Geisinger Choice PPO with No Referral Required and Preventive Services
Summary of Benefits
Philips North America LLC

	Preferred Provider	Non-Preferred Provider
Deductible	$0 single $0 family	$250 single $750 family
Deductible must be satisfied every coverage period before coinsurance applies. Copayments do not apply to the deductible.		
Coinsurance	0%	20%
Coinsurance Maximum	$0 single $0 family	$2,500 single $7,500 family
Deductible does not apply to coinsurance maximum.		
Maximum Out of Pocket	$7,150 single $14,300 family	$0 single $0 family
Lifetime Benefit	Unlimited	Unlimited

SERVICES covered when medically necessary	**Preferred Provider You Pay**	**Non-Preferred Provider You Pay ***
Outpatient Services		
PCP office visits.	$20	20% after deductible
Specialist office visit.	$20	20% after deductible
Periodic health assessments/routine physicals.	$20	20% after deductible
Outpatient surgery.	$0	20% after deductible
Preventive Services For a Full list of preventive services refer to https://www.healthcare.gov/what-are-my-preventive- care-benefits All PPACA Preventive Services including but not limited to:		
Mammograms.	$0	20% after deductible
Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel.	$0	20% after deductible
Pap smears.	$0	20% after deductible
Chlamydia screening for females ages 16-25.	$0	20% after deductible
Dexa scan.	$0	20% after deductible
Fecal occult blood testing.	$0	20% after deductible
Cholesterol screening.	$0	20% after deductible
Diabetes care including HbA1c testing, LDL-C screening and nephropathy screening.	$0	20% after deductible
Lipid panel.	$0	20% after deductible
Newborn screening: one hematocrit and hemoglobin screening for infants under 24 months.	$0	20% after deductible
Colorectal Cancer Screening		
Colorectal cancer screening, limited to flexible sigmoidoscopy, colonoscopy and related services covered 100%. Note: preparation medication is not covered under the medical benefit. However, preparation medication may be covered under your pharmacy benefit, which will be subject to your normal pharmacy benefit cost-sharing.	$0	20% after deductible
Well-Child Services		
Well-child office visits (age 0-21)	$0	20% after deductible
Testing Services		
X-rays, laboratory and other diagnostic tests.	$0	20% 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	20% after deductible
All Other Diagnostic Services		
Ostomy supplies.	$0	Not Covered
Medically necessary urological supplies.	$0	Not Covered
Other diagnostic services.	$0	20% after deductible
Well-Woman Care		
Annual gynecological examination.	$0	20% after deductible
Maternity Care		
Maternity Hospitalization. Limit: 90 inpatient days per benefit year when services are performed by a non-preferred provider.	$50/day (max $250/admission)	20% after deductible
Maternity care by your physician before and after the birth of your baby. No referral required for In-Network benefits.	$0	20% after deductible
Hospitalization		
Care in a semi-private room at a participating facility. Includes intensive care, cardiac care unit services, obstetrical care, newborn care, transplant services, medications and diagnostic tests. Limit: 90 inpatient days per benefit year when services are performed by a non-preferred provider.	$50/day (max $250/admission)	20% after deductible
Medical and surgical specialist care, including anesthesia.	$0	20% after deductible
Surgery for Correction of Obesity		
Facility charges.	$2,000 (does not apply to out-of-pocket maximum)	Not covered
Professional charges.	$0	Not covered
Emergency Services		
Emergency care.	$50 (waived if admitted to hospital)	$50 (waived if admitted to hospital)
Ambulance service to and from hospital.	$0	$0
Critical response air transport.	$0	$0
Urgent care.	$20	$20
Rehabilitation Services..		
Physical therapy for back pain, limited to 2 series of 5 visits each, per benefit period.	$20 per series	Not covered
Spinal injections for back pain	$0, if coinsurance is 0% then 30% coinsurance applies	Not covered
Physical, Occupational and Speech Therapy	$20	20% after deductible
Cardiac rehabilitation, outpatient, up to 36 sessions/benefit year.	$0	20% after deductible
Pulmonary rehabilitation benefit, outpatient, limit to 36 sessions per benefit year	$0	20% after deductible
Diabetes Services and Supplies[1]		
Diabetic eye examination.	$0	20% after deductible
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.	25% coinsurance for 34-day supply per prescription or refill	Not Covered
Diabetic foot orthotics.	$0	Not covered
Home blood glucose monitors: Lifescan brand diabetic supplies only. Must be purchased at a participating pharmacy.	$0	Not covered
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	$0	Not covered
[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	20% after deductible
Home health care	$0	20% after deductible
Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.	$0	20% after deductible
Implanted Devices (medical and contraceptive)		
Drug delivery.	50%	
Contraceptives	$0	50% plus 20% coinsurance

