

| Geisinger All-Access PPO 20/40/1500 | | Gold |
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| 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) | \$9,100/\$18,200 | \$15,000/\$30,000 |
| Medical EHB Deductible (Embedded) | \$1,500/\$3,000 | \$5,000/\$10,000 |
| Drug EHB Deductible | \$0/\$0 | Limited to In Network |
| Combined Medical and Drug EHB Deductible | NA | NA |
| Coinsurance | 0% | 30% |
| Primary Care Visit to Treat an Injury or Illness | \$20 | 30% after deductible |
| Specialist - Office Visit | \$40 | 30% after deductible |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | \$20 | 30% after deductible |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | \$150 copay after deductible | 30% after deductible |
| Outpatient Surgery Physician/Surgical Services | 0% after deductible | 30% after deductible |
| Hospice Services | Residential - \$40 per visit, Facility - \$100 per day | 30% after deductible |
| Infertility Treatment (Note Exclusions) | 0% after deductible | 30% after deductible |
| Routine Eye Exam (Adult) | Not Covered | Not Covered |
| Urgent Care Centers or Facilities | \$20 | \$20 |
| Home Health Care Services (60 visits per year - visit limits do not apply to mental health/ substance use disorder benefits) | \$0 | 30% after deductible |
| Emergency Room Services | \$200 | \$200 |
| Emergency Transportation (Ambulance/Air) | \$0 | \$0 |
| Inpatient Hospital Services (e.g., Hospital Stay) | \$200 per stay after deductible | 30% after deductible |
| Inpatient Physician and Surgical Services | 0% after deductible | 30% after deductible |
| Skilled Nursing Facility (120 days per year) | 0% after deductible | 30% after deductible |
| Prenatal and Postnatal Care (Office Visit) | \$0 | 30% after deductible |
| Delivery and All Inpatient Services for Maternity Care | 0% after deductible | 30% after deductible |
| Mental/Behavioral Health Outpatient Services | \$20 | 30% after deductible |
| Mental/Behavioral Health Inpatient Services | \$200 per stay after deductible | 30% after deductible |
| Substance Abuse Disorder Outpatient Services | \$20 | 30% after deductible |
| Substance Abuse Disorder Inpatient Services | \$200 per stay after deductible | 30% after deductible |
| 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 | \$40 | 30% after deductible |

* EHB = Essential Health Benefits

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| Outpatient Cardiac Rehabilitation Services (36 visits per benefit period) | \$0 | 30% after deductible |
| Outpatient Pulmonary Rehab/Respiratory Rehab Services (36 visits per benefit period) | \$0 | 30% after deductible |
| Habilitation Services | \$40 | 30% after deductible |
| Habilitative Speech Therapy | \$40 | 30% after deductible |
| Habilitative Occupational and Physical Therapy | \$40 | 30% after deductible |
| Chiropractic Care (20 visits per benefit period) | \$20 | 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) | \$150 copay after deductible | 30% after deductible |
| Preventive Care/Screening/Immunization | \$0 | Limited to In Network |
| Routine Eye Exam for Children | \$40 | Limited to In Network |
| Eyeglasses for Children | 50% | 50% |
| Rehabilitative Speech Therapy | \$40 | 30% after deductible |
| Rehabilitative Occupational and Rehabilitative Physical Therapy | \$40 | 30% after deductible |
| Well Baby Visits and Care | \$0 | Limited to In Network |
| Laboratory Outpatient | 0% after deductible | 30% after deductible |
| X-rays | 0% after deductible | 30% after deductible |
| 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 | \$200 copay after deductible | 30% after deductible |
| Accidental Dental (medically necessary) | 0% after deductible | 30% after deductible |
| Dialysis | 0% after deductible | 30% after deductible |
| Allergy Testing | 0% after deductible | 30% after deductible |
| Chemotherapy | 0% after deductible | 30% after deductible |
| Radiation | 0% after deductible | 30% after deductible |
| Diabetes Education | \$0 | Limited to In Network |
| Prosthetic Devices | 0% after deductible | Limited to In Network |
| Infusion Therapy | \$0 | 30% after deductible |
| Nutritional Counseling | \$40 | 30% after deductible |
| Reconstructive Surgery | \$200 copay after deductible | 30% 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% after deductible | 30% after deductible |

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| Colorectal - Fecal Occult and Flexible Sigmoidoscopy | \$0 | Limited to In Network |
| Colorectal - Colonoscopy | \$0 | Limited to In Network |
| Maternity - Office diagnostic services procedures | 0% after deductible | 30% after deductible |
| 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 | 30% after deductible |
| Implanted Devices (Medical) - All other non-contraceptive implanted devices | 0% after deductible | 30% after deductible |
| Orthotic Devices | 0% after deductible | Limited to In Network |
| Outpatient Opioid Detoxification | 0% after deductible | 30% after deductible |
| Abortion (Elective) | Not Covered | Not Covered |
| High Cost Specialty Drugs/Select Injectables | \$150 | 30% after deductible |
| Injectable Drugs - Physician | \$0 | 30% after deductible |
| Injectable Drugs - Facility | 0% after deductible | 30% after deductible |
| Spinal Injections | 0% after deductible | Limited to In Network |
| Dental Anesthesia | 0% after deductible | 30% after deductible |
| Impacted Wisdom Teeth | 0% after deductible | 30% after deductible |
| Medical Foods/PKU | \$0 | Limited to In Network |
| Pulmonary Function Tests | 0% after deductible | 30% after deductible |
| Spirometry | \$0 | 30% 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 | 30% after deductible |
| Telehealth (Behavioral Health Services) | \$5 | 30% after deductible |
| Telehealth (Specialist Services) | \$10 | 30% after deductible |
| Gender-Affirming Care | \$200 per stay after deductible | 30% after deductible |
| Mental Health/Substance Abuse Urgent Care Services | \$0 | \$0 |