

POS

Summary of Benefits

Hope Enterprises Inc - POS

	Referred to a participating provider	Self-Referred to a participating or non- participating provider
Deductible	Not Applicable	\$250 single \$750 family
Must be satisfied every coverage period.		
Copayments do not apply to the deductible.		
Coinsurance	Not Applicable	20%
Lifetime Benefit	Not Applicable	\$1,000,000 lifetime/member
Applies to all eligible covered services.		
Coinsurance Maximum	Not Applicable	\$2,500 single \$7,500 family
Deductible does not apply to coinsurance maximum.		

SERVICES covered when medically necessary	Referred to a participating provider You Pay	Self-Referred to a participating or non- participating provider You Pay *
Outpatient Services		
Routine office visits.	\$10	20% after deductible
Specialist office visit with referral.	\$10	20% after deductible
Periodic health assessments/routine physicals.	\$10	20% after deductible
Immunizations covered in accordance with accepted medical practices, excluding immunizations necessary for international travel.	\$0	20% after deductible
Outpatient surgery.	\$0	20% after deductible
Ostomy supplies.	\$0	20% after deductible
Well-Baby Care		
Pediatric office visits, including well-child care.	\$10	20% after deductible
Pediatric immunizations and inoculations.	\$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
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	20% after deductible
Annual mammogram for women forty (40) years of age and older.	\$0	20% after deductible
Maternity Care		
Maternity care by your physician before and after the birth of your baby. No referral required.	\$10 copay for first visit only; subsequent visits covered 100%	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 calendar year when services are performed by a non-preferred provider.	\$0	20% after deductible
Medical and surgical specialist care, including anesthesia.	\$0	20% after deductible
Surgery for Correction of Obesity		
Facility charges.	\$2,000	Not covered

Emergency Services		
Emergency care.	\$75 (waived if admitted to hospital)	\$75 (waived if admitted to hospital)
Ambulance service to and from hospital.	\$0	\$0
Critical response air transport.	\$0	\$0
Rehabilitation Services		
Physical therapy, speech therapy, occupational therapy, for up to 45 dates of service per calendar year.	\$10	20% after deductible
Cardiac rehabilitation, outpatient, up to 36 sessions/year. Requires prior Plan approval.	\$0	20% after deductible
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	Covered In-Network only
Diabetic foot orthotics.	\$0	Covered In-Network only
Home blood glucose monitors: Lifescan brand diabetic supplies only. Must be purchased at a participating pharmacy.	\$0	Covered In-Network only
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	\$0	Covered In-Network only
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
Skilled nursing in-home for members not requiring hospitalization.	\$0	20% after deductible
Home health care by primary care physician.	\$10	20% after deductible
Home health care by specialist.	\$10	20% after deductible
Home health care by other participating skilled professional.	\$0	20% after deductible
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	20% after deductible
Breast Prosthetic Benefit	\$0	Covered In-Network only
Implanted Devices (medical and contraceptive)		
Drug delivery.	50%	50% plus 20% coinsurance
Contraceptives (must have contraceptive rx rider for coverage to apply.)	50%	50% plus 20% coinsurance
Specialty Drugs		
For select high-cost specialty drugs. \$1,200 maximum out-of-pocket per calendar year.	\$50 per injection/infusion	20% after deductible
Alcohol and Drug Abuse Treatment²		
Inpatient detoxification. Up to 7 days per admission. Lifetime limit: 4 admissions.	\$0	Covered In-Network only
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.	Covered In-Network only
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.	Covered In-Network only
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		
Care by psychiatrist, licensed psychologist or other licensed behavioral health professional: 30 outpatient visits (55-minute)/calendar year.	\$25 copay/individual therapy visit \$10 copay/group therapy session	Covered In-Network only
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	Covered In-Network only

⁴No 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.

* Covered services provided by a non-participating provider will be based on the Health Plan's 'non-participating provider fee schedule.' This may subject the member to significant out-of-pocket expenses for services received from a non-participating provider. Emergency care or covered services not available from a non-participating provider and approved by the Health Plan are NOT subject to this fee schedule.

Supplemental benefits through "RIDERS"	Referred to a participating provider You Pay	Self-Referred to a participating or non-participating provider You Pay *
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	Covered In-Network only
Eye Exams		
One eye exam per year to determine the refractive error of the eye.	\$0	Covered In-Network only
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	Covered In-Network only
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	Covered In-Network only
Orthotic Devices		
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	50% coinsurance	Covered In-Network only
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	Covered In-Network only
Triple Choice Option for Outpatient Prescription Drugs⁵		
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	Covered at participating pharmacies only 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	Covered at participating pharmacies only 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	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	Covered In-Network only
--	------	-------------------------

Please review individual rider documents for limitations and exclusions.

*Covered services provided by a non-participating provider will be based on the Health Plan's 'non-participating provider fee schedule.' This may subject the member to significant out-of-pocket expenses for services received from a non-participating provider. Emergency care or covered services not available from a non-participating provider and approved by the Health Plan are NOT subject to this fee schedule.

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.

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.

Precertification: a process where all non-emergent inpatient hospital admissions and designated procedures and services covered under the point-of-service rider are reviewed and approved by the Plan, prior to provision of services.

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.

To receive coverage at "in-network" benefit levels:: 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 the Plan's behavioral health manager.

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 * 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 * 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 * External 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 * 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 * 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 * Chiropractic services unless specified in a supplemental rider * Cosmetic or reconstructive surgery, unless deemed medically necessary to restore normal physiological function