# Geisinger Funding Alternative All-Access Extra HMO Summary of Benefits GFA All Access HMO Extra 3000 Plan C

You Pay

\$0

\$0

\$0

**Deductible** \$3,000 single \$6,000 family

Deductible must be satisfied every coverage period before coinsurance applies.

Services covered when medically necessary

Copayments do not apply to the deductible.

Pap smears.

Dexa scan.

Chlamydia screening ages 16-25.

Coinsurance 0%

Coinsurance Maximum \$0 single \$0 family

Deductible does not apply to coinsurance maximum.

Maximum Out of Pocket \$9,450 single \$18,900 family

**Outpatient Physician Services.** \$20 Primary care physician office visit (PCP). Office visits at an Extra site (PHN). \$10 \$40 Specialist office visit. Periodic health assessments/routine physicals (PCP). \$0 Periodic health assessments/routine physicals at an Extra site (PHN). \$0 Telehealth (virtual visit) \$5 Primary care physician \$10 Specialist physician Behavioral health and substance abuse therapy \$5 **Emergency Services** Emergency care. \$150 (waived if admitted to hospital) Emergency ambulance transportation. \$0 Critical response air transport. \$0 Urgent care. \$20 Urgent care for mental health and substance abuse. Preventive Services: For a Full list of preventive services refer to healthcare.gov/coverage/preventive-carebenefits. All PPACA Preventive Services including but not limited to: \$0 Mammograms. Immunizations covered in accordance with accepted medical practices, excluding \$0 immunizations necessary for international travel.

Fecal account blood testing.  Cholesteral screening.  Diabetes care including HBA1c testing, LDL-C screening and nephropathy screening.  So  Diabetes care including HBA1c testing, LDL-C screening and nephropathy screening.  So  Newborn screening: one hematocrit and hemoglobin screening for infants under 24 months.  So  Well-Child Services  Well-Child Services  Well-Woman Care  Annual genecological care care and reterms for diagnostic testing and treatment services evaluating to genecological care and reterms for diagnostic testing and treatment services.  Outpatient Services.  Outpatient Services.  Outpatient Services.  Outpatient Services.  On safter deductable  Or safter deductable  New intervent or or safter			
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	Eye Exams		
Rehabilitation Services	One eye exam per year to determine the refractive error of the eye.	\$0	
	Rehabilitation Services		

