Solutions Extra
Summary of Benefits
OneSource Temp Staffing Solutions

Deductible Deductible must be satisfied every coverage period before coinsurance applies. Copayments do not apply to the deductible.	$7,100 single $21,300 family
Coinsurance	0%
Coinsurance Maximum Deductible does not apply to coinsurance maximum.	$0 single $0 family
Maximum Out of Pocket	$7,150 single $14,300 family

SERVICES covered when medically necessary	**You Pay**
PCP Office Services	
Office visits (PCP).	$40
Office visits at an Extra site (PCP).	$25
Periodic health assessments/routine physicals (PCP).	$40
Periodic health assessments/routine physicals at an Extra site (PCP).	$25
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
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 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
Testing Services	
X-rays, laboratory and other 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
All Other Diagnostic Services	
Ostomy supplies.	0% after deductible
Medically necessary urological supplies.	0% after deductible
Other diagnostic services.	0% after deductible
Specialist Office Services	
Office visits.	$75
Office procedures.	0% after deductible
Well-Woman Care	
Annual gynecological examination.	$0

Maternity Care	
Maternity care by your physician before and after the birth of your baby. No referral required.	$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	
Facility charges.	$2,000 (does not apply to out-of-pocket maximum)
Professional charges.	0% after deductible
Emergency Services	
Emergency care.	$300 (waived if admitted to hospital)
Emergency ambulance transportation.	$0
Critical response air transport.	$0
Urgent care.	$40
Rehabilitation Services..	
Physical therapy for back pain, limited to 2 series of 5 visits each, per benefit period.	$75 per series
Spinal injections for back pain	0% after deductible, if coinsurance 0% then 30% coinsurance applies
Physical, Occupational and Speech Therapy	$75
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.	50% coinsurance for 34-day supply per prescription or refill
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
[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% after deductible
Home health care	$0
Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.	$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.	$150 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%
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
Alcohol and Drug Abuse Treatment...[2]	
Inpatient detoxification.	0% after deductible
Non-hospital residential inpatient rehabilitation.	0% after deductible
Outpatient rehabilitation at an alcoholism/drug abuse facility.	$40 individual therapy session /$40 group therapy session
[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% 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.	$40/individual therapy session $40/group therapy session
[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.	0% after deductible/ inpatient facility 0% after deductible/inpatient professional visit 0% after deductible/partial hospitalization day
[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.	0% after deductible inpatient facility 0% after deductible/inpatient professional visit 0% after deductible/partial hospitalization day
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
Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist.	$40 individual therapy session /$40 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.	$75 per day
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	$75 per day
[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.	

Additional Services — 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.	50% coinsurance for 34-day supply per prescription or refill
Contraceptives; includes diaphragms.	Copayment amount depends on tier for 30-day supply

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 of 50%/90-day supply
[7]*The Plan reserves the right to restrict vendors and apply quantity limitations.*	
Eye Exams	
One eye exam per year to determine the refractive error of the eye. No PCP referral required.	$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 ®
- 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) 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 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 Service 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 Service 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: that are not available from the member's PCP but are available within the Plan's network must be authorized in advance by your PCP, with the exception of obstetrical or gynecological services for which you may self-refer. Mental health and substance abuse services require prior authorization from United Behavorial Health. 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.

PCP: primary care physician.

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.

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 * When self-referred in or out-of-network: implanted devices for drug delivery and contraception; organ, bone marrow, stem cell or corneal transplants, evaluations and related services * 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 type of services, supplies or treatments not specifically provided for in the Subscription Certificate and riders * Unauthorized services * Amounts that exceed the maximum benefit limit * Non-emergency services or supplies received from non-participating providers * Prosthetics, orthotics, durable medical equipment and medical supplies unless specified in a supplemental rider * Mental health inpatient and partial hospitalization services unless specified in a supplemental rider * Charges to the extent payment has been made under Medicare when Medicare is the primary carrier or by any other federal, state or local government program * Sexual dysfunction services, devices and equipment * 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

:OneSource Temp Staffing Solutions:PGHME3O51 dev. gen. 10/26/2017