GEISINGER HEALTH OPTIONS®

HMO
Summary of Benefits
Central Susquehanna Trust

Deductible (per annual benefit period) $0 single
$0 family

Deductible must be satisfied every coverage period before coinsurance applies. Copayments do not apply to the deductible.

Coinsurance (per annual benefit period) 0%

Coinsurance Maximum $0 single
$0 family

Deductible does not apply to coinsurance maximum.

Maximum out-of-pocket $6,350 single
(Deductible, coinsurance, and copayments apply) $12,700 family

SERVICES covered when medically necessary	You Pay
Outpatient Services	
Routine office visits.	$20 per visit
Periodic health assessments/routine physicals.	$20 per visit
Preventive Services For a Full list of preventive services refer to http://www.healthcare.gov/law/about/provisions/services/lists.html All PPACA Preventive Services including but not limited to:	
Mammograms.	$0
Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel.	$0
Pap smears.	$0
Chlamydia screening for females ages 16-25.	$0
Dexa scan.	$0
Fecal occult blood testing.	$0
Cholesterol screening.	$0
Diabetes care for ages 18-75 including HbA1c testing, LDL-C screening and nephropathy screening.	$0
Lipid panel.	$0
Newborn screening: one hematocrit and hemoglobin screening for infants under 24 months.	$0
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
Well-Child Services	
Well-child office visits (age 0-21)	$0
Pediatric immunizations and inoculations.	$0
Testing Services	
X-rays, laboratory and other diagnostic tests.	$0
Computed Axial Tomography (CAT Scan), Magnetic Resonance Imaging (MRI), and Position Emission Tomography (PET Scan), Magnetic Resonance Angiography (MRA) and nuclear cardiology.	$0

All Other Diagnostic Services	
Ostomy supplies.	$0
Medically necessary urological supplies.	$0
Other diagnostic services.	$0
Specialist Office Services	
Office visits.	$35 per visit
Office procedures.	$0
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. No referral required.	$0
Maternity Care	
Maternity care by your physician before and after the birth of your baby. No referral required.	$0
Outpatient Facility and Physician Services	$0
Hospitalization	
Medical and surgical specialist care, including anesthesia.	$0
Care in a semi-private room at a participating facility. Includes intensive care, cardiac care unit services, obstetrical care, newborn care, medications, diagnostic tests and transplant services.	$0
Surgery for Correction of Obesity	
Facility charges.	$2,000
Emergency Services	
Emergency care.	$100 (waived if admitted to hospital)
Emergency ambulance transportation.	$0
Critical response air transport.	$0
Out-of-area urgent care.	$35 per visit
Rehabilitation Services	
Physical therapy, speech therapy, occupational therapy, for up to 45 dates of service per benefit year.	$35 per visit
Cardiac rehabilitation, outpatient, up to 36 sessions/benefit year.	$0
Pulmonary rehabilitation benefit, outpatient, limit to 36 sessions per benefit year	$0
Diabetes Services and Supplies[1]	
Diabetic eye examination.	$0
Prescription/supply coverage: Lifescan test strips, box of 100 test strips per copayment (One-Touch, One-Touch Ultra, Surestep and FastTake) and lancets are covered. The following may be limited to specific vendors: insulin, syringes and needles for the administration of insulin only, oral agents used to control blood sugar (1 copayment/34 day supply) and Glucagon emergency kit (two per copayment). Mail order discount does not apply.	Tier 1: $15 for 34-day supply Tier 2: $30 for 34-day supply Tier 3: $50 for 34-day supply
Diabetic foot orthotics.	$0
Home blood glucose monitors: Lifescan brand diabetic supplies only. Must be purchased at a participating pharmacy.	$0
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	$0
[1]The Plan reserves the right to restrict vendors and apply quantity limitations.	
Skilled Nursing/Home Health Services	
Short-term, non-custodial medical care in a licensed, skilled nursing facility, as approved by a Plan physician and the Plan, for up to 60 days.	$0
Home health care by primary care physician.	$20 per visit
Home health care by specialist.	$35 per visit
Home health care by other participating skilled professional.	$0
Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.	$0
Breast Prosthetic Benefit	$0
Implanted Devices (medical and contraceptive)	
Drug delivery	50%
Contraceptives	$0
Specialty Drugs	
For select high-cost specialty drugs. $1,500 maximum out-of-pocket per benefit year.	$100 per injection/infusion