Specialty Drugs		
For select high-cost specialty drugs. $1,500 maximum out-of-pocket per benefit year.	$150 copay per injection/infusion	20% after deductible
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	Not covered
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	Not covered
Orthotic Devices		
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	50% coinsurance	Not covered
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	Not covered
Alcohol and Drug Abuse Treatment..[2]		
Inpatient detoxification. Limit: 90 inpatient days per benefit year when services are performed by a non-preferred provider.	$50/day (max $250/admission)	20% after deductible
Non-hospital residential inpatient rehabilitation. Limit: 90 inpatient days per benefit year when services are performed by a non-preferred provider.	$50/day (max $250/admission)	20% after deductible
Outpatient rehabilitation at an alcoholism/drug abuse facility.	$20 individual therapy session /$20 group therapy session	20% after deductible
[2]No 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]		
Subutex and Suboxone are covered as part of this treatment if the member has a GHP drug rider. If the member does not have a GHP drug rider, the detox sessions are covered but Subutex or Suboxone are not covered.	$0	20% after deductible
[3]No 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 individual therapy session /$20 group therapy session	20% after deductible
[4]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.		
Serious Mental Illness (SMI) Rider...[5]		
Care provided for the following serious mental illnesses: schizoprenia, 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.	$50/day (max $250/admission)/inpatient facility $0/inpatient professional visit $0/partial hospitalization day	20% after deductible
[5]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.		
Non-Serious Mental Illness Rider...		
Non-Serious mental illnesses that exclude schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulemia 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.	$50/day (max $250/admission)/ inpatient facility $0/inpatient professional visit $0/partial hospitalization per day	20% after deductible
Autism Spectrum Disorder Rider[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 rider or 50% coinsurance for members with no prescription drug rider	Not covered

Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist.	$20 individual therapy session /$20 group therapy session	20% 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.	$20 per day	20% after deductible
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	$20 per day	20% after deductible
[6]For 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.		
[*]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.		

Additional Services	**Preferred Provider** **You Pay**	**Non-Preferred Provider** **You Pay ***
Outpatient Prescription Drugs[7]		
Outpatient prescription drugs from a participating pharmacy are covered if specified in the Health Plan's formulary, a continually updated list of drugs covered by the Health Plan. 34-day supply per copayment. Formulary drugs may require prior authorization. Non-formulary exceptions may be approved for coverage at the provider's request. Coverage is for generic drugs when they have equivalent ratings in the drug products list (Orange Book - U.S. Department of Health and Human Services). In this case, the brand drug is covered only when medically necessary. If not medically necessary, members can select the brand drug and pay the difference between the two, which can be substantial. Includes insulin and insulin syringes. To answer your questions regarding this benefit, please call Pharmacy Services at (800) 988-4861.	25% coinsurance for 34-day supply per prescription or refill	Not Covered
Contraceptives; includes diaphragms.	Copayment amount depends on tier for 30-day supply	Not Covered
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 of 25%/90-day supply	Not covered
[7]The Plan reserves the right to restrict vendors and apply quantity limitations.		
Therapeutic Adjustment Services		
Manipulative treatment, electrical stimulation-attended, ultrasound, exercise therapy for strength and endurance and range of motion, re-education posture and proprioception, and exercise therapy to improve functional performance. Services must be performed by a participating provider. Maximum: 15 visits/benefit year.	$20	Not covered
Eye Exams		
One eye exam per year to determine the refractive error of the eye. No PCP referral required.	$0	Not covered
Please review individual rider documents for limitations and exclusions.		
[*]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.		

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 ®

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 Service Team.

Medical Necessity or Medically Necessary: covered services rendered by a health care provider that the insurer determines are: a) appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury; b) provided for the diagnosis, or the direct care and treatment of the member's condition, illness, disease or injury; c) in accordance with current standards of medical practice; d) not primarily for the convenience of the member, or the member's health care provider; and e) the most appropriate source or level of service that can safely be provided to the member. When applied to hospitalization, this further means that the member requires acute care as an inpatient due to the nature of the services rendered or the member's condition, and the member cannot receive safe or adequate care as an outpatient.

