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 allowed amount, below.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 providers: (Tier 1): \$4,000 individual / \$8,000 family (Tier 2): \$7,900 individual / \$15,800 family Non-preferred providers: \$12,000 individual / \$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 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 / \$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 out-of-pocket limit for this plan? | Preferred providers: \$9,100 individual / \$18,200 family Non-preferred providers: \$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 limit</u> s 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 network provider? | Yes. See www.GeisingerHealthPlan.com or call 1-866-379-4489 for a list of network providers. | This plan uses a <u>provider network</u> . You will pay the least if you use a <u>provider</u> in Tier 1. You pay more if you use a <u>provider</u> in Tier 2. 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 <u>provider's</u> 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 <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| | | What You Will Pay: | | Limitations, Exceptions, & | |
|---|---------------------------------------|--|--|---|--|
| Common Medical Event | Services You May Need | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | Other Important Information | |
| | Primary care visit to treat an injury | Tier 1: \$20 copay / visit Tier 2: \$60 copay / visit | 40% coinsurance | None. | |
| | or illness | Deductible does not apply. | | | |
| If you visit a health care provider's office or clinic | <u>Specialist</u> visit | Tier1: \$40 <u>copay</u> / visit Tier 2: \$80 <u>copay</u> / visit <u>Deductible</u> does not apply. | 40% coinsurance | None. | |
| | Preventive care / screening / | No charge | Not covered | Limited to 1 routine exam per year. | |
| | immunization | Deductible does not apply. | | 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 | Diagnostic test (x-ray, blood work) | No charge | 40% coinsurance | Diagnostic: None. Imaging: Precertification/prior- | |
| ii you nave a test | Imaging (CT/PET scans, MRIs) | \$150 <u>copay</u> / day | 40% coinsurance | authorization required. | |
| If you need drugs to treat your illness or condition More information about | Generic drugs: (Tier 2- Preferred) | Retail / Mail Order: \$3 <u>copay</u> / prescription 90 Day Retail: \$6 <u>copay</u> / prescription <u>Deductible</u> 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). | |
| prescription drug coverage is available at 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: \$50 copay / prescription | Not covered | | |
| | | 90 Day Retail: \$100 copay / prescription | | | |

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| | | | What Yo | ou Will Pay: | Limitationa Evacutiona 9 | |
|---|---|---|--|---|--|--|
| | Common Medical Event | Services You May Need | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
|) | f you need drugs to treat your illness or condition | Non-preferred brand drugs: (Tier 5) | Retail / Mail Order: \$85 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). | |
| 1 | More information about orescription drug coverage is available at | | 90 Day Retail: \$170 copay / prescription | | Specialty drugs (Tier 6) have no mail order option. | |
| 7 | | Specialty drugs: (Tier 6) | 50% coinsurance up to \$9,100 | Not covered | Tier 1 is limited to \$0 copay/prescription. Deductible does not apply. | |
| | you have outpatient urgery | Facility fee (e.g.,ambulatory surgery center) | \$150 <u>copay</u> / day | 40% coinsurance | Precertification/prior authorization may be required. | |
| | | Physician/surgeon fees | No charge | 40% coinsurance | | |
| | you need immediate | Emergency room care | \$200 <u>copay</u> / visit | \$200 <u>copa</u> y / visit | Emergency services: Copay waived if admitted to the hospital. | |
| | nedical attention | Emergency medical transportation | | No charge Deductible does not apply. | Emergency medical transportation: None. Urgent care: Mental health & substance | |
| | | Urgent care | \$20 <u>copay</u> / visit <u>Deductible</u> does not apply. | \$20 <u>copay</u> / visit <u>Deductible</u> does not apply. | abuse urgent care visit \$0. <u>Deductible</u> does not apply. | |
| | you have a hospital tay | Facility Fee (e.g.,hospital room) | | 40% coinsurance | Precertification/prior authorization required. | |
| | | Physician/surgeon fees | No charge | 40% coinsurance | | |
| ı | behavioral health, or | Outpatient services | \$20 <u>copay</u> / visit <u>Deductible</u> does not apply. | 40% coinsurance | Outpatient Services: None. Inpatient Services: Precertification/ | |
| | substance abuse services | Inpatient services | · | 40% coinsurance | <u>prior authorization</u> required. | |
| | | Office visits | No charge Deductible does not apply. | 40% coinsurance | Pregnancy office visits: None. <u>Cost sharing</u> does not apply for | |
| | If you are pregnant | Childbirth/delivery professional services | No charge | 40% coinsurance | preventive services. Maternity care may include tests and services as described elsewhere in the SBC (i.e., ultrasound). | |
| | | Childbirth/delivery facility services | \$200 copay / admission | 40% coinsurance | Depending on the type of services, a copayment, coinsurance or deductible may apply. Inpatient professional and facility services; Precertification/prior authorization required. | |