Durable Medical Equipment	
Equipment which can stand repeated use, such as wheelchairs, hospital beds and oxygen equipment. Standard equipment is covered when prescribed by a participating provider, purchased from a participating vendor. The Plan reserves the right to restrict vendor.	$0
Prosthetic Devices	
Externally worn appliance or apparatus which replaces a missing body part, such as artificial limbs. Must be prescribed by participating provider. Medically necessary replacements covered every 5 years.	$0
Orthotic Devices	
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	50% coinsurance
Alcohol and Drug Abuse Treatment...2	
Inpatient detoxification.	$0
Non-hospital residential inpatient rehabilitation.	$0
Outpatient rehabilitation at an alcoholism/drug abuse facility.	$0
2No PCP referral required. Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839- 7972 for more information. Pre-authorization is required for all services except routine outpatient visits.	
Outpatient Opioid Detoxification Treatment...3	
Benefit limit of an uninterrupted 4 month period per member lifetime when received by a participating behavioral health provider.	$0
3No PCP referral required. Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839- 7972 for more information. Pre-authorization is required for all services except routine outpatient visits.	
Mental Health...4	
Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional.	$20 per visit /individual therapy session $20 per visit /group therapy session
4Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839-7972 for more information. Pre-authorization is required for all services except routine outpatient visits.	
Serious Mental Illness (SMI) 5	
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. Care for these conditions by a participating provider facility.	$0 inpatient facility copay $0/inpatient professional visit $0/partial hospitalization day
5Services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839-7972 for more information. Pre-authorization is required for all services except routine outpatient visits.	
Autism Spectrum Disorder 6	
Care provided for members under 21 years of age for the treatment of autism spectrum disorders (as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental disorders (DSM), or its successor including autistic disorder, Asperger's disorder and Pervasive Development Disorder not otherwise specified.) which includes, pharmacy, psychiatric and psychological, rehabilitative and therapeutic care.	
Pharmacy care	Copayment per outpatient prescription drug or 50% coinsurance for members with no prescription drug coverage
Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist.	$20 per visit individual therapy session / $20 per visit 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.	$35 per day
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	$35 per day
6For psychiatric, psychological and rehabilitative care, services must be provided by facilities participating with the Plan's behavioral health manager. Call (888) 839-7972 for more information. Pre-authorization is required for all services except routine outpatient visits.	
Additional Services	**You Pay**
Non-Serious Mental Illness	
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. Care for acute short-term psychiatric conditions in a participating provider facility: No PCP referral required. Services must be provided by facilities participating with the Plan's behavioral health manager. You must receive pre-authorization by calling (888) 839-7972.	$0 inpatient facility $0/inpatient professional visit $0 /partial hospitalization day

Eye Exams	
One eye exam per year to determine the refractive error of the eye. No PCP referral required.	$0
Impacted Wisdom Teeth Extraction	
Oral surgery by participating provider for extraction of partially or totally bony impacted third molars. Service covered in the physician's office. Hospital and ambulatory surgical center services are not covered.	$0
Triple Choice Option for Outpatient Prescription Drugs[7]	
34-day supply per copayment for outpatient prescription drugs from a participating pharmacy. Most covered drugs are listed on the formulary, a continually updated list of commonly covered drugs. Each drug assigned to a tier. Tier 1: most generic drugs; prior authorization is generally not required. Tier 2: certain generic drugs and formulary brand name drugs with no generic equivalent; prior authorization may be required. Tier 3: some formulary brand name drugs with generic equivalents and other brand name drugs, including some not listed on the formulary; it may include certain generic drugs; prior authorization may be required. Provider must request prior authorization. For information call Pharmacy Services at (800) 988-4861.	Tier 1: $15 for 34-day supply Tier 2: $30 for 34-day supply Tier 3: $50 for 34-day supply
Contraceptives; includes diaphragms	$0 generic / $0 brand name drugs with no generic equivalent
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/90 -day supply

[7]The Plan reserves the right to restrict vendors and apply quantity limitations.

Additional discounts

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

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

Member Information

We want our members to be well informed. The following information is available by contacting our Customer Service 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 drugs/procedures
- Pharmacy formulary
- Provider credentialing process
- Summary of quality assurance program
- Provider privileges at contracted hospitals

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