Geisinger All-Access PPO 25/50/2000 1xded		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	$15,000/$30,000
Medical EHB Deductible (Embedded)	$2,000/$2,000	$10,000/$20,000
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	$25	30% after deductible
Specialist - Office Visit	$50	30% after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant)	$25	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$100 copay after deductible	30% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	30% after deductible
Hospice Services	Residential - $50 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	$25	$25
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)	$100 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	$25	30% after deductible
Mental/Behavioral Health Inpatient Services	$100 per stay after deductible	30% after deductible
Substance Abuse Disorder Outpatient Services	$25	30% after deductible
Substance Abuse Disorder Inpatient Services	$100 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	$50	30% after deductible

* EHB = Essential Health Benefits

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	$50	30% after deductible
Habilitative Speech Therapy	$50	30% after deductible
Habilitative Occupational and Physical Therapy	$50	30% after deductible
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	30% after deductible
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	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50	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	$100 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	$50	30% after deductible
Reconstructive Surgery	$100 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	$100 per stay after deductible	30% after deductible
Mental Health/Substance Abuse Urgent Care Services	$0	$0

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