Spinal injections for back pain One after deductible, if coinsurance 0% then 30% coinsurance applies Physical, Occupational and Speech Thorapy \$40 Cardiac rehabilitation, outpatient, up to 36 sessions-benefit year. \$50 Diabetes Services and Supplies 1 Diabetic Services and Supplies 1 Diabetic seve examination. Prescription-supply occurage: LifeScan test strips (OneTouch, OneTouch Ultra, and So single South of Court Verbroit and Innoversal Court of Court Verbroit and Innoversal Court Verbroit Cour			
Physical, Occupational and Speech Therapy 540  Cardiac rehabilitation, outpatient, up to 36 sessions/benefit year. 550  Diabetes Services and Supplies 1  Diabetes Services and Supplies 1  Diabetes Services and Supplies 1  Diabete open examination. 550  Prescription/supply coverage. LifeScan test strips (OneTouch, OneTouch Ultra, and OneTouch Verley) and lancets are covered. The following may be limited to specific vendors: insulin, syringse and needles for the administration of insulin only, oral agents used to control to the control of the	Physical therapy for back pain, limited to 2 series of 5 visits each, per benefit period.	\$40 per series	
Cardiac rehabilitation, outpatient, up to 36 sessions/benefit year.  Pulmonary rehabilitation benefit, outpatient, limit to 36 sessions per benefit year  Diabetos Services and Supplies ¹  Diabetos Services and Supplies ¹  Diabetos yeasemination.  Peascriptionisuspily coverage: Urls Scan test strips (OneTouch, OneTouch, Ultra, and OneTouch Wero) and laneats are covered. The following may be limited to specific vendors: institution strains and needles for the administration of institution only, oral agents used to control units 1:3 for 34-day supply) and Glucagon emergency kit (two per copayment).  Diabetic foot orthotics.  Diabetic foot orthotics.  Diabetic foot orthotics.  Home blood glucose monitors: LifeScan brand diabetic supplies only. Must be purchased at a participating pharmacy.  Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.  **The Plan reserves the right to restrict vendors and apply quantity limitations.  **Skilled Nursing/Home Health Services**  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.  Home health care  **Poping delivery.**  Solow Specialty Drugs  For select high-cost specialty drugs. \$1,500 maximum out-of-pocket per benefit year. (cost shorted repaired requiremt is covered when prescribed by a participating provider, deputing provider, purchased from a specialty wendor will follow the pharmacy benefit)  **Durable Medical Equipment**  Equipment Sinader depatement acceptation which replaces a missing body part, such as artificial introl. Must be prescribed by participating provider. Medically necessary replacements.  **Dorthotic Devices**  Rigid appolance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	Spinal injections for back pain	· ·	
Pulmonary rehabilitation benefit, outpatient, limit to 36 sessions per benefit year  Diabetes Services and Supplies 1  Diabetic sye examination.  Prescription/supply coverage: LifeScan test strips (OneTouch, OneTouch Ultra, and OneTouch Verio) and lancets are covered. The following may be limited to specific vendors: install, syringes and needles for the administration of install, one single and needles for the administration of install noise), or special parts used to control blood sugar (1 copayment/34 day supply) and Glucagon emergency kit (two per copayment). Time? 2 \$45 for 34-day supply) Time? 2 \$45 for 34-day supply Time? 2 \$45 for 34-day supply Time? 3 \$70 for 34-day supply Time?	Physical, Occupational and Speech Therapy	\$40	
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Prescription/supply coverage: LifeScan test strips (OneTouch, OneTouch Ultra, and OneTouch Verio) and lancests are covered. The following may be limited to specific vendors: install, syrings and needles for the administration of insulin only, onal agents used to our 15 st for 34-day supply Tier 2: \$45 for 34-day supply Tier 3: \$70 for	Diabetes Services and Supplies <sup>1</sup>		
One Touch Verlo) and lancets are covered. The following may be limited to specific vendors: Install, syrings and neadles for the administration of insulin only, not agents used to count of Ter 1: 15 for 34-day supply and Slucagon emergency kit (two per copayment).  Diabetic foot orthotics.  O% after deductible  Diabetic foot orthotics: LifeScan brand diabetic supplies only. Must be purchased at a participating pharmacy.  Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.  **The Plan reserves the right for restrict vendors and apply quantity limitations.**  Skilled Nursing/Home Health Services  Short-term, non-custodial medical care in a licensed, skilled nursing facility, as approved by a Plan physician and the Plan, for up to 60 days.  Home health care  \$0  **Hospice care: home and inpatient care including home health aide and homemaker services, courseling and medical social services.  **Implanted Devices (medical and contraceptive)**  Drug delivery.  50%  Contraceptives  \$5  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 vendor will follow the pharmacy benefit)  Durable Medical Equipment  Equipment Which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating provider. Medically necessary replacements  Orthotic Devices  Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.  Orthotic Devices  Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	Diabetic eye examination.	\$0	
Home blood glucose monitors: LifeScan brand diabetic supplies only. Must be purchased at a participating pharmacy.  Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.  **The Plan reserves the right to restrict vendors and apply quantity limitations.**  Skilled Nursing/Home Health Services  Short-term, non-custodial medical care in a licensed, skilled nursing facility, as approved by a Plan physician and the Plan, for up to 60 days.  Home health care  \$0  Hospice care: home and inpatient care including home health aide and homemaker services, so counseling and medical social services.  Implanted Devices (medical and contraceptive)  Drug delivery.  \$0  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 vendor will follow the pharmacy benefit)  Durable Medical Equipment  Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen quipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.  Prosthetic Devices  Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.  Orthotic Devices  Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	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 family deductible which must be met first then Tier 1: \$15 for 34-day supply Tier 2: \$45 for 34-day supply	
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.  1 The Plan reserves the right to restrict vendors and apply quantity limitations.  Skilled Nursing/Home Health Services  Short-term, non-custodial medical care in a licensed, skilled nursing facility, as approved by a Plan physician and the Plan, for up to 60 days.  Home health care  \$0  Wafter deductible Plan physician and the Plan, for up to 60 days.  Home health care  \$0  Wafter deductible Plan physician and the Plan, for up to 60 days.  Home health care  \$0  Sophish provides and inpatient care including home health aide and homemaker services, counseling and medical social services.  Implanted Devices (medical and contraceptive)  Drug delivery.  \$0  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 vendor will follow the pharmacy benefit)  Durable Medical Equipment  Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.  Prosthetic Devices  Externally worn appliance or apparatus which replaces a missing body part, such as artificial limits. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.  Orthotic Devices  Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	Diabetic foot orthotics.	0% after deductible	
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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.  Home health care  Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.  Implanted Devices (medical and contraceptive)  Drug delivery.  50%  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 vendor will follow the pharmacy benefit)  Durable Medical Equipment  Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.  Prosthetic Devices  Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.  80  60  60  60  60  60  60  60  60  60	Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	\$0	
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Implanted Devices (medical and contraceptive)  Drug delivery.  Contraceptives  So  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 vendor will follow the pharmacy benefit)  Durable Medical Equipment  Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.  Prosthetic Devices  Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.  Orthotic Devices  Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	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	
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Drug delivery.  Contraceptives  \$0  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 vendor will follow the pharmacy benefit)  Surable Medical Equipment  Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.  Prosthetic Devices  Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.  Orthotic Devices  Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.	\$0	
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equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.  Prosthetic Devices  Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.  Orthotic Devices  Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	Durable Medical Equipment		
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limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.  Orthotic Devices  Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.  50%	Prosthetic Devices		
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	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	
prescribed by participating provider.	Orthotic Devices		
Impacted Wisdom Teeth Extraction	Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	50%	
	Impacted Wisdom Teeth Extraction		

