Geisinger All-Access PPO 25/50/2000 1xded	Geisinger All-Access PPO 25/50/2000 1xded	
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	1х сорау	Limited to In Network
90-Day Retail	2x copay	Limited to In Network
Outpatient Rehabilitation Services	\$50	30% after deductible

Obstache In National State Abstack Processor Pechals Services (26 visits per henefit period) 30 30% after deductible Habilitation Services \$50 30% after deductible Complete Medical Equipment (cord sharing does not apply to mental health/fulbatance used forontic \$100 capps after deductible Penerative Carro/Servening/Inmunitration \$100 capps after deductible Requises for Children \$50 Uninies to In Network Replaces for Children \$50 Uninies to In Network Replaces for Children \$50 S0% after deductible Rehabilitative Pocupational and Rehabilitative Physical Therapy \$50 S0% after deductible Rehabilitative Speech Therapy \$50 S0% after deductible Rehabilitative Docupational and Rehabilitative Physical Therapy \$50 S0% after deductible Rehabilitative Docupational and Rehab	Outpatient Cardiac Rehabilitation Services (36 visits per benefit period)	\$0	30% after deductible
Habilitative Speech Therapy		· ·	
Habilitative Speech Threrapy		· ·	
Habilitative Occapational and Physical Therapy Chiroprocific Care (DO Visils per hemetit period) Chiroprocific Care (Soremain primarization Chiroprocific Care (Soremain primarization) Chiroprocific Care (Children) Chiroprocific Care (Children) Chiroprocific Children Chiroprocific Chi		· ·	
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Durable Medical Equipment Lost sharing does not apply to mental health/substance use disorder diagnosis. TyPET Scans, MRIk) Imaging (CT/PET Scans, MRIk) Preventive Curry/Screening/Immunization So Diso Coppay after deductible So Disorder Spee Exam for Children So Disorder Speech Throngy So Sc Disorder Speech Throng		•	
diagnosity O'S after deductible Invited to In Network Inaging (CTPET Scans, MRIx) 500 copay after deductible 30% after deductible Pewenthe Care/Sere, ening/Immunization 50 Imitiact to In Network Routine Eye Exam for Children 50% 50% Eyeglasses for Children 50% 30% after deductible Rehabilitative Occupational and Rehabilitative Physical Therapy 50 30% after deductible Well Blaby Visits and Care 50 1.00 (and the Network of Intelligence of Intellig		\$23	Limited to in Network
Preventive Care/Screening/Immunization		0% after deductible	Limited to In Network
Routine Eye Exam for Children	Imaging (CT/PET Scans, MRIs)	\$100 copay after deductible	30% after deductible
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 Laboratory Outpatient 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 deductible Orthodontia - Child (Medicaliy necessary) 50% coinsurance after deductible Limited to In Network deductible Accidental Care - Child 50% coinsurance after deductible Limited to In Network deductible Transplant 50% coinsurance after deductible Limited to In Network 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 deduc	Preventive Care/Screening/Immunization	\$0	Limited to In Network
Rehabilitative Speech Therapy 550 30% after deductible Rehabilitative Occupational and Rehabilitative Physical Therapy 550 30% after deductible Well Baby Visits and Care 50 Limited to In Network Laboratory Outpatient 30% after deductible 30% after deductible X-rays 0% after deductible 30% after deductible Basic Dental Care - Child 50 Limited to In Network Basic Dental Care - Child (Medically necessary) 50% coinsurance after deductible Limited to In Network deductible Major Dental Care - Child 50% coinsurance after deductible Limited to In Network deductible Accidental Dental (medically necessary) 0% after deductible 30% after deductible Accidental Dental (medically necessary) 0% after deductible 30% after deductible Allergy Testing 0% after deductible 30% after deductible Allergy Testing 0% after deductible 30% after deductible Chenotherapy 0% after deductible 30% after deductible Realation 0% after deductible 30% after deductible Diabetes Education 50 Limited to In Network <	Routine Eye Exam for Children	\$50	Limited to In Network
