

HMO

Summary of Benefits

Hope Enterprises Inc - HMO

SERVICES covered when medically necessary

You Pay

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| Outpatient Services | |
| Routine office visits. | \$10 |
| Specialist office visit with referral. | \$10 |
| Periodic health assessments/routine physicals. | \$10 |
| Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel. | \$0 |
| Outpatient surgery. | \$0 |
| Ostomy supplies. | \$0 |
| Well-Baby Care | |
| Office visits, including well-child care. | \$10 |
| 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 |
| 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. | \$10 if performed by PCP \$10 if performed by specialist |
| Annual mammogram for women forty (40) years of age and older. | \$0 |
| Maternity Care | |
| Maternity care by your physician before and after the birth of your baby. No referral required. | \$10 for first visit only subsequent visits covered 100% |
| Hospitalization | |
| Care in a semi-private room at a Plan-approved facility. Includes intensive care, cardiac care unit services, obstetrical care, newborn care, medications, diagnostic tests and transplant services. | \$0 |
| Medical and surgical specialist care, including anesthesia. | \$0 |
| Surgery for Correction of Obesity | |
| Facility charges. | \$2,000 |
| Emergency Services | |
| Emergency care. | \$75 (waived if admitted to hospital) |
| Emergency ambulance transportation. | \$0 |
| Critical response air transport. | \$0 |
| Rehabilitation Services | |
| Physical therapy, speech therapy, occupational therapy, for up to 45 dates of service per calendar year. | \$10 |
| Cardiac rehabilitation, outpatient, up to 36 sessions/year. Requires prior Plan approval. | \$0 |
| Diabetes Services and Supplies¹ | |
| Prescription/supply coverage: Lifescan test strips, 34-day supply 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). | Tier 1: \$20 for 34-day supply Tier 2: \$35 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. | \$10 |
| Home health care by specialist. | \$10 |

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| 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. \$10,000 lifetime maximum per member. | \$0 |
| Breast Prosthetic Benefit | \$0 |
| Implanted Devices (medical and contraceptive) | |
| Drug delivery. | 50% |
| Contraceptives (must have contraceptive rx rider for coverage to apply.) | 50% |
| Specialty Drugs | |
| For select high-cost specialty drugs. \$1,200 maximum out-of-pocket per calendar year. | \$50 per injection/infusion |
| Alcohol and Drug Abuse Treatment² | |
| Inpatient detoxification. Up to 7 days per admission. Lifetime limit: 4 admissions. | \$0 |
| Non-hospital residential inpatient rehabilitation; up to 30 days/year. Lifetime limit: 90 inpatient days. | No copay for initial course of rehabilitation. 50% copayment applies to second and subsequent episodes of care. |
| Outpatient rehabilitation at an alcoholism/drug abuse facility up to 30 visits/year. An additional 30 visits are available if authorized by the primary care physician, which can be exchanged two visits for one day of inpatient rehabilitation services. Lifetime limit: 120 outpatient visits. | No copay for initial course of rehabilitation. 50% copayment applies to second and subsequent episodes of care. |
| 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 by is required for all services except routine outpatient visits. | |
| Mental Health³ | |
| Mental health care by psychiatrist, licensed clinical psychologist or other licensed behavioral health professional: 30 outpatient visits (55-minute) per calendar year. | \$25 copay/individual therapy visit \$10 copay/group therapy session |
| 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 by is required for all services except routine outpatient visits. | |
| Serious Mental Illness (SMI) Rider⁴ | |
| 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: up to 30 inpatient days per calendar year and 60 outpatient visits per calendar year. Conversion option: 1 inpatient day (SMI) to either 2 outpatient visits or 2 partial hospitalization days. | \$0 inpatient facility copay \$25 copay/inpatient professional visit \$25 copay/partial hospitalization day |
| ⁴ 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 by is required for all services except routine outpatient visits. | |

Supplemental benefits through "RIDERS"

You Pay

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| Non-Serious Mental Illness Rider | |
| 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: up to 30 inpatient days per calendar year (subject to a limit of 30 inpatient days per admission). Conversion option: 1 inpatient day for 2 partial hospitalization days. Lifetime limit: 90 inpatient mental health days or 180 partial hospitalization days. 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 copay \$25 copayment/professional visit \$25 copayment/partial hospitalization per day |
| Eye Exams | |
| One eye exam per year to determine the refractive error of the eye. No PCP referral required. | \$0 |
| 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, up to \$2,500 per member per calendar year. 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. Plan pays up to \$5,000 per member per calendar year. 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 |
| 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 Drugs⁵ | |