| | | What You Will Pay: | | Limitationa Evacationa 9 | |
|--|----------------------------|--|--|---|--|
| Common Medical Event | Services You May Need | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| If you need help recovering | Home health care | No charge Deductible does not apply. | 40% coinsurance | Limited to 60 visits / member / benefit period. Visit limits do not apply to mental health/substance use disorder benefits. | |
| | Rehabilitation services | Tier 1: \$40 copay / visit Tier 2: \$80 copay / visit Deductible does not apply. | 40% coinsurance | None. | |
| | Habilitation services | Tier 1: \$40 copay / visit Tier 2: \$80 copay / visit Deductible does not apply. | 40% coinsurance | | |
| | Skilled nursing care | No charge | 40% 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: \$40 copay/visit Facility: \$100 copay/day Deductible does not apply. | 40% coinsurance | None. | |
| If your child needs dental or eye care | Children's eye exam | Tier 2: \$80 <u>copay</u> / visit <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% 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 | 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.)

- 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

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| 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 <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, 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 <u>plan</u> 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 plan's overall deductible | \$4,000 |
|---|---------|
| ■ Specialist copayment | \$40 |
| Hospital (facility) copayment | \$200 |
| 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 Evennela Coat

| \$12,700 | | |
|---------------------------------|--|--|
| In this example, Peg would pay: | | |
| Cost Sharing | | |
| \$4,000 | | |
| \$200 | | |
| \$0 | | |
| | | |
| \$0 | | |
| \$4,200 | | |
| | | |

Managing Joe's Type 2 Diabetes

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,000 |
|---|---------|
| ■ Specialist copayment | \$40 |
| ■ Hospital (facility) copayment | \$200 |
| 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

Durable medical equipment (glucose meter)

| Total Example Cost | \$5,600 | |
|---------------------------------|---------|--|
| In this example, Joe would pay: | | |
| Cost Sharing | | |
| Deductibles | \$300 | |
| Copayments | \$1,000 | |
| Coinsurance | \$0 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Joe would pay is | \$1,300 | |

Mia's Simple Fracture

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

| ■ The plan's overall deductible | \$4,000 |
|---------------------------------|---------|
| ■ Specialist copayment | \$40 |
| ■ Hospital (facility) copayment | \$200 |
| Other <u>coinsurance</u> | 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 | Cost Sharing | | |
| <u>Deductibles</u> | \$1,300 | | |
| Copayments | \$200 | | |
| Coinsurance | \$0 | | |
| What isn't covered | | | |
| Limits or exclusions | \$0 | | |
| The total Mia would pay is | \$1,500 | | |

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: Nũu bịn nói Tiũng Viŭt, có các dích vũ hữ try ngôn ngừ 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).

.711 WFB456 WHA YHYY WYE 800-447-4000 WYJA YHHA YHIYYA CA JYDIOH AJIBYA TÜVYBYA EYWIX JEY ABYA IÇYO IİTOH ZƏÇ OY AVITIYM

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).

AIWh: Ks S\p ZK^hSj Zs_Sh es, Ss iW:BoD [hch deh] dpahB S\h^h \hN°; X nV Jp. YsW D^s 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).