




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-863-6850 or visit [www.GeisingerHealthPlan.com](http://www.GeisingerHealthPlan.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary.com](http://www.healthcare.gov/sbc-glossary.com) or call 1-844-863-6850 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$8,550 individual / \$17,100 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.GeisingerHealthPlan.com">www.GeisingerHealthPlan.com</a> or call 1-844-863-6850 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay:		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> / visit	Not covered	None.
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a> / visit	Not covered	None.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	Diagnostic: None. Imaging: <a href="#">Precertification/prior-authorization</a> required.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.GeisingerHealthPlan.com">www.GeisingerHealthPlan.com</a>	Generic drugs: (Tier 1)	Retail: \$15 <a href="#">copay</a> / prescription Mail order: \$30 <a href="#">copay</a> / prescription	Not covered	Covers up to a 34-day supply (retail prescription). Mail order covers up to a 90-day supply.
	Preferred brand drugs: (Tier 2)	Retail: \$30 <a href="#">copay</a> / prescription Mail order: \$60 <a href="#">copay</a> / prescription.	Not covered	
	Non-preferred brand drugs: (Tier 3)	Retail: \$50 <a href="#">copay</a> / prescription Mail order: \$100 <a href="#">copay</a> / prescription.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay:		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non- Participating Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.GeisingerHealthPlan.com">www.GeisingerHealthPlan.com</a></p>	<a href="#">Specialty drugs</a> : (Tier 4)	<a href="#">Copay</a> varies by drug based on above.	Not covered	Covers up to a 34-day supply (retail prescription)
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	<p><a href="#">Precertification/prior authorization</a> may be required.</p>
	Physician/surgeon fees	No charge	Not covered	
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> / visit	\$100 <a href="#">copay</a> / visit	<p><a href="#">Emergency services</a>: Copay waved if admitted to the hospital. <a href="#">Emergency medical transportation</a>: None. <a href="#">Urgent care</a>: None.</p>
	<a href="#">Emergency medical transportation</a>	No charge	No charge	
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> / visit	\$35 <a href="#">copay</a> / visit	
<p><b>If you have a hospital stay</b></p>	Facility Fee (e.g., hospital room)	No charge	Not covered	<p><a href="#">Precertification/prior authorization</a> required.</p>
	Physician/surgeon fees	No charge	Not covered	
<p><b>If you need mental health, behavioral health, or substance abuse services</b></p>	Outpatient services	\$20 <a href="#">copay</a> / visit	Not covered	<p>Outpatient Services: None. Inpatient Services: <a href="#">Precertification/ prior authorization</a> required.</p>
	Inpatient services	No charge	Not covered	
<p><b>If you are pregnant</b></p>	Office visits	\$20 <a href="#">copay</a> for first visit only; subsequent visits no charge.	Not covered	<p>Pregnancy office visits: None. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a>. Maternity care may include tests and services as described elsewhere in the SBC (i.e., ultrasound). Depending on the type of services, a <a href="#">copayment</a>, <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Inpatient professional and facility services; <a href="#">Precertification/prior authorization</a> required.</p>
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay:		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Primary care:\$20 <a href="#">copay</a> / visit  Specialist:\$35 <a href="#">copay</a> / visit  Other professional: No charge / visit	Not covered	None.
	<a href="#">Rehabilitation services</a>	\$35 <a href="#">copay</a> / visit	Not covered	None.
	<a href="#">Habilitation services</a>	\$35 <a href="#">copay</a> / visit	Not covered	
	<a href="#">Skilled nursing care</a>	No charge	Not covered	60 days / benefit period / person.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	None.
	<a href="#">Hospice services</a>	No charge	Not covered	None.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 exam / benefit period.
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	None.

**Excluded Services & Other Covered Services:**

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Chiropractic Care</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids</li> <li>• Infertility Treatment</li> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Routine Foot Care (Adult)</li> </ul>
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Bariatric Surgery	• Routine Eye Care (Adult)	• Weight Loss Programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov.ebsa/healthreform](http://www.dol.gov.ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov.ebsa/healthreform](http://www.dol.gov.ebsa/healthreform), or the Pennsylvania Insurance Department at 1-877-881-6388 or [www.insurance.pa.gov/Consumers](http://www.insurance.pa.gov/Consumers).

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:** To access our Language helpline, please call 1-800-447-4000.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

**Total Example Cost \$12,700**

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$10</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

**Total Example Cost \$5,600**

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,700</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

**Total Example Cost \$2,800**

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.