Rehabilitative Occupational and Rehabilitative Physical Therapy So Limited to In Network Laboratory Outpatient Owafter deductible Scrays Owafter deductible Sol Limited to In Network Laboratory Outpatient Owafter deductible Sol Limited to In Network Laboratory Outpatient Sol Limited to In Network Laboratory Outpatient Sol Limited to In Network Limited to In Network Basic Dental Care - Child Care - Child Care - Child (Medically necessary) Orthodontia - Child (Medically necessary) Sol Coinsurance after deductible Coinsurance after deductible Sol Coinsurance after deductible Sol Coinsurance after deductible Sol Coinsurance after deductible Owafter deductible Owaf	Eyeglasses for Children	50%	50%
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 30% after deductible Reconstructive Surgery \$1	Rehabilitative Speech Therapy	\$50	30% after deductible
Laboratory Outpatient X-rays 0% after deductible 30% after deductible 20% after deductible 30% after deductible 20% after deductible 20% after deductible 20% after deductible 20% coinsurance after deductible 20% after deductible 30%	Rehabilitative Occupational and Rehabilitative Physical Therapy	\$50	30% after deductible
X-rays 0% after deductible 30% after deductible Dental Checkup for Children 50 Limited to In Network	Well Baby Visits and Care	\$0	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 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 30% after deductible Infusion Therapy \$0 30% after deductible Nutritional Counseling \$50 30% after deductible Reconstructive Surgery \$100 copay after deductible Preventive - Physical (1 per benefit period) \$0 <td< td=""><td>Laboratory Outpatient</td><td>0% after deductible</td><td>30% after deductible</td></td<>	Laboratory Outpatient	0% after deductible	30% after deductible
Basic Dental Care - Child Crhodontia - Child (Medically necessary) Major Dental Care - Child Sino copay after deductible Sino copay after	X-rays	0% after deductible	30% after deductible
Basic Dental Care - Child Orthodontia - Child (Medically necessary) Major Dental Care - Child Soll coinsurance after deductible Soll copay after deductible 30% after deductible 20% after deductible Limited to In Network 30% after deductible 30% after deductible 20% af	Dental Checkup for Children	\$0	Limited to In Network
Major Dental Care - Child food deductible Limited to In Network deductible Limited to In Network food coinsurance after deductible S100 copay after deductible 30% after deductible 40% after	Basic Dental Care - Child		Limited to In Network
Transplant \$100 copay after deductible \$100 copay after de	Orthodontia - Child (Medically necessary)		Limited to In Network
Accidental Dental (medically necessary) Dialysis O% after deductible O% after deductib	Major Dental Care - Child		Limited to In Network
Dialysis Allergy Testing O% after deductible Diabetes Education O% after deductible Limited to In Network O% after deductible	Transplant	\$100 copay after deductible	30% after deductible
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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 - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network	Infusion Therapy	\$0	30% after deductible
Preventive - Physical (1 per benefit period) 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 - Diabetes \$0 Limited to In Network Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network	Nutritional Counseling	\$50	30% after deductible
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 - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network	Reconstructive Surgery	\$100 copay after deductible	30% after deductible
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 Preventive - Lipid Panel	Preventive - Physical (1 per benefit period)	\$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	Preventive - Mammograms	\$0	Limited to In Network
Preventive - Diabetes \$0 Limited to In Network Preventive - Lipid Panel \$0 Limited to In Network	Preventive - Pap Smears	\$0	Limited to In Network
Preventive - Lipid Panel \$0 Limited to In Network	Preventive - Cholesterol	\$0	Limited to In Network
	Preventive - Diabetes	\$0	Limited to In Network
Specialist - Procedure 0% after deductible 30% after deductible	Preventive - Lipid Panel	\$0	Limited to In Network
	Specialist - Procedure	0% after deductible	30% after deductible

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	\$O	\$0