Geisinger Premier HMO 25/50/2000		Gold
Summary of Benefits	**In-Network**	**Out-of-Network**
Maximum Out of Pocket for Medical EHB Benefits	NA	NA
Maximum Out of Pocket for Drug EHB Benefits	NA	NA
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)	$7,350/$14,700	Limited to In Network
Medical EHB Deductible (Embedded)	$2,000/$4,000	Limited to In Network
Drug EHB Deductible	$0/$0	Limited to In Network
Combined Medical and Drug EHB Deductible	NA	NA
Coinsurance	0%	Limited to In Network
Primary Care Visit to Treat an Injury or Illness	$25	Limited to In Network
Specialist - Office Visit	$50	Limited to In Network
Other Practitioner Office Visit (Nurse, Physician Assistant)	$25	Limited to In Network
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$100 copay after deductible	Limited to In Network
Outpatient Surgery Physician/Surgical Services	0% after deductible	Limited to In Network
Hospice Services	Residential - $50 per visit, Facility - $100 per day	Limited to In Network
Infertility Treatment (Note Exclusions)	0% after deductible	Limited to In Network
Routine Eye Exam (Adult)	Not Covered	Not Covered
Urgent Care Centers or Facilities	$25	$25
Home Health Care Services (60 visits per year - visit limits do not apply to mental health/ substance use disorder benefits)	$0	Limited to In Network
Emergency Room Services	$200	$200
Emergency Transportation (Ambulance/Air)	$0	$0
Inpatient Hospital Services (e.g., Hospital Stay)	$100 per stay after deductible	Limited to In Network
Inpatient Physician and Surgical Services	0% after deductible	Limited to In Network
Skilled Nursing Facility (120 days per year)	0% after deductible	Limited to In Network
Prenatal and Postnatal Care (Office Visit)	$0	Limited to In Network
Delivery and All Inpatient Services for Maternity Care	0% after deductible	Limited to In Network
Mental/Behavioral Health Outpatient Services	$25	Limited to In Network
Mental/Behavioral Health Inpatient Services	$100 per stay after deductible	Limited to In Network
Substance Abuse Disorder Outpatient Services	$25	Limited to In Network
Substance Abuse Disorder Inpatient Services	$100 per stay after deductible	Limited to In Network
Tier 2 - Preferred Generic Drugs	$10	Limited to In Network
Tier 3 - Non-Preferred Generic Drugs	$20	Limited to In Network
Tier 4 - Preferred Brand Drugs	$40	Limited to In Network
Tier 5 - Non-Preferred Brand Drugs	$80	Limited to In Network
Tier 6 - Specialty Drugs	40% coinsurance up to $250	Limited to In Network
Tier 1 - $0 Rx	$0	Limited to In Network
Mail-Order Rx	1x copay	Limited to In Network
90-Day Retail	2x copay	Limited to In Network
Outpatient Rehabilitation Services	$50	Limited to In Network
Outpatient Cardiac Rehabilitation Services (36 visits per benefit period)	$0	Limited to In Network

