Coverage for: Individual and Family | Plan Type:PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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 <u>provider</u> s: \$6,000 / individual or \$12,000 / family Non-preferred <u>provider</u> s: \$12,000 / individual or \$24,000 / family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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 <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Preferred <u>provider</u> s: \$9,100 individual / \$18,200 family Non-preferred <u>provider</u> s: \$15,000 individual / \$30,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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 <u>network provider</u> ?	Yes. See www.GeisingerHealthPlan.com or call 1-866-379-4489 for a list of network providers.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> 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.

		What You	ı Will Pay:	Limitations, Exceptions, &	
Common Medical Event	Common Medical Event Services You May Need		Ay Need Preferred Provider Non-Preferred Provider (You will pay the least) (You will pay the most)		
	Primary care visit to treat an injury or illness	\$30 <u>copay</u> / visit <u>Deductible</u> does not apply.	30% coinsurance	None.	
If you visit a health care	Specialist visit	\$60 <u>copay</u> / visit <u>Deductible</u> does not apply.	30% coinsurance	None.	
provider's office or clinic	vider's office or clinic Preventive care / screening / immunization		Not covered	Limited to 1 routine exam per year. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% coinsurance	Diagnostic: None. Imaging: Precertification/prior-	
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	authorization required.	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs: (Tier 2- Preferred)	Retail / Mail Order: \$3 copay / prescription 90 Day Retail: \$6 copay / prescription Deductible does not apply.	Not covered	Tier 2-4: Covers up to a 34 day supply (retail); Covers between an 82-102 day supply (90 day retail/mail order).	
www.GeisingerHealthPlan.	(Tier 3- Non-Preferred)	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: \$45 copay /prescription	Not covered		
		90 Day Retail: \$90 copay / prescription			

		What Yo	ou Will Pay:	Limitations Executions 9		
Common Medical Event	Common Medical Event Services You May Need		Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information		
If you need drugs to treat your illness or condition	Non-preferred brand drugs: (Tier 5)	Retail / Mail Order: \$80 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).		
More information about prescription drug coverage		90 Day Retail: \$160 copay / prescription		Specialty drugs (Tier 6) have no mail		
is available at www.GeisingerHealthPlan.com	Specialty drugs: (Tier 6)	50% coinsurance up to \$9,100.	Not covered	order option. Tier 1 is limited to \$0 copay/prescription. Deductible does not apply.		
If you have outpatient surgery	Facility fee (e.g.,ambulatory surgery center)	\$100 <u>copay</u> / day	30% coinsurance	Precertification/prior authorization may be required.		
	Physician/surgeon fees	No charge	30% coinsurance			
If you need immediate	Emergency room care	\$250 <u>copay</u> / visit	\$250 <u>copay</u> / visit	Emergency services: Copay waived if admitted to the hospital.		
medical attention	Emergency medical transportation	No charge Deductible does not apply.	No charge <u>Deductible</u> does not apply.	Emergency medical transportation: None. Urgent care: Mental health & substance		
	<u>Urgent care</u>	\$30 <u>copay</u> / visit <u>Deductible</u> does not apply.	\$30 <u>copay</u> / visit <u>Deductible</u> does not apply.	abuse urgent care visit \$0. Deductible does not apply.		
If you have a hospital stay	Facility Fee (e.g.,hospital room)	No charge	30% coinsurance	Precertification/prior authorization required.		
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>			
If you need mental health, behavioral health, or	Outpatient services	\$30 <u>copay</u> / visit <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Outpatient Services: None. Inpatient Services: Precertification/		
substance abuse services	Inpatient services	No charge	30% coinsurance	prior authorization required.		
	Office visits	No charge Deductible does not apply.	30% coinsurance	Pregnancy office visits: None. <u>Cost sharing</u> does not apply for		
If you are pregnant	Childbirth/delivery professional services	No charge	30% coinsurance	preventive services. Maternity care may include tests and services as described elsewhere in the SBC (i.e., ultrasound).		
jou die program	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u>	Depending on the type of services, a copayment, coinsurance or deductible may apply. Inpatient professional and facility services; Precertification/prior authorization required.		

		What You	ı Will Pay :	Limitations Evacations 9 Other		
Common Medical Event Services You May Need		Preferred Provider Non-Preferred Provider (You will pay the least) (You will pay the most)		Limitations, Exceptions, & Other Important Information		
	Home health care	No charge <u>Deductible</u> does not apply.	30% coinsurance	Limited to 60 visits / member / benefit period. Visit limits do not apply to mental health/substance use disorder benefits.		
If you need help recovering or have other special health needs	Rehabilitation services	\$60 <u>copay</u> / visit <u>Deductible</u> does not apply.	30% coinsurance	None.		
neeus	Habilitation services	\$60 <u>copay</u> / visit <u>Deductible</u> does not apply.	30% coinsurance			
	Skilled nursing care	No charge	30% coinsurance	120 days / benefit period / person.		
	Durable medical equipment	No charge	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.	30% coinsurance	None.		
If your child needs dental or eye care	Children's eye exam	\$60 <u>copay</u> <u>Deductible</u> does not apply.	Not covered	Limited to 1 exam / benefit period / up to age 19.		
·	Children's glasses	50% <u>coinsurance</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u> <u>Deductible</u> 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.)

Serv	Services four <u>Flair</u> Generally boes NOT Cover (Check your policy of plan document for more information and a list of any other excluded services.)				
• /	Acupuncture	•	Hearing Aids	•	Routine eye care (Adult)
• [Bariatric Surgery	•	Long Term Care	•	Routine Foot Care
• (Cosmetic Surgery	•	Non-emergency care when traveling outside the	•	Weight Loss Programs
• [Dental Care (Adult)		U.S.		
		•	Private Duty Nursing		

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: The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov.ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 if you have a complaint against your plan for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov.ebsa/healthreform</u>, or the Pennsylvania Insurance Department at 1-877-881-6388 or <u>www.insurance.pa.gov/Consumers</u>.

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? Yes.

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$6,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	0%
■ Other <u>coinsurance</u>	0%

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

i otai Example Cost	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$6,000	
<u>Copayments</u>	\$10	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Peg would pay is	\$6,010	

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$6,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	0%
Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
<u>Deductibles</u>	\$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 <u>plan's</u> overall <u>deductible</u>	\$6,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	0%
Other coinsurance	0%

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			
<u>Deductibles</u>	\$1,300		
Copayments	\$300		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$1,600		

The <u>plan</u> 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 Plandoes 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).

CHÚ Ý: Nữu bịn nói Tiũng Viŭt, có các dịch vũ hữ try ngôn ngữ miữn phí dành cho bịn. Gfi sử 800-447-4000 (TTY: 711).

ACHTUNG:

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

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

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ATTENTION: Sivous 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).

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

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