Coverage Period: 01/01/2019 - 12/31/2019

Geisinger Marketplace PPO **20/40/3000**

Coverage for: Individual and Family| Plan Type: PPO

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?	For Preferred providers: $3,000 person / $6,000 family For non-Preferred providers: $10,000 person / $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 www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Preferred providers: $7,350 person / $14,700 family For non-Preferred providers: $15,000 person / $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.

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
		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	$20 copayment/visit Deductible does not apply.	40% coinsurance	None
	Specialist visit	$40 copayment/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 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	40% coinsurance	Diagnostic: Deductible does not apply to laboratory services and x-rays. Imaging: Precertification/prior authorization required.
	Imaging (CT/PET scans, MRIs)	No charge Deductible does not apply.	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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.GeisingerHealthPlan.com	Generic drugs (Tier 1-Preferred) (Tier 2 – Non-Preferred)	Retail: $3 copayment/prescription Mail order: $6 copayment/ prescription Deductible does not apply.	Not covered	Covers up to a 34-day supply.
		Retail: $15 copayment/ prescription Mail order: $30 copayment/ prescription Deductible does not apply.		
	Preferred brand drugs (Tier 3)	Retail: $35 copayment/prescription Mail order: $70 copayment/prescription Deductible does not apply.	Not covered	
	Non-preferred brand drugs (Tier 4)	Retail: $55 copayment/prescription Mail Order: $110 copayment/prescription Deductible does not apply.	Not covered	Specialty drugs (Tier 5) have no mail order option.
	Specialty drugs (Tier 5)	40% coinsurance up to $150 Deductible does not apply.	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)	$250 copayment/visit	40% coinsurance	Precertification/prior authorization may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification/prior authorization may be required.

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 immediate medical attention	Emergency room care	$250 copayment/visit Deductible does not apply.	$250 copayment/visit Deductible does not apply.	Emergency services: Copay waived if admitted to the hospital. Emergency medical transportation: None Urgent care: None
	Emergency medical transportation	$150 copayment/ground $500 copayment/air Deductible does not apply.	$150 copayment/ground $500 copayment/air Deductible does not apply.	
	Urgent care	$20 copayment/visit Deductible does not apply.	$20 copayment/visit Deductible does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment/admission	40% coinsurance	Precertification/prior authorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification/prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment Deductible does not apply.	40% coinsurance	Outpatient Services: None Inpatient Services: Precertification/ prior authorization required.
	Inpatient services	$250 copayment/admission	40% coinsurance	
If you are pregnant	Office visits	No charge Deductible does not apply.	40% coinsurance	Pregnancy office visits: None.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	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	$250 copayment/admission	40% coinsurance	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
		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.
	Rehabilitation services	$40 copayment/visit Deductible does not apply.	40% coinsurance	None
	Habilitation services	$40 copayment/visit Deductible does not apply.	40% coinsurance	
	Skilled nursing care	$50 copayment/day	40% coinsurance	120 days/period of confinement/person
	Durable medical equipment	20% coinsurance	Not covered	None
	Hospice services	Residential: $40 copayment/ visit Facility: $100 copayment/day Deductible does not apply.	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$40 copayment Deductible does not apply.	Not covered	Limited to 1 exam/member/benefit period.
	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	Up to age 19 only.

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 to continue 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	$3,000
Specialist copayment	$40
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	$3,000
Copayments	$300
Coinsurance	$500
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$3,810

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

The plan's overall deductible	$3,000
Specialist copayment	$40
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	$3,000
Specialist copayment	$40
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	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,000

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).

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