Geisinger Quality Options : PPO with No Referral Plan

Coverage Period: 07/01/2017 - 06/30/2018

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual or Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.thehealthplan.com or by calling 1-800-504-0443 .

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For preferred providers $500 person/ $1500 family For non-preferred providers $1000 person/$3000 family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out -of -pocket limit on my expenses?	Yes. For preferred providers $6850 person/ $13700 family For non-preferred providers $0 person/ $0 family per benefit period.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out -of -pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.thehealthplan.com or call 1-800-504-0443.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Provider	Your Cost if You Use a Non-Preferred Provider	Limitations
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	20%	none
	Specialist visit	$40 copay/visit	20%	none
	Other practitioner office visit	$20	Not covered	15 visits/member/benefit period.
	Preventive care/screening/immunization	No charge	20%	none
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20%	Deductible (if any) applies.
	Imaging (CT/PET scans, MRIs)	No charge	20%	Deductible (if any) applies. Precert/prior auth required.

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Provider	Your Cost if You Use a Non-Preferred Provider	Limitations
If you need drugs to treat your illness or condition	Generic drugs	$10	Not covered	Covers up to a 34-day supply.
	Preferred brand drugs	$35	Not covered	Covers up to a 34-day supply.
	Non-Preferred brand drugs	$60	Not covered	Covers up to a 34-day supply.
More information about **prescription drug coverage** is available at www.thehealthplan.com	Specialty drugs