Geisinger All-Access PPO 10/20/0		Platinum
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)	$6,000/$12,000	$10,000/$20,000
Medical EHB Deductible (Embedded)	$0/$0	$1,000/$2,000
Drug EHB Deductible	$0/$0	Limited to In Network
Combined Medical and Drug EHB Deductible	NA	NA
Coinsurance	0%	20%
Primary Care Visit to Treat an Injury or Illness	$10	20% after deductible
Specialist - Office Visit	$20	20% after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant)	$10	20% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$150 copay	20% after deductible
Outpatient Surgery Physician/Surgical Services	$0	20% after deductible
Hospice Services	Residential - $20 per visit, Facility - $50 per day	20% after deductible
Infertility Treatment (Note Exclusions)	$0	20% after deductible
Routine Eye Exam (Adult)	Not Covered	Not Covered
Urgent Care Centers or Facilities	$10	$10
Home Health Care Services (60 visits per year - visit limits do not apply to mental health/ substance use disorder benefits)	$0	20% after deductible
Emergency Room Services	$75	$75
Emergency Transportation (Ambulance/Air)	$0	$0
Inpatient Hospital Services (e.g., Hospital Stay)	$200 per stay	20% after deductible
Inpatient Physician and Surgical Services	$0	20% after deductible
Skilled Nursing Facility (120 days per year)	$50 per day	20% after deductible
Prenatal and Postnatal Care (Office Visit)	$0	20% after deductible
Delivery and All Inpatient Services for Maternity Care	$0	20% after deductible
Mental/Behavioral Health Outpatient Services	$10	20% after deductible
Mental/Behavioral Health Inpatient Services	$200 per stay	20% after deductible
Substance Abuse Disorder Outpatient Services	$10	20% after deductible
Substance Abuse Disorder Inpatient Services	$200 per stay	20% after deductible
Tier 2 - Preferred Generic Drugs	$3	Limited to In Network
Tier 3 - Non-Preferred Generic Drugs	$5	Limited to In Network
Tier 4 - Preferred Brand Drugs	$25	Limited to In Network
Tier 5 - Non-Preferred Brand Drugs	$50	Limited to In Network
Tier 6 - Specialty Drugs	40% coinsurance up to $150	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	$20	20% after deductible

* EHB = Essential Health Benefits

Outpatient Cardiac Rehabilitation Services (36 visits per benefit period)	$0	20% after deductible
Outpatient Pulmonary Rehab/Respiratory Rehab Services (36 visits per benefit period)	$0	20% after deductible
Habilitation Services	$20	20% after deductible
Habilitative Speech Therapy	$20	20% after deductible
Habilitative Occupational and Physical Therapy	$20	20% after deductible
Chiropractic Care (20 visits per benefit period)	$10	Limited to In Network
Durable Medical Equipment (cost sharing does not apply to mental health/substance use disorder diagnosis)	10%	Limited to In Network
Imaging (CT/PET Scans, MRIs)	$100	20% after deductible
Preventive Care/Screening/Immunization	$0	Limited to In Network
Routine Eye Exam for Children	$20	Limited to In Network
Eyeglasses for Children	50%	50%
Rehabilitative Speech Therapy	$20	20% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$20	20% after deductible
Well Baby Visits and Care	$0	Limited to In Network
Laboratory Outpatient	$0	20% after deductible
X-rays	$0	20% after deductible
Dental Checkup for Children	$0	Limited to In Network
Basic Dental Care - Child	50% coinsurance	Limited to In Network
Orthodontia - Child (Medically necessary)	50% coinsurance	Limited to In Network
Major Dental Care - Child	50% coinsurance	Limited to In Network
Transplant	$200 per stay	20% after deductible
Accidental Dental (medically necessary)	$0	20% after deductible
Dialysis	$0	20% after deductible
Allergy Testing	$0	20% after deductible
Chemotherapy	$0	20% after deductible
Radiation	$0	20% after deductible
Diabetes Education	$0	Limited to In Network
Prosthetic Devices	10%	Limited to In Network
Infusion Therapy	$0	20% after deductible
Nutritional Counseling	$20	20% after deductible
Reconstructive Surgery	$200 per stay	20% after deductible
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	20% after deductible
Colorectal - Fecal Occult and Flexible Sigmoidoscopy	$0	Limited to In Network
Colorectal - Colonoscopy	$0	Limited to In Network

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Maternity - Office diagnostic services procedures	$0	20% after deductible
Correction for Obesity - Facility	Not Covered	Not Covered
Ostomy Supplies	$0	Limited to In Network
Urology Supplies	$0	Limited to In Network
Diabetic Services/Supplies - Eye Exam	$0	Limited to In Network
Diabetic Services/Supplies - Rx Supplies	Rx copays apply	Limited to In Network
Diabetic Services/Supplies - Foot Orthotics	$0	Limited to In Network
Diabetic Services/Supplies - Home Blood Glucose Monitor	Rx copays apply	Limited to In Network
Diabetic Services/Supplies - Medical Equipment	$0	Limited to In Network
Implanted Devices (Medical) - Drug Delivery	25%	20% after deductible
Implanted Devices (Medical) - All other non-contraceptive implanted devices	$0	20% after deductible
Orthotic Devices	10%	Limited to In Network
Outpatient Opioid Detoxification	$0	20% after deductible
Abortion (Elective)	Not Covered	Not Covered
High Cost Specialty Drugs/Select Injectables	$150	20% after deductible
Injectable Drugs - Physician	$0	20% after deductible
Injectable Drugs - Facility	$0	20% after deductible
Spinal Injections	$0	Limited to In Network
Dental Anesthesia	$0	20% after deductible
Impacted Wisdom Teeth	$0	20% after deductible
Medical Foods/PKU	$0	Limited to In Network
Pulmonary Function Tests	$0	20% after deductible
Spirometry	$0	20% after deductible
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	20% after deductible
Telehealth (Behavioral Health Services)	$5	20% after deductible
Telehealth (Specialist Services)	$10	20% after deductible
Gender-Affirming Care	$200 per stay	20% after deductible
Mental Health/Substance Abuse Urgent Care Services	$0	$0

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