* EHB = Essential Health Benefits

Outpatient Pulmonary Rehab/Respiratory Rehab Services (36 visits per benefit period)	$0	Limited to In Network
Habilitation Services	$50	Limited to In Network
Habilitative Speech Therapy	$50	Limited to In Network
Habilitative Occupational and Physical Therapy	$50	Limited to In Network
Chiropractic Care (20 visits per benefit period)	$25	Limited to In Network
Durable Medical Equipment (cost sharing does not apply to mental health/substance use disorder diagnosis)	0% after deductible	Limited to In Network
Imaging (CT/PET Scans, MRIs)	$100 copay after deductible	Limited to In Network
Preventive Care/Screening/Immunization	$0	Limited to In Network
Routine Eye Exam for Children	$50	Limited to In Network
Eyeglasses for Children	50%	50%
Rehabilitative Speech Therapy	$50	Limited to In Network
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50	Limited to In Network
Well Baby Visits and Care	$0	Limited to In Network
Laboratory Outpatient	0% after deductible	Limited to In Network
X-rays	0% after deductible	Limited to In Network
Dental Checkup for Children	$0	Limited to In Network
Basic Dental Care - Child	50% coinsurance after deductible	Limited to In Network
Orthodontia - Child (Medically necessary)	50% coinsurance after deductible	Limited to In Network
Major Dental Care - Child	50% coinsurance after deductible	Limited to In Network
Transplant	$100 copay after deductible	Limited to In Network
Accidental Dental (medically necessary)	0% after deductible	Limited to In Network
Dialysis	0% after deductible	Limited to In Network
Allergy Testing	0% after deductible	Limited to In Network
Chemotherapy	0% after deductible	Limited to In Network
Radiation	0% after deductible	Limited to In Network
Diabetes Education	$0	Limited to In Network
Prosthetic Devices	0% after deductible	Limited to In Network
Infusion Therapy	$0	Limited to In Network
Nutritional Counseling	$50	Limited to In Network
Reconstructive Surgery	$100 copay after deductible	Limited to In Network
Preventive - Physical (1 per benefit period)	$0	Limited to In Network
Preventive - Mammograms	$0	Limited to In Network
Preventive - Pap Smears	$0	Limited to In Network
Preventive - Cholesterol	$0	Limited to In Network
Preventive - Diabetes	$0	Limited to In Network
Preventive - Lipid Panel	$0	Limited to In Network
Specialist - Procedure	0% after deductible	Limited to In Network
Colorectal - Fecal Occult and Flexible Sigmoidoscopy	$0	Limited to In Network

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Colorectal - Colonoscopy	$0	Limited to In Network
Maternity - Office diagnostic services procedures	0% after deductible	Limited to In Network
Correction for Obesity - Facility	Not Covered	Not Covered
Ostomy Supplies	0% after deductible	Limited to In Network
Urology Supplies	0% after deductible	Limited to In Network
Diabetic Services/Supplies - Eye Exam	$0	Limited to In Network
Diabetic Services/Supplies - Rx Supplies	Rx copay applies	Limited to In Network
Diabetic Services/Supplies - Foot Orthotics	0% after deductible	Limited to In Network
Diabetic Services/Supplies - Home Blood Glucose Monitor	Rx copay applies	Limited to In Network
Diabetic Services/Supplies - Medical Equipment	0% after deductible	Limited to In Network
Implanted Devices (Medical) - Drug Delivery	0% after deductible	Limited to In Network
Implanted Devices (Medical) - All other non-contraceptive implanted devices	0% after deductible	Limited to In Network
Orthotic Devices	0% after deductible	Limited to In Network
Outpatient Opioid Detoxification	0% after deductible	Limited to In Network
Abortion (Elective)	Not Covered	Not Covered
High Cost Specialty Drugs/Select Injectables	$150	Limited to In Network
Injectable Drugs - Physician	$0	Limited to In Network
Injectable Drugs - Facility	0% after deductible	Limited to In Network
Spinal Injections	0% after deductible	Limited to In Network
Dental Anesthesia	0% after deductible	Limited to In Network
Impacted Wisdom Teeth	0% after deductible	Limited to In Network
Medical Foods/PKU	$0	Limited to In Network
Pulmonary Function Tests	0% after deductible	Limited to In Network
Spirometry	$0	Limited to In Network
Scheduled Transportation (Ambulance/Air)	$0	Limited to In Network
Contact Lenses	50%	50%
Well Child Office Visits (0-21)	$0	Limited to In Network
Well Woman Exam	$0	Limited to In Network
Telehealth (PCP Services)	$5	Limited to In Network
Telehealth (Behavioral Health Services)	$5	Limited to In Network
Telehealth (Specialist Services)	$10	Limited to In Network
Gender-Affirming Care	$100 per stay after deductible	Limited to In Network
Mental Health/Substance Abuse Urgent Care Services	$0	$0

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