

Geisinger Choices PPO 30/50/0 Copay Based			Gold
Summary of Benefits	In-Network	In-Network (Tier 2)	Out-of-Network
Maximum Out of Pocket for Medical EHB Benefits	NA	NA	NA
Maximum Out of Pocket for Drug EHB Benefits	NA	NA	NA
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)	\$9,450/\$18,900	\$9,450/\$18,900	\$15,000/\$30,000
Medical EHB Deductible (Embedded)	\$0/\$0	\$0/\$0	\$4,000/\$8,000
Drug EHB Deductible	\$0/\$0	NA	Limited to In Network
Combined Medical and Drug EHB Deductible	NA	NA	NA
Coinsurance	0%	0%	30%
Primary Care Visit to Treat an Injury or Illness	\$30	\$60	30% after deductible
Specialist - Office Visit	\$50	\$100	30% after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$30	\$60	30% after deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$350	\$700	30% after deductible
Outpatient Surgery Physician/Surgical Services	\$0	\$0	30% after deductible
Hospice Services	Residential - \$50 per visit, Facility - \$100 per day	NA	30% after deductible
Infertility Treatment (Note Exclusions)	\$350	\$700	30% after deductible
Routine Eye Exam (Adult)	Not Covered	Not Covered	Not Covered
Urgent Care Centers or Facilities	\$30	\$30	\$30
Home Health Care Services (60 visits per year - visit limits do not apply to mental health/substance use disorder benefits)	\$0	\$0	30% after deductible
Emergency Room Services	\$300	\$300	\$300
Emergency Transportation (Ambulance/Air)	\$0	\$0	\$0
Inpatient Hospital Services (e.g., Hospital Stay)	\$350 per stay	\$700 per stay	30% after deductible
Inpatient Physician and Surgical Services	\$0	\$0	30% after deductible
Skilled Nursing Facility (120 days per year)	\$550 per admit	\$1,100 per admit	30% after deductible
Prenatal and Postnatal Care (Office Visit)	\$0	\$0	30% after deductible
Delivery and All Inpatient Services for Maternity Care	\$0	\$0	30% after deductible
Mental/Behavioral Health Outpatient Services	\$30	NA	30% after deductible
Mental/Behavioral Health Inpatient Services	\$350 per stay	NA	30% after deductible
Substance Abuse Disorder Outpatient Services	\$30	NA	30% after deductible
Substance Abuse Disorder Inpatient Services	\$350 per stay	NA	30% after deductible
Tier 2 - Preferred Generic Drugs	\$3	NA	Limited to In Network
Tier 3 - Non-Preferred Generic Drugs	\$15	NA	Limited to In Network
Tier 4 - Preferred Brand Drugs	\$35	NA	Limited to In Network
Tier 5 - Non-Preferred Brand Drugs	\$55	NA	Limited to In Network
Tier 6 - Specialty Drugs	40% coinsurance up to \$150	NA	Limited to In Network
Tier 1 - \$0 Rx	\$0	NA	Limited to In Network
Mail-Order Rx	1x copay	NA	Limited to In Network
90-Day Retail	2x copay	NA	Limited to In Network
Outpatient Rehabilitation Services	\$50	\$100	30% after deductible