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| 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; no prior authorization required. Tier 2: certain 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; prior authorization may be required. Provider must request prior authorization. For information call Pharmacy Services at (800) 988- 4861. | Tier 1: \$20 for 34-day supply Tier 2: \$35 for 34-day supply Tier 3: \$50 for 34-day supply |
| 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 amount(s) depending on tier/90-day supply |
| ⁵ The Plan reserves the right to restrict vendors and apply quantity limitations. | |
| American Specialty Health Network, Inc. Manipulative Treatment Services Rider | |
| Direct access to participating providers for chiropractic services which may include patient exams, manipulation, adjunctive therapy, X-rays and clinical lab tests. Chiropractic appliances covered up to \$50/year when prescribed by participating provider. Maximum: 15 visits/calendar year. Members with American Specialty Health Network's (ASHN) Chiropractic Services Rider should log on to www.thehealthplan.com or contact ASHN at (800) 972-4226 for network information. | \$10 |
| <i>Please review individual rider documents for limitations and exclusions.</i> | |

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
- Description of process for Formulary exception
- Provider credentialing process
- Summary of provider reimbursement methodologies
- Procedures for covering experimental drugs/procedures
- Summary of quality assurance program
- Provider List and/or monthly Provider List Updates
- Pharmacy formulary
- 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 Behavioral 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 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.

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: * Acupuncture * Amounts that exceed the maximum benefit limit * 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 * Artificially created blood products * Batteries required for diabetic medical equipment * Benefits for persons whose permanent residence is outside the Plan service area * Biofeedback * Care for covered services that state or local law requires to be treated in a public facility * 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 related to autistic disease of childhood, hyperkinetic syndrome, learning disabilities, behavioral problems and mental retardation, which extends beyond traditional medical management * Charges of missed appointments by the member * 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 * Custodial, domiciliary or convalescent care for which the facilities of acute general hospital or of a skilled nursing facility are not medically necessary * 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 * Drugs and devices for contraception, or as may be covered under a supplemental rider * Drugs and prescribed medications provided on a daily basis, unless specifically covered under a supplemental rider * Drugs, services, supplies or treatments for which the member would have no obligation to pay * Elective abortion * Enteral feeding and food supplements except as expressly covered for certain diagnosis * Expenses associated with surrogate motherhood * Experimental medical or surgical procedures as determined by the Plan * Genetic counseling and testing * Hair removal * Hospital or ambulatory surgical center services to manage a member solely on the basis of the member's age * Hypnosis * Implants, bridges, crowns & root canals * Infertility procedures * Maxillary or mandibular osteotomies * Mental health inpatient and partial hospitalization services unless specified in a supplemental rider * Non-emergency services or supplies received from non-participating providers * Obesity surgery and podiatric services are not covered when a member self-refers * Organ donation to non-members * Orthoptic therapy * Personal comfort items in the hospital (such as radio, television, telephone and special meals) * Physical, psychiatric or psychological examinations, diagnostic testing, reports, vaccinations, or immunizations for a third party which are not medically necessary * Podiatry services as follows: treatment of bunions except capsular or bone surgery, corns, calluses, fallen arches, flat feet, foot strain except for diabetic conditions) * Private duty nursing * Procedures, services and supplies related to sex transformations * Prosthetics, orthotics, durable medical equipment and medical supplies unless specified in a supplemental rider * Refer to supplemental riders for a complete description of covered and non-covered services * Reversal of sterilization * Routine nail trimmings * Services provided by a member's relative * Services required as a result of a member's participation in a riot or insurrection * Services required as a result of commission or attempted commission of a felony by the member * Sexual dysfunction services, devices and equipment * Splints for TMJ conditions * Storage of blood including autologous blood and cord blood * Stretcher/wheelchair van transportation and transportation services for convenience * Surgery for the removal of excessive skin and its subcutaneous tissue, revision of external ear, vein sclerosing and stripping and breast reduction * The purchase, fitting, or adjustment of corrective devices including but not limited to eyeglasses, contact lenses and hearing aids * Travel expenses for transplant services * Weight reduction programs for non-morbid obesity, except as offered by the Plan's designated vendor * 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 * Whole blood and blood plasma * Refractions unless specified in a supplemental rider * Chiropractic services unless specified in a supplemental rider * Cosmetic or reconstructive surgery, unless deemed medically necessary to restore normal physiological function