
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-379-4489 or visit www.GeisingerHealthPlan.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary.com or call 1-866-379-4489 to request a copy.

| Important Questions | Answers | Why This Matters |
|---|---|---|
| What is the overall deductible ? | Preferred providers : \$4,900 / individual or \$9,800 / family Non-preferred providers : \$10,000 / individual or \$20,000 / family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care services are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. \$500 / individual or \$1,000 / family for prescription drug coverage . | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan ? | Preferred providers : \$9,100 / individual or \$18,200 / family Non-preferred providers : \$15,000 / individual or \$30,000 / family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.GeisingerHealthPlan.com or call 1-866-379-4489 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . |

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 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay: | | Limitations, Exceptions, & Other Important Information |
|--|--|--|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$30 copay / visit Deductible does not apply. | 40% coinsurance | None. |
| | Specialist visit | \$60 copay / visit Deductible does not apply. | 40% coinsurance | None. |
| | Preventive care / screening / immunization | No charge Deductible does not apply. | Not covered | Limited to 1 routine exam per year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 30% coinsurance | 40% coinsurance | Diagnostic: Cost sharing does not apply to mental health / substance use disorder diagnosis for preferred providers. Imaging: Precertification/ prior-authorization required. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 40% coinsurance | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.GeisingerHealthPlan.com . | Preferred Generic Drugs (Tier 2) | Retail / Mail Order: \$3 copay / prescription 90 Day Retail: \$6 copay / prescription Deductible does not apply. | Not covered | Tier 1 is limited to \$0 copay / prescription. Deductible does not apply. Tier 2-4: Covers up to a 34 day supply (retail); Covers between an 82-102 day supply (90 day retail/mail order). |
| | Non-Preferred Generic Drugs (Tier 3) | Retail / Mail Order: \$20 copay / prescription 90 Day Retail: \$40 copay / prescription Deductible does not apply. | Not covered | |
| | Preferred Brand Drugs (Tier 4) | Retail / Mail Order: \$50 copay / prescription 90 Day Retail: \$100 copay / prescription | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay: | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|--|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.GeisingerHealthPlan.com . | Non-Preferred Brand Drugs (Tier 5) | Retail / Mail Order: \$85 copay / prescription 90 Day Retail: \$170 copay / prescription | Not covered | Tier 5: Covers up to a 34 day supply (retail);Covers between an 82-102 day supply (90 day retail/mail order). Specialty Drugs (Tier 6) have no mail order option. |
| | Specialty Drugs (Tier 6) | 50% coinsurance up to \$9,100 | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 40% coinsurance | Precertification/ prior authorization may be required. |
| | Physician/surgeon fees | 30% coinsurance | 40% coinsurance | |
| If you need immediate medical attention | Emergency room care | \$300 copay / visit | \$300 copay / visit | Emergency services : Copay waived if admitted to the hospital. Emergency medical transportation : None. Urgent care : Mental health & substance abuse urgent care visit \$0. Deductible does not apply. |
| | Emergency medical transportation | No charge Deductible does not apply. | No charge Deductible does not apply. | |
| | Urgent care | \$30 copay / visit Deductible does not apply. | \$30 copay / visit Deductible does not apply. | |
| If you have a hospital stay | Facility Fee (e.g., hospital room) | 30% coinsurance | 40% coinsurance | Precertification/ prior authorization required. |
| | Physician/surgeon fees | 30% coinsurance | 40% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 copay / visit Deductible does not apply. | 40% coinsurance | Outpatient Services: None. Inpatient Services: Precertification/ prior authorization required. |
| | Inpatient services | 30% coinsurance | 40% coinsurance | |
| If you are pregnant | Office visits | No charge Deductible does not apply. | 40% coinsurance | Pregnancy office visits: None. Cost sharing does not apply for preventive services . Maternity care may include tests and services as described elsewhere in the SBC (i.e., ultrasound). Depending on the type of services, a copayment , coinsurance or deductible may apply. Inpatient professional and facility services; Precertification/ prior authorization required. |
| | Childbirth/delivery professional services | 30% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay: | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | No charge Deductible does not apply | 40% coinsurance | Limited to 60 visits / member / benefit period. Visit limits do not apply to mental health / substance use disorder benefits. |
| | Rehabilitation services | \$60 copay / visit Deductible does not apply. | 40% coinsurance | None. |
| | Habilitation services | \$60 copay / visit Deductible does not apply. | 40% coinsurance | None. |
| | Skilled nursing care | 30% coinsurance | 40% coinsurance | 120 days / benefit period / person. Day limit does not apply to mental health / substance use disorder diagnosis. |
| | Durable medical equipment | 30% coinsurance | Not covered | Cost sharing does not apply to mental health / substance use disorder diagnosis. |
| | Hospice services | Residential: \$60 copay /visit Facility: \$100 copay /day Deductible does not apply. | 40% coinsurance | None. |
| If your child needs dental or eye care | Children's eye exam | \$60 copay Deductible does not apply. | Not covered | Limited to 1 exam / benefit period / up to age 19. |
| | Children's glasses | 50% coinsurance Deductible does not apply. | 50% coinsurance Deductible does not apply. | Up to age 19 only. 1 frame every 12 months. |
| | Children's dental check-up | No charge Deductible does not apply. | Not covered | 1 exam per 6 months up to age 19. |

Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .) | | |
|--|---|---|
| <ul style="list-style-type: none"> Abortion (except in case of rape, incest, or where medically necessary to avert the death of the mother) Acupuncture Bariatric Surgery Cosmetic Surgery | <ul style="list-style-type: none"> Dental Care (Adult) Hearing Aids Long Term Care Non-emergency care when traveling outside the U.S. Private Duty Nursing | <ul style="list-style-type: none"> Routine eye care (Adult) Routine Foot Care Weight Loss Programs |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none"> Chiropractic Care | <ul style="list-style-type: none"> Infertility Treatment | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Pennsylvania Insurance Department at 1-877-881-6388 or www.pa.gov/agencies/insurance, or Pennie®, Pennsylvania's [health insurance marketplace](#), at www.Pennie.com or 844-844-8040. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.Pennie.com or call 844-844-8040.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Pennsylvania Insurance Department at 1-877-881-6388 or www.pa.gov/agencies/insurance.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Not Applicable.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services: To access our Language helpline, please call 1-800-447-4000.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the cost-sharing amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$4,900
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$4,900 |
| Copayments | \$10 |
| Coinsurance | \$2,200 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$7,110 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$4,900
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$300 |
| Copayments | \$1,100 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,400 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$4,900
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,300 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,600 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Discrimination is against the law

Geisinger Quality Options, Inc., complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity and sex stereotypes). Geisinger Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Geisinger Quality Options, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - » Qualified sign language interpreters
 - » Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - » Qualified interpreters
 - » Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, call Geisinger Health Plan at 800-447-4000 or TTY: 711.

If you believe that Geisinger Quality Options, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 N. Academy Ave., Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225
ghpcivilrights@thehealthplan.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the civil rights grievance coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-447-4000 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-447-4000 (TTY: 711) o hable con su proveedor.

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-447-4000 (TTY: 711) 或與您的提供者討論。

אכטונג: אויב איר רעדט אידיש, זענען דא אומזיסטע שפראך הילף סערוויסעס וואס קענען צוגעשטעלט ווערן פאר אייך. נויטיגע צוגאבליכע הילף און סערוויסעס כדי צו צושטעלן אינפארמאציע אין א צוגענגליכע פארמאטן ווערן אויך צוגעשטעלט פריי פון אפצאל. רופט 1-800-447-4000 (TTY: 711) אדער רעדט צו אייער פראוויידער.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-447-4000 (TTY: 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (TTY: 711) (1-800-447-4000) أو تحدث إلى مقدم الخدمة

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-447-4000 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-447-4000 (Người khuyết tật: 1-711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-447-4000 (TTY: 711) ou parlez à votre fournisseur.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-447-4000 (tty: 711) o parla con il tuo fornitore.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-447-4000 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-447-4000 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
ध्यान आपो: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-447-4000 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-800-447-4000 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
AKIYESI: Ti o ba so Yorùbá, awon ise iranlowo ede ofe wa fun o. Awon iranlowo iranlowo ti o ye ati awon ise lati pese alaye ni awon ona kika wiwole tun wa laisi idiyele. Pe 1-800-447-4000 (TTY: 711) tabi soro si olupese re.
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվական անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես տրամադրվում են անվճար: Չանգահարեք 1-800-447-4000 հեռախոսահամարով (TTY՝ 711) կամ խոսեք Ձեր մատակարարի հետ: