Bucknell UNIVERSITY | FACULTY AND STAFF HEALTH PLAN

HMO
Summary of Benefits
Effective January 1, 2021

Deductible

Deductible must be satisfied every coverage period before coinsurance applies.

Copayments do not apply to the deductible.

$500 single
$1,000 family

Coinsurance 10%

Maximum Out of Pocket
(Deductible, copayments and coinsurance apply)

$3,000 single
$6,500 family

SERVICES covered when medically necessary	You Pay
Outpatient Services	
ProvenHealth Navigator® (PHN) PCP office visits.	$20
Non-PHN PCP office visits.	$25
Specialist office visit	$30
Periodic health assessments/routine physicals.	$0
Nutritional Counseling	$30
Outpatient surgery.	10% 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
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, but is covered under the pharmacy benefit with no member cost-sharing.	$0
Well-Child Services	
Well-child office visits (age 0-21)	$0
Testing Services	
X-rays, laboratory and other diagnostic tests.	10% after deductible
Computed Axial Tomography (CAT Scan), Magnetic Resonance Imaging (MRI), and Position Emission Tomography (PET Scan), Magnetic Resonance Angiography (MRA) and nuclear cardiology.	10% after deductible
Pulmonary Function Test	10% after deductible
All Other Diagnostic Services	
Ostomy supplies.	10% after deductible

Medically necessary urological supplies.	10% after deductible
Other diagnostic services.	10% 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.	$0
Maternity Care	
Maternity care by your physician before and after the birth of your baby.	$0
Maternity hospitalization.	10% after deductible
One postpartum home health care visit for early discharge.	$0
Hospitalization...	
Medical and surgical specialist care, including anesthesia.	10% 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.	10% after deductible
Surgery for Correction of Obesity	
Facility charges. Prior Authorization is required; services must be provided at a fully accredited ACS BSCN facility.	10% after deductible
Emergency Services	
Emergency care.	$200 (waived if admitted to hospital)
Transport: Ambulance (medically necessary)	10% coinsurance (no deductible)
Critical response air transport.	10% coinsurance (no deductible)
Urgent Care.	$50

Rehabilitation and Habilitative Services	
Physical therapy for back pain management, limited to 2 series of 5 visits per member, per benefit period.	$30 per series
Physical therapy, unlimited visits.	$30
Orthoptic therapy, speech therapy and occupational therapy, unlimited visits.	$30
Cardiac rehabilitation, unlimited visits.	10% after deductible
Respiratory therapy, unlimited visits.	10% after deductible
Pulmonary rehabilitation, unlimited visits.	10% after deductible
Diabetes Services and Supplies[1]	
Diabetic eye examination.	$0
Prescription/supply coverage: Lifescan test strips (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.	Tier 1: $10 for 34-day supply Tier 2: $40 for 34-day supply Tier 3: $75 for 34-day supply
Diabetic foot orthotics.	10% after deductible
Home blood glucose monitors: Lifescan brand diabetic supplies only. Must be purchased at a participating pharmacy.	10% after deductible
Diabetic medical equipment: The following may be limited to specific vendors: injection aids, insulin pumps, syringe reservoirs and infusion sets.	10% 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.	10% after deductible
Home health care by primary care physician.	$20 PHN/$25 non-PHN
Home health care by specialist.	$30
Home health care by other participating skilled professional.	10% after deductible
Home health care, including select injectable drugs.	$0
Private duty nursing, limited to 240 hours per benefit period	10% after deductible
Hospice care: home and inpatient care including home health aide and homemaker services, counseling and medical social services.	10% after deductible
Breast Prosthetic Benefit	$0
Implanted Devices (medical and contraceptive)	
Drug delivery.	10% after deductible
Contraceptives	$0
Specialty Drugs	
For select high-cost specialty drugs.	$75
Infertility Services	

Artificial Insemination (AI) and In Vitro Fertilization (IVF) include infertility counseling, testing and services. The benefit period maximum includes the cost of injectables related to infertility services administered and/or dispensed in the physician's office. Limited to 3 attempts per lifetime per subscriber.	10% after deductible
Self-administered fertility drugs	Subject to the applicable prescription drug copayment
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.	10% 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.	10% after deductible
Orthotic Devices	
Rigid appliance used to support, align or correct bone and muscle deformities. Must be prescribed by participating provider.	10% after deductible
Alcohol and Drug Abuse Treatment...[2]	
Inpatient detoxification.	10% after deductible
Non-hospital residential inpatient rehabilitation.	10% after deductible
Outpatient rehabilitation at an alcoholism/drug abuse facility.	10% after deductible
Outpatient services when provided by other professional providers.	$20 PHN PCP/$25 non-PHN PCP/$30 SCP
[2]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.	10% after deductible
[3]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.	$25/individual therapy session $25/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) [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.	10% after deductible/inpatient facility 10% after deductible /inpatient professional visit 10% after deductible/partial hospitalization day 10% after deductible/non-hospital residential inpatient
[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.	
Autism Spectrum Disorder [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	Tier 1: $10 for 34-day supply Tier 2: $40 for 34-day supply Tier 3: $75 for 34-day supply
Psychiatric and Psychological Care: direct or consultative services provided by a psychiatrist or psychologist.	$25 individual therapy session /$25 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.	$30 per day
Therapeutic Care: includes services provided by speech pathologists, occupational therapists or physical therapists.	$30 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
Non-Serious Mental Illness	
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: Services must be provided by facilities participating with the Plan's behavioral health manager. You must receive pre-authorization by calling (888) 839-7972.	10% after deductible/inpatient facility 10% after deductible/inpatient professional visit 10% after deductible/partial hospitalization day 10% after deductible /non-hospital residential inpatient
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.	10% after deductible
Triple Choice Option for Outpatient Prescription Drugs[7]	
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; 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 and other brand name drugs, including some not listed on the formulary; it may include certain generic drugs; prior authorization may be required. Provider must request prior authorization. For information call Pharmacy Services at (800) 988-4861.	Tier 1: $10 for 34-day supply Tier 2: $40 for 34-day supply Tier 3: $75 for 34-day supply
Contraceptives; includes diaphragms.	$0 generic/brand with no generic equivalent
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 1/2 flat copays amount(s) depending on tier/90-day supply
[7]*The 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.	$30
Telehealth Services	
Telehealth (virtual visit) • Primary care physician • Specialist physician • Behavioral health and substance abuse therapy	 • $20 • $30 • $20
Please review Summary Plan Description for limitations and exclusions.	

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
- 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

Additional discounts

Through our Accessories Program, you have access to money-saving discounts on a host of health-related products and services.

- 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 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 member 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.

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 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 Summary Plan Description under which a member is enrolled. This managed care plan may not cover all your health care expenses.

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