




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](http://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](http://www.healthcare.gov/sbc-glossary.com) or call 1-866-379-4489 to request a copy.

Important Questions	Answers	Why This Matters
<b>What is the overall <a href="#">deductible</a>?</b>	Preferred <a href="#">providers</a> : \$6,000 / individual or \$12,000 / family Non-preferred <a href="#">providers</a> : \$12,000 / individual or \$24,000 / family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$500 / individual or \$1,000 / family for <a href="#">prescription drug coverage</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Preferred <a href="#">providers</a> : \$9,100 individual / \$18,200 family Non-preferred <a href="#">providers</a> : \$15,000 individual / \$30,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.GeisingerHealthPlan.com">www.GeisingerHealthPlan.com</a> or call 1-866-379-4489 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	None.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge <a href="#">Deductible</a> does not apply.	Not covered	Limited to 1 routine exam per year. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	30% <a href="#">coinsurance</a>	Diagnostic: None. Imaging: <a href="#">Precertification/prior-authorization</a> required.
	Imaging (CT/PET scans, MRIs)	No charge	30% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.GeisingerHealthPlan.com">www.GeisingerHealthPlan.com</a>	Generic drugs: (Tier 2- Preferred)	Retail / Mail Order: \$3 <a href="#">copay</a> / prescription 90 Day Retail: \$6 <a href="#">copay</a> / prescription <a href="#">Deductible</a> 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).
	(Tier 3- Non-Preferred)	Retail / Mail Order: \$20 <a href="#">copay</a> / prescription 90 Day Retail: \$40 <a href="#">copay</a> / prescription <a href="#">Deductible</a> does not apply.	Not covered	
	Preferred brand drugs: (Tier 4)	Retail / Mail Order: \$45 <a href="#">copay</a> / prescription  90 Day Retail: \$90 <a href="#">copay</a> / 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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.GeisingerHealthPlan.com">www.GeisingerHealthPlan.com</a>	Non-preferred brand drugs: (Tier 5)	Retail / Mail Order: \$80 <a href="#">copay</a> /prescription  90 Day Retail: \$160 <a href="#">copay</a> / 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).  <a href="#">Specialty drugs</a> (Tier 6) have no mail order option.  Tier 1 is limited to \$0 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.
	<a href="#">Specialty drugs</a> : (Tier 6)	50% <a href="#">coinsurance</a> up to \$9,100.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g.,ambulatory surgery center)	\$100 <a href="#">copay</a> / day	30% <a href="#">coinsurance</a>	<a href="#">Precertification/prior authorization</a> may be required.
	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> / visit	\$250 <a href="#">copay</a> / visit	<a href="#">Emergency services</a> : Copay waived if admitted to the hospital. <a href="#">Emergency medical transportation</a> : None.  <a href="#">Urgent care</a> : Mental health & substance abuse urgent care visit \$0. <a href="#">Deductible</a> does not apply.
	<a href="#">Emergency medical transportation</a>	No charge <a href="#">Deductible</a> does not apply.	No charge <a href="#">Deductible</a> does not apply.	
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	\$30 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	
<b>If you have a hospital stay</b>	Facility Fee (e.g.,hospital room)	No charge	30% <a href="#">coinsurance</a>	<a href="#">Precertification/prior authorization</a> required.
	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	Outpatient Services: None. Inpatient Services: <a href="#">Precertification/prior authorization</a> required.
	Inpatient services	No charge	30% <a href="#">coinsurance</a>	
<b>If you are pregnant</b>	Office visits	No charge <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	Pregnancy office visits: None. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services as described elsewhere in the SBC (i.e., ultrasound). Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Inpatient professional and facility services; <a href="#">Precertification/prior authorization</a> required.
	Childbirth/delivery professional services	No charge	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	30% <a href="#">coinsurance</a>	

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	<a href="#">Home health care</a>	No charge <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	Limited to 60 visits / member / benefit period. Visit limits do not apply to mental health/substance use disorder benefits.
	<a href="#">Rehabilitation services</a>	\$60 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	None.
	<a href="#">Habilitation services</a>	\$60 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	30% <a href="#">coinsurance</a>	120 days / benefit period / person.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	<a href="#">Cost sharing</a> does not apply to mental health/substance use disorder diagnosis.
	<a href="#">Hospice services</a>	Residential: \$60 <a href="#">copay</a> /visit Facility: \$100 <a href="#">copay</a> /day <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	None.
If your child needs dental or eye care	Children's eye exam	\$60 <a href="#">copay</a> <a href="#">Deductible</a> does not apply.	Not covered	Limited to 1 exam / benefit period / up to age 19.
	Children's glasses	50% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply.	Up to age 19 only. 1 frame every 12 months.
	Children's dental check-up	No charge <a href="#">Deductible</a> does not apply.	Not covered	1 exam per 6 months up to age 19.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> 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](http://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](http://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](http://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 [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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Pennsylvania Insurance Department at 1-877-881-6388 or [www.insurance.pa.gov/Consumers](http://www.insurance.pa.gov/Consumers).

**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 [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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$6,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$6,010</b>

### Managing Joe's Type 2 Diabetes

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

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

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,400</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,600</b>

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

