



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.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 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 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 deductible amount before this plan 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 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 the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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 .

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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 provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1: \$20 copay / visit Tier 2: \$60 copay / visit Deductible does not apply.	40% coinsurance	None.
	Specialist visit	Tier1: \$40 copay / visit Tier 2: \$80 copay / 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 aren't 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: None. Imaging: Precertification/prior-authorization required.
	Imaging (CT/PET scans, MRIs)	\$150 copay / day	40% coinsurance	
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 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).
	(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 90 Day Retail: \$100 copay / 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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.GeisingerHealthPlan.com	Non-preferred brand drugs: (Tier 5)	Retail / Mail Order: \$85 copay / prescription 90 Day Retail: \$170 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). Specialty drugs (Tier 6) have no mail order option. Tier 1 is limited to \$0 copay /prescription. Deductible does not apply.
	Specialty drugs : (Tier 6)	50% coinsurance up to \$9,100	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay / day	40% coinsurance	Precertification/prior authorization may be required.
	Physician/surgeon fees	No charge	40% coinsurance	
If you need immediate medical attention	Emergency room care	\$200 copay / visit	\$200 copay / visit	Emergency services : Copay waived if admitted to the hospital. Emergency medical transportation : None. Urgent care : Mental health & substance abuse urgent care visit \$0. Deductible does not apply.
	Emergency medical transportation	No charge Deductible does not apply.	No charge Deductible does not apply.	
	Urgent care	\$20 copay / visit Deductible does not apply.	\$20 copay / visit Deductible does not apply.	
If you have a hospital stay	Facility Fee (e.g., hospital room)	\$200 copay / admission	40% coinsurance	Precertification/prior authorization required.
	Physician/surgeon fees	No charge	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay / visit Deductible does not apply.	40% coinsurance	Outpatient Services: None. Inpatient Services: Precertification/prior authorization required.
	Inpatient services	\$200 copay / admission	40% coinsurance	
If you are pregnant	Office visits	No charge Deductible does not apply.	40% coinsurance	Pregnancy office visits: None. 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. Inpatient professional and facility services; Precertification/prior authorization required.
	Childbirth/delivery professional services	No charge	40% coinsurance	
	Childbirth/delivery facility services	\$200 copay / admission	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 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. 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 1: \$40 copay / visit Tier 2: \$80 copay / visit Deductible does not apply.	Not covered	Limited to 1 exam / benefit period / up to age 19.
	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	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 .)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery Cosmetic Surgery Dental Care (Adult) 	<ul style="list-style-type: none"> Hearing Aids Long Term Care Non-emergency care when traveling outside the U.S. Private-duty Nursing 	<ul style="list-style-type: none"> 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: 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 [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, or the Pennsylvania Insurance Department at 1-877-881-6388 or 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 plan's overall deductible	\$4,000
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$200
■ Other coinsurance	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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$4,200

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$4,000
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$200
■ Other coinsurance	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
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 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

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