* EHB = Essential Health Benefits

Outpatient Cardiac Rehabilitation Services (36 visits per benefit period)	\$0	\$100	30% after deductible
Outpatient Pulmonary Rehab/Respiratory Rehab Services (36 visits per benefit period)	\$0	\$100	30% after deductible
Habilitation Services	\$50	\$100	30% after deductible
Habilitative Speech Therapy	\$50	\$100	30% after deductible
Habilitative Occupational and Physical Therapy	\$50	\$100	30% after deductible
Chiropractic Care (20 visits per benefit period)	\$30	\$35	Limited to In Network
Durable Medical Equipment (cost sharing does not apply to mental health/substance use disorder diagnosis)	\$0	\$0	Limited to In Network
Imaging (CT/PET Scans, MRIs)	\$350	\$700	30% after deductible
Preventive Care/Screening/Immunization	\$0	\$0	Limited to In Network
Routine Eye Exam for Children	\$50	\$100	Limited to In Network
Eyeglasses for Children	50%	50%	50%
Rehabilitative Speech Therapy	\$50	\$100	30% after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$50	\$100	30% after deductible
Well Baby Visits and Care	\$0	\$0	Limited to In Network
Laboratory Outpatient	\$0	\$0	30% after deductible
X-rays	\$50	\$100	30% after deductible
Dental Checkup for Children	\$0	NA	Limited to In Network
Basic Dental Care - Child	50%	NA	Limited to In Network
Orthodontia - Child (Medically necessary)	50%	NA	Limited to In Network
Major Dental Care - Child	50%	NA	Limited to In Network
Transplant	\$350 per stay	\$700 per stay	30% after deductible
Accidental Dental (medically necessary)	\$0	\$0	30% after deductible
Dialysis	\$0	\$0	30% after deductible
Allergy Testing	\$0	\$0	30% after deductible
Chemotherapy	\$0	\$0	30% after deductible
Radiation	\$0	\$0	30% after deductible
Diabetes Education	\$0	\$0	Limited to In Network
Prosthetic Devices	\$0	\$0	Limited to In Network
Infusion Therapy	\$0	\$0	30% after deductible
Nutritional Counseling	\$50	\$100	30% after deductible
Reconstructive Surgery	\$350 per stay	\$700 per stay	30% after deductible
Preventive - Physical (1 per benefit period)	\$0	\$0	Limited to In Network
Preventive - Mammograms	\$0	\$0	Limited to In Network
Preventive - Pap Smears	\$0	\$0	Limited to In Network
Preventive - Cholesterol	\$0	\$0	Limited to In Network
Preventive - Diabetes	\$0	\$0	Limited to In Network
Preventive - Lipid Panel	\$0	\$0	Limited to In Network
Specialist - Procedure	\$0	\$0	30% after deductible
Colorectal - Fecal Occult and Flexible Sigmoidoscopy	\$0	\$0	Limited to In Network

Colorectal - Colonoscopy	\$0	\$0	Limited to In Network
Maternity - Office diagnostic services procedures	\$0	\$0	30% after deductible
Correction for Obesity - Facility	Not Covered	Not Covered	Not Covered
Ostomy Supplies	\$0	\$0	Limited to In Network
Urology Supplies	\$0	\$0	Limited to In Network
Diabetic Services/Supplies - Eye Exam	\$0	\$0	Limited to In Network
Diabetic Services/Supplies - Rx Supplies	Rx copay applies	NA	Limited to In Network
Diabetic Services/Supplies - Foot Orthotics	\$0	\$0	Limited to In Network
Diabetic Services/Supplies - Home Blood Glucose Monitor	Rx copay applies	NA	Limited to In Network
Diabetic Services/Supplies - Medical Equipment	\$0	\$0	Limited to In Network
Implanted Devices (Medical) - Drug Delivery	\$0	\$0	30% after deductible
Implanted Devices (Medical) - All other non-contraceptive implanted devices	\$0	\$0	30% after deductible
Orthotic Devices	\$0	\$0	Limited to In Network
Outpatient Opioid Detoxification	\$0	\$0	30% after deductible
Abortion (Elective)	Not Covered	Not Covered	Not Covered
High Cost Specialty Drugs/Select Injectables	\$150	\$150	30% after deductible
Injectable Drugs - Physician	\$0	\$0	30% after deductible
Injectable Drugs - Facility	\$0	\$0	30% after deductible
Spinal Injections	\$0	\$0	Limited to In Network
Dental Anesthesia	\$0	\$0	30% after deductible
Impacted Wisdom Teeth	\$0	\$0	30% after deductible
Medical Foods/PKU	\$0	\$0	Limited to In Network
Pulmonary Function Tests	\$0	\$0	30% after deductible
Spirometry	\$0	\$0	30% after deductible
Scheduled Transportation (Ambulance/Air)	\$0	\$0	Limited to In Network
Contact Lenses	50%	50%	50%
Well Child Office Visits (0-21)	\$0	\$0	Limited to In Network
Well Woman Exam	\$0	\$0	Limited to In Network
Telehealth (PCP Services)	\$5	\$60	30% after deductible
Telehealth (Behavioral Health Services)	\$5	NA	30% after deductible
Telehealth (Specialist Services)	\$10	\$100	30% after deductible
Gender-Affirming Care	\$350 per stay	\$700 per stay	30% after deductible
Mental Health/Substance Abuse Urgent Care Services	\$0	\$0	\$0