

**PA Trust/Central Susquehanna Trust
Geisinger All-Access HDHP 1650 Plan
Administered by GIIC
Summary of Benefits
Effective January 1, 2025**

Deductible \$1,650 single
\$3,300 family

Applies to all services, prescription drugs and medical equipment. Must be satisfied every coverage period before copayment/coinsurance applies.

Coinsurance 0%

Coinsurance Maximum \$0 single
\$0 family

Deductible does not apply to coinsurance maximum.

Maximum Out of Pocket \$8,300 single
\$16,600 family

Services covered when medically necessary You Pay

| Outpatient Physician Services | |
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| Primary care office visits (PCP). | \$20 after deductible |
| Periodic health assessments/routine physicals. | \$0 |
| Specialist office visit. | \$40 after deductible |
| Telehealth (virtual visit) | |
| Primary care physician | \$20 after deductible |
| Specialist physician | \$40 after deductible |
| Behavioral health and substance abuse therapy | \$20 after deductible |
| Emergency Services | |
| Emergency care. | \$100 after deductible (waived if admitted to hospital) |
| Emergency ambulance transportation. | 0% after deductible |
| Critical response air transport. | 0% after deductible |
| Urgent care. | \$50 after deductible |
| Urgent care for mental health and substance abuse. | 0% after deductible |
| Preventive Services: For a Full list of preventive services refer to healthcare.gov/coverage/preventive-care-benefits. All PPACA Preventive Services including but not limited to: | |
| Mammograms. | \$0 |
| Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel. | \$0 |
| Pap smears. | \$0 |
| Chlamydia screening. | \$0 |
| Dexa scan. | \$0 |
| Fecal occult blood testing. | \$0 |
| Cholesterol screening. | \$0 |

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| Diabetes care 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 |
| Well-Child Services | |
| Well-child office visits (age 0-21) | \$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. | \$0 |
| Outpatient Services | |
| Outpatient surgery. | 0% after deductible |
| X-rays, laboratory, and diagnostic tests. | 0% 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 |
| Ostomy supplies. | 0% after deductible |
| Urological supplies. | 0% after deductible |
| Other diagnostic services. | 0% after deductible |
| Colorectal Cancer Screening | |
| Colorectal cancer screening, limited to flexible sigmoidoscopy, colonoscopy and related services covered 100%. Includes preparation medication. | \$0 |
| Maternity Care | |
| Maternity care by your physician before and after the birth of your baby. | \$0 |
| Maternity hospitalization. | 0% after deductible |
| Hospitalization | |
| Medical and surgical specialist care, including anesthesia. | 0% after deductible |
| 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% after deductible |
| Surgery for Correction of Obesity (cost sharing does not apply to maximum out-of-pocket) | |
| Facility charges. | \$2,000 |
| Professional charges. | 0% after deductible |
| Rehabilitation Services | |
| Spinal injections for back pain | 0% after deductible |
| Speech Therapy. Limited to 12 visits per benefit period. | \$40 after deductible |

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| Physical, Occupational, and respiratory Therapy. Limited to 20 visits each per benefit period. | \$40 after deductible |
| Cardiac rehabilitation, outpatient, up to 36 sessions/benefit year. | 0% after deductible |
| Pulmonary rehabilitation benefit, outpatient, limit to 36 sessions per benefit year | 0% after deductible |
| Diabetes Services and Supplies ¹ | |
| Diabetic eye examination. | \$0 |
| 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). | After deductible: Tier 1: \$10 for 34-day supply Tier 2: \$30 for 34-day supply Tier 3: \$75 for 34-day supply |
| Diabetic foot orthotics. | 0% after deductible |
| 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% after deductible |
| 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 per period of confinement per person (limit waived for Mental Health / Substance Use diagnosis). | 0% after deductible |
| Home health care. | 0% after deductible |
| Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services. | 0% after deductible |
| Implanted Devices (medical and contraceptive) | |
| Drug delivery. | 0% after deductible |
| Contraceptives | 0% after deductible |
| 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) | \$100 after deductible 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% after deductible |
| 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% after deductible |
| Orthotic Devices | |
| Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider. | 0% after deductible |
| Alcohol and Drug Abuse Treatment | |
| Inpatient detoxification. | 0% after deductible |

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| Non-hospital residential inpatient rehabilitation. | 0% after deductible |
| Outpatient rehabilitation at an alcoholism/drug abuse facility. | \$20 individual therapy session after deductible \$20 group therapy session after deductible |
| Outpatient Opioid Detoxification Treatment | |
| Buprenorphine and buprenorphine/naloxone are covered as part of this treatment. | 0% after deductible |
| Mental Health | |
| Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional. | \$20/individual therapy session after deductible \$20/group therapy session after deductible |
| 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 |
| Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist. | \$20 individual therapy session after deductible \$20 group therapy session 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. | \$40 per day after deductible |
| Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists. | \$40 per day after deductible |
| Applied behavioral analysis (ABA) for autism. | \$20 after deductible |

Additional Services

You Pay

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| Triple Choice Option for Outpatient Prescription Drugs ² | |
| 34-day supply per copayment for outpatient prescription drugs from a participating pharmacy. Most covered drugs are listed on the formulary, a continually updated list of commonly covered drugs. Each drug is assigned to a tier. Tier 1: most generic drugs; prior authorization is generally not required. Tier 2: certain generic drugs and formulary brand name drugs with no generic equivalent; prior authorization may be required. Tier 3: some formulary brand name drugs with generic equivalents, other brand name drugs, and non-formulary drugs if approved; prior authorization may be required. Provider must request prior authorization. For information call Pharmacy Services at (800) 988-4861. | After deductible: Tier 1: \$10 for 34-day supply Tier 2: \$30 for 34-day supply Tier 3: \$75 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 |

²The Plan reserves the right to restrict vendors and apply quantity limitations.

Manipulative Treatment Services Rider

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 20 visits/benefit year.

\$40 per visit after deductible

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% after deductible

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 (844) 863-6850.

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 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 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.

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 Summary Plan Description and applicable riders under which a member is enrolled. This managed care plan may not cover all your health care expenses. Read your Summary Plan Description and riders carefully to determine which health care services are covered.