mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.	0% after deductible/inpatient professional visit 0% after deductible/partial	30% after deductible
disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder. facility 0% after deductible/inpatient professional visit 0% after deductible/partial hospitalization per day Autism Spectrum Disorder Rider	Non-Serious Mental Illness Services		
· · · · · · · · · · · · · · · · · · ·	Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.	facility 0% after deductible/inpatient professional visit 0% after deductible/partial	30% after deductible
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	Autism Spectrum Disorder Rider		
	Care provided for members under 21 years of age for the treatment of a	utism 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 rider	Services limited to a preferred pharmacy
Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist.	\$40 individual therapy session /\$40 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.	\$75 per day	30% after deductible
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	\$75 per day	30% after deductible
Manipulative Treatment Services		
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.	\$40	Services limited to preferred providers
*Covered services provided by a non-preferred provider will be based or member to significant out-of-pocket expenses for services received from available from a preferred provider and approved by the Health Plan are	n a non-preferred provider. Emergency	

Additional Services

Preferred Provider You Pay

Non-Preferred Provider You Pay*

		You Pay*
Triple Choice Option for Outpatient Prescription Drug	S ²	
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 is 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, other brand name drugs, and non-formulary drugs if approved; prior authorization may be required. Provider must request prior authorization. For information call Pharmacy Services at (800) 988-4861.	\$0 single \$0 family deductible which must be met first then Tier 1: \$15 for 34-day supply Tier 2: \$45 for 34-day supply Tier 3: \$70 for 34-day supply	Services limited to a preferred pharmacy
Contraceptives; includes diaphragms.	Copayment amount depends on tier for 34-day supply	Services limited to a preferred pharmacy
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 copays amount(s) depending on tier/3-month supply	Services limited to a preferred pharmacy
² The Plan reserves the right to restrict vendors and apply quantity limitat	ions.	
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	Services limited to a preferred pharmacy
Please review individual rider documents for limitations and exclusions.	•	•
*Covered services provided by a non-preferred provider will be based or member to significant out-of-pocket expenses for services received from available from a preferred provider and approved by the Health Plan are	a non-preferred provider. Emergency	

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 ®

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 Summary of provider reimbursement Provider List and/or monthly Provider List

methodologies Updates

Description of process for Formulary exception Procedures for covering experimental Pharmacy formulary

drugs/procedures

Provider credentialing process Summary of quality assurance program 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.

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.

:PPO \$8000 Plan C:GFAO51 gen. 09/28/2022