Precertification: the process of calling the PPO to receive authorization for whereby all non-emergency inpatient hospital admissions and designated procedures and services listed in the Subscription Certificate are reviewed and approved for coverage determination by the PPO, prior to the prevision of services.

PCP: primary care physician.

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.

The following services are not covered under the benefits provided: * ayurveda * craniosacral therapy * guided imagery * hippotherapy * homeopathy * massage therapy * naturopathy * reiki * therapeutic touch * yoga * Acupuncture * Drugs and prescribed medications provided on a daily basis, unless specifically covered under a supplemental rider * Drugs and devices for contraception, or as may be covered under a supplemental rider * Personal comfort items in the hospital (such as radio, television, telephone and special meals) * Custodial, domiciliary or convalescent care for which the facilities of acute general hospital or of a skilled nursing facility are not medically necessary * Physical, psychiatric or psychological examinations, diagnostic testing, reports, vaccinations, or immunizations for a third party which are not medically necessary * Reversal of sterilization * Dental care including but not limited to restoration, correction of malocclusion and/or orthodontia, repair or extraction of erupted teeth or impacted teeth, dental X-rays, anesthesia, analgesia, or other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures * Whole blood and blood plasma * Artifically created blood products * Routine nail trimmings * Infertility procedures * Private duty nursing * Hair removal * Implants, bridges, crowns & root canals * Surgery for the removal of excessive skin and its subcutaneous tissue, revision of external ear, vein sclerosing and stripping and breast reduction * Experimental medical or surgical procedures as determined by the Plan * Procedures, services and supplies related to sex transformations * Care for military service connected disabilities for which the member is legally entitled to covered services and for which facilities are accessible to the member * Care for covered services that state or local law requires to be treated in a public facility * Elective abortion * Services required as a result of commission or attempted commission of a felony by the member * The purchase, fitting, or adjustment of corrective devices including but not limited to eyeglasses, contact lenses and hearing aids * Maxillary or mandibular osteotomies * Hospital or ambulatory surgical center services to manage a member solely on the basis of the member's age * Expenses associated with surrogate motherhood * Drugs, services, supplies or treatments for which the member whould have no obligation to pay * Services required as a result of a member's participation in a riot or insurrection * Charges of missed appointments by the member * Genetic counseling and testing * Orthoptic therapy * Hypnosis * Weight reduction programs for non-morbid obesity, except as offered by the Plan's designated vendor * Stretcher/wheelchair van transportation and transportation services for convenience * Enteral feeding and food supplements except as expressly covered for certain diagnosis * Storage of blood including autologous blood and cord blood * Travel expenses for transplant services * Batteries required for diabetic medical equipment * Splints for TMJ conditions * Biofeedback * Organ donation to non-members * Obesity surgery and podiatric services are not covered when a member self-refers * Podiatry services as follows: treatment of bunions except capsular or bone surgery, corns, calluses, fallen arches, flat feet, foot strain except for diabetic conditions) * Services provided by a member's relative * Antihemophilic agents unless specified in a supplemental rider * Any cost for non-preferred provider services that exceed the lifetime maximum benefit, the non-preferred provider fee schedule amount, or all non-emergency inpatient hospital admissions and certain designated procedures and services for which precertification is not obtained * Benefits for persons whose permanent residence is outside the PPO service area * Any type of services, supplies or treatments not specifically provided for in the Subscription Certificate and riders * Government-sponsored health benefit programs which include charges to the extent payment had been made by any federal, state, or local government program * Services obtained from non-preferred providers: mental health or substance abuse services; organ, bone marrow or stem cell transplants, evaluations and related services; diabetic medical equipment, supplies, prescriptions and foot orthotics; enternal feedings/food supplements; obesity surgery; podiatric services and genetic counseling and testing * Refractions unless specified in a supplemental rider * Chiropractic services unless specified in a supplemental rider * Complications that occur as a result of non-covered procedure/service * Cosmetic or reconstructive surgery, unless deemed medically necessary to restore normal physiological function * Complications that occur as a result of cosmetic procedure/service