Oral surgery by participating provider for extraction of partially or totally bony impacted third molars. Service covered in the physician's office. Hospital and ambulatory surgical center services are not covered without a prior-authorization.	\$0	
Alcohol and Drug Abuse Treatment		
Inpatient detoxification.	0% after deductible	
Non-hospital residential inpatient rehabilitation.	0% after deductible	
Outpatient rehabilitation at an alcoholism/drug abuse facility.	\$20 individual therapy session /\$20 group therapy session	
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 does not have a GHP drug rider, the detox sessions are covered but buprenorphine or buprenorphine/naloxone are not covered.	0% after deductible	
Mental Health		
Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional.	\$20/individual therapy session \$20/group therapy session	
Serious Mental Illness (SMI) Services		
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 0% after deductible/inpatient professional visit 0% after deductible/partial hospitalization day	
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.	0% after deductible inpatient facility 0% after deductible/inpatient professional visit 0% after deductible/partial hospitalization day	
Autism Spectrum Disorder Rider		
Care provided for members under 21 years of age for the treatment of autism spectrum disorders (as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental disorders (DSM), or its successor including autistic disorder, Asperger's disorder and Pervasive Development Disorder not otherwise specified.) which includes, pharmacy, psychiatric and psychological, rehabilitative and therapeutic care.		
Pharmacy care	Copayment per outpatient prescription drug rider or 50% coinsurance for members with no prescription drug rider	
Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist.	\$20 individual therapy session /\$20 group therapy session	
Rehabilitative Care: professional services and treatment programs, including applied behavioral analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.	\$40 per day	
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	\$40 per day	
Applied behavioral analysis (ABA) for autism.	\$20	
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.	\$20	
Additional Services	You Pay	

## Additional Services

Triple Choice Option for Outpatient Prescription Drugs <sup>2</sup>	
34-day supply per copayment for outpatient prescription drugs from a participating pharmacy.	\$0 single

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 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	
Contraceptives; includes diaphragms.	\$0	
Mail Order Pharmacy. Prescriptions can be received through the mail by using the Plan'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	
<sup>2</sup> The Plan reserves the right to restrict vendors and apply quantity limitations.		
Select Free Generic Drug Program		
Members will pay a \$0 copay for certain generic drugs as part of Tier 1. All other Tier 1 drugs will have applicable copay applied. Deductible applies first, if applicable.	\$0	
Please review individual rider documents for limitations and exclusions.		

#### **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 methodologies
Provider List and/or monthly Provider List 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 Plan nurses assist members with serious conditions to obtain appropriate support and services so that members can achieve their optimal level of health.

Concurrent review a process to ensure that medically necessary, appropriate care is delivered to a hospitalized member.

Confidentiality the Plan'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 Plan 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.

Continuity of care for new members (Act 68) Under the provisions of Act 68, a new member can continue on-going treatment with a non-participating physician for the first 60 days of enrollment. If a member is in her second or third trimester of pregnancy, services will be covered through delivery and postpartum care. To initiate this request, the member must contact the Customer Care Team prior to receiving treatment. The Plan will confer with the provider to determine if the provider will accept the Plan's terms and conditions for payment. If the provider does not agree, the services of the non-participating provider will not be covered.

Covered services Covered services that are not available within the Plan's network or are out of the Plan's service area must be authorized in advance by the Plan.

Medical Necessity or Medically Necessary covered services rendered by a health care provider that the Plan 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 provider; and e) the most appropriate source or level or 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.

Prior authorization the process by which approval is given by the Plan for covered services based on medical necessity, eligibility and benefit

availability at the time the covered services are to be provided prior to the services being performed.

**Retrospective review** to determine the appropriateness of treatment, the Plan 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.

: GFA All Access HMO Extra 3000 Plan C:SOLO51 gen. 10/12/2023