Coverage Period: 01/01/2020 - 12/31/2020

# Geisinger Marketplace Extra HMO 10/50/500

Coverage for: Individual and Family| Plan Type: HMO

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 or call 1-866-379-4489 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $500 person / $1,000 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 www.healthcare.gov/coverage/preventive-care-benefits. |
| Are there other deductibles for specific services? | Yes. $500 person / $1,000 family 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?** | $5,000 person / $10,000 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. |



OMB Control Numbers 1545-2229, 1210-0147,and 0938-1146
Released on April 6, 2016

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 |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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 | Extra Site: $10 copayment/visit<br><br>$50 copayment/visit<br><br>Deductible does not apply. | Not covered | To qualify for the lower copay, you must Select a primary care site designated as an Extra site. Click on the Plan Brochure link for a list of Extra sites or go to www.geisingerhealthplan.com/providersearch. |
| | Specialist visit | $50 copayment/visit<br><br>Deductible does not apply. | Not covered | None |
| | Preventive care/screening/immunization | No charge<br><br>Deductible does not apply. | Not covered | Limited to 1 routine exam per year.<br><br>You may have to pay for services that are not 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) | No charge | Not covered | Diagnostic: Deductible does not apply to laboratory services and xrays.<br>Imaging: Precertification/prior authorization required. |
| | Imaging (CT/PET scans, MRIs) | $300 copayment | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.GeisingerHealthPlan.com | Generic drugs<br>(Tier 1-Preferred) | Retail: $3 copayment/prescription<br>Mail order: $6 copayment/ prescription<br><br>Deductible does not apply. | Not covered | Retail: Covers up to a 34-day supply.<br><br>Mail order: Covers up to 102-day supply. |
| | (Tier 2 – Non-Preferred) | Retail: $20 copayment/ prescription<br>Mail order: $40 copayment/ prescription<br><br>Deductible does not apply. | | |
| | Preferred brand drugs<br>(Tier 3) | Retail:<br>$45 copayment/prescription<br>Mail order:<br>$90 copayment/prescription | Not covered | |
| | Non-preferred brand drugs<br><br>(Tier 4) | Retail:<br>$80 copayment/prescription<br>Mail Order:<br>$160 copayment/prescription | Not covered | Specialty drugs (Tier 5) have no mail order option. |
| | Specialty drugs (Tier 5) | 50% coinsurance up to $5,000 | Not covered | Tier 6 is limited to $0 copayment/ prescription. Deductible does not apply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $400 copayment | Not covered | Precertification/prior authorization may be required. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | Precertification/prior authorization may be required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $200 copayment/visit<br>Deductible does not apply. | $200 copayment/visit<br>Deductible does not apply. | Emergency services: Copay waived if admitted to the hospital.<br>Emergency medical transportation: None<br>Urgent care: None |
| | Emergency medical transportation | $150 copayment/ground<br>$500 copayment/air<br>Deductible does not apply. | $150 copayment/ground<br>$500 copayment/air<br>Deductible does not apply. | |
| | Urgent care | $50 copayment/visit<br>Deductible does not apply. | $50 copayment/visit<br>Deductible does not apply. | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $300 copayment/admission | Not covered | Precertification/prior authorization required. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | Precertification/prior authorization required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $50 copayment<br>Deductible does not apply. | Not covered | Outpatient Services: None<br>Inpatient Services: Precertification/prior authorization required. |
| | Inpatient services | $300 copayment/admission | Not covered | |
| **If you are pregnant** | Office visits | No charge<br>Deductible does not apply. | Not covered | Pregnancy office visits: None. |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered | 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. |
| | Childbirth/delivery facility services | $300 copayment/admission | Not covered | Inpatient professional and facility services; Precertification/prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | No charge<br>Deductible does not apply. | Not covered | Limited to 60 visits/Member/benefit period. |
| | Rehabilitation services | $50 copayment/visit<br>Deductible does not apply. | Not covered | None |
| | Habilitation services | $50 copayment/visit<br>Deductible does not apply. | Not covered | |
| | Skilled nursing care | $50 copayment/day | Not covered | 120 days/benefit period/person. |
| | Durable medical equipment | 20% coinsurance | Not covered | None |
| | Hospice services | Residential: $50 copayment/visit<br>Facility: $100 copayment/day<br><br>Deductible does not apply. | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | $50 copayment<br>Deductible does not apply. | Not covered | Limited to 1 exam/benefit period/up to age 19. |
| | Children's glasses | 50% coinsurance<br>Deductible does not apply. | 50% coinsurance<br>Deductible does not apply. | Up to age 19 only. 1 frame every 12 months. |
| | Children's dental check-up | No charge<br>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.)

- Abortion (except in cases of rape, incest, or where medically necessary to avert the death of the mother)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- 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.)

- Chiropractic Care
- Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want tocontinue your coverage after it ends. The contact information for those agencies is: Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov/Consumers, or HealthCare.gov at www.healthcare.gov or 1-800-318-2596. 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.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help you 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 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.insurance.pa.gov/Consumers.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standard, 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 | $500 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

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 | $12,800 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $300 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| The total Peg would pay is | $1,310 |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

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 | $7,400 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Joe would pay is | $960 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

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 | $1,900 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $500 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,010 |

The plan would be responsible for the other costs of these EXAMPLE covered services.

# Discrimination is against the law

Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company (the "Health Plan") comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

The Health Plan:

- Provides free aids and services to people with disabilities 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 these services, call the Health Plan at 800-447-4000 or TTY: 711.

If you believe that the Health Plan 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 North Academy Avenue, 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 Avenue 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.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-447-4000 (رقم هاتف الصم والبكم:711.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-447-4000 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711).

HPM 50 alb: Nondiscrimination dev. 9.12.16
Y0032_16242_2 File and Use 9/2/16