Geisinger

PEBTF Custom HMO – Pennsylvania Employees Benefit Trust Fund
Active Members *(Northeast PA Region)*
In Network Benefit Only

Referral Required – treatment for medical services must be coordinated by a Primary Care Physician (PCP)

	Network Providers **(All care directed by Primary Care Physician)**
DEDUCTIBLE (per calendar year)	None
OUT-OF-POCKET MAXIMUM ***Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).***	$8,700 single $17,400 family Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.
PREVENTIVE CARE	
• See the PEBTF Summary Plan Description (SPD) for a list of preventive benefits	Covered 100% If not available in-network, full cost shall be covered without cost sharing
MATERNITY SERVICES	
• Office visits	Covered 100% including first prenatal visit
• Hospital and newborn care	Covered 100%
PHYSICIAN VISITS	
• Office visits (PCPs include family practice, general practice, internal medicine and pediatrics)	$5 Copayment per office visit
• Specialist office visits	$10 Copayment per office visit
• Lab tests, X-rays, inpatient visits, surgery and anesthesia	Covered 100%
OUTPATIENT THERAPIES	
• Outpatient physical & occupational therapy • Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental) • Cardiac Rehabilitation • Pulmonary Rehabilitation • Respiratory therapy • Manipulation therapy (restorative, chiropractic Medically Necessary visits; not for maintenance of a condition)	$5 Copayment per visit Combined Maximum of 60 visits per year for all outpatient therapies (Therapy services are considered visits. If the same provider performs different types of therapies on the same date, to the same Member, it counts as one visit for each type of therapy performed.)
OTHER PROVIDER SERVICES	
• Radiation therapy, chemotherapy, kidney dialysis • Home Health Care (60 visits in 90 days) • Hospice • Skilled Nursing Facility (180 days per calendar year)	Covered 100%

	Network Providers (All care directed by Primary Care Physician)
OUTPATIENT HOSPITAL SERVICES	
• Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis, anesthesia & surgery	Covered 100%
• Outpatient Diabetic Education	Covered 100%
INPATIENT HOSPITAL SERVICES	
• Professional fees & facility services including: room & board & other Covered Services	Covered 100% (365 days per calendar year)
EMERGENCY CARE	
• Urgent care	$50 Copayment
• Emergency treatment for accident or medical emergency	$150 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital)
• Ambulance services for emergency care	Covered 100%
DURABLE MEDICAL EQUIPMENT	
• Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics, in accordance with the medical plan's DME policy	Covered 100%
LIFETIME MAXIMUM BENEFIT	Unlimited

NOTE: All benefits are limited to Covered Services that are determined by the HMO to be Medically Necessary.

For a list of providers, visit www.thehealthplan.com/PEBTF

This chart is intended as an easy-to-read summary. Benefits, limitations and exclusions are provided in accordance with the PEBTF SPD. Services provided by Geisinger Indemnity Insurance Company.