

# Geisinger All-Access PPO

## Summary of Benefits

### PPO 8000 Plan A

#### Preferred Provider

#### Non-Preferred Provider

#### Deductible

\$8,000 single  
\$16,000 family

\$8,500 single  
\$17,000 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

\$9,100 single  
\$18,200 family

\$0 single  
\$0 family

#### Services covered when medically necessary

#### Preferred Provider You Pay

#### Non-Preferred Provider You Pay\*

| Outpatient Physician Services                                                                                                                                                                                                                                  |                                        |                                        |
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| Primary care office visits (PCP).                                                                                                                                                                                                                              | \$40                                   | 30% after deductible                   |
| Periodic health assessments/routine physicals.                                                                                                                                                                                                                 | \$0                                    | 30% after deductible                   |
| Specialist office visit.                                                                                                                                                                                                                                       | \$75                                   | 30% after deductible                   |
| Telehealth (virtual visit)                                                                                                                                                                                                                                     |                                        |                                        |
| Primary care physician                                                                                                                                                                                                                                         | \$5                                    | 30% after deductible                   |
| Specialist physician                                                                                                                                                                                                                                           | \$10                                   | 30% after deductible                   |
| Behavioral health and substance abuse therapy                                                                                                                                                                                                                  | \$5                                    | 30% after deductible                   |
| Emergency Services                                                                                                                                                                                                                                             |                                        |                                        |
| Emergency care.                                                                                                                                                                                                                                                | \$300 (waived if admitted to hospital) | \$300 (waived if admitted to hospital) |
| Ambulance service to and from hospital.                                                                                                                                                                                                                        | \$0                                    | \$0                                    |
| Critical response air transport.                                                                                                                                                                                                                               | \$0                                    | \$0                                    |
| Urgent care.                                                                                                                                                                                                                                                   | \$40                                   | \$40                                   |
| Preventive Services: For a Full list of preventive services refer to <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> . 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 ages 16-25.                                                                                                                                                                                                                                | \$0                                    | 30% after deductible                   |
| Dexa scan.                                                                                                                                                                                                                                                     | \$0                                    | 30% after deductible                   |

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| 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                    |
| <b>Well-Child Services</b>                                                                                                                                                                                                                                                                                                            |                     |                                         |
| Well-child office visits (age 0-21)                                                                                                                                                                                                                                                                                                   | \$0                 | 30% after deductible                    |
| <b>Well-Woman Care</b>                                                                                                                                                                                                                                                                                                                |                     |                                         |
| 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                    |
| <b>Outpatient Services.</b>                                                                                                                                                                                                                                                                                                           |                     |                                         |
| 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                    |
| <b>Colorectal Cancer Screening</b>                                                                                                                                                                                                                                                                                                    |                     |                                         |
| 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                    |
| <b>Maternity Care</b>                                                                                                                                                                                                                                                                                                                 |                     |                                         |
| 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                    |
| <b>Hospitalization</b>                                                                                                                                                                                                                                                                                                                |                     |                                         |
| 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                    |
| <b>Surgery for Correction of Obesity (cost sharing does not apply to maximum out-of-pocket)</b>                                                                                                                                                                                                                                       |                     |                                         |
| Facility charges.                                                                                                                                                                                                                                                                                                                     | \$2,000             | Services limited to preferred           |

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| Professional charges.                                                                                                                                                                                                                                                                                                                                                  | 0% after deductible                                                                                                                                                    | Services limited to preferred providers  |
| <b>Eye Exams</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                        |                                          |
| One eye exam per year to determine the refractive error of the eye.                                                                                                                                                                                                                                                                                                    | \$0                                                                                                                                                                    | Services limited to preferred providers  |
| <b>Rehabilitation Services</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                        |                                          |
| 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                     |
| <b>Diabetes Services and Supplies <sup>1</sup></b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                        |                                          |
| 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<br>\$0 family deductible which must be met first then<br>Tier 1: \$20 for 34-day supply<br>Tier 2: \$40 for 34-day supply<br>Tier 3: \$60 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  |
| <sup>1</sup> The Plan reserves the right to restrict vendors and apply quantity limitations.                                                                                                                                                                                                                                                                           |                                                                                                                                                                        |                                          |
| <b>Skilled Nursing/Home Health Services</b>                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                        |                                          |
| 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                     |
| <b>Implanted Devices (medical and contraceptive)</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                        |                                          |
| Drug delivery.                                                                                                                                                                                                                                                                                                                                                         | 50%                                                                                                                                                                    | 50% plus 30% coinsurance                 |
| Contraceptives                                                                                                                                                                                                                                                                                                                                                         | \$0                                                                                                                                                                    | 50% plus 30% coinsurance                 |
| <b>Specialty Drugs</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                        |                                          |
| 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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| vendor will follow the pharmacy benefit)                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                   |                                         |
| <b>Durable Medical Equipment</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                   |                                         |
| 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                                                                                                                                               | Services limited to preferred providers |
| <b>Prosthetic Devices</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                   |                                         |
| 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                                                                                                                                               | Services limited to preferred providers |
| <b>Orthotic Devices</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                         |
| Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.                                                                                                                                                                                                                                                                                                           | 50% coinsurance                                                                                                                                   | Services limited to preferred providers |
| <b>Impacted Wisdom Teeth Extraction</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                         |
| 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 without a prior-authorization.                                                                                                                                                                                   | \$0                                                                                                                                               | Services limited to preferred providers |
| <b>Alcohol and Drug Abuse Treatment</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                         |
| 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.                                                                                                                                                                                                                                                                                                                                                                        | \$40 individual therapy session /\$40 group therapy session                                                                                       | 30% after deductible                    |
| <b>Outpatient Opioid Detoxification Treatment</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                   |                                         |
| 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                    |
| <b>Mental Health</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                   |                                         |
| Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional.                                                                                                                                                                                                                                                                                                                   | \$40 individual therapy session /\$40 group therapy session                                                                                       | 30% after deductible                    |
| <b>Serious Mental Illness (SMI) Services</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                         |
| 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 facility<br>0% after deductible/inpatient professional visit<br>0% after deductible/partial hospitalization day     | 30% after deductible                    |
| <b>Non-Serious Mental Illness Services</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |
| 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.                                                                                                                                                                                             | 0% after deductible/inpatient facility<br>0% after deductible/inpatient professional visit<br>0% after deductible/partial hospitalization per day | 30% after deductible                    |
| <b>Autism Spectrum Disorder Rider</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                   |                                         |
| 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. |                                                                                                                                                   |                                         |

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| 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                     |
| <i>*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.</i> |                                                                                                                 |                                          |

| Additional Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Preferred Provider<br>You Pay                                                                                                                                          | Non-Preferred<br>Provider<br>You Pay*    |
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| <b>Triple Choice Option for Outpatient Prescription Drugs <sup>2</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                        |                                          |
| 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<br>\$0 family deductible which must be met first then<br>Tier 1: \$20 for 34-day supply<br>Tier 2: \$40 for 34-day supply<br>Tier 3: \$60 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 |
| <sup>2</sup> The Plan reserves the right to restrict vendors and apply quantity limitations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                        |                                          |
| <b>Select Free Generic Drug Program</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                        |                                          |
| 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 |
| <b>Manipulative Treatment Services Rider</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                        |                                          |
| 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  |
| <i>Please review individual rider documents for limitations and exclusions.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                        |                                          |
| <i>*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.</i>                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                        |                                          |

## 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

## Member Information

We want our members to be well informed. The following information is available by contacting our Customer Care Team at (800) 447-4000.

|                                                |                                                       |                                                    |
|------------------------------------------------|-------------------------------------------------------|----------------------------------------------------|
| Geisinger Health Plan Board of Directors       | Summary of provider reimbursement methodologies       | Provider List and/or monthly Provider List Updates |
| Description of process for Formulary exception | Procedures for covering experimental drugs/procedures | Pharmacy formulary                                 |
| 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 provision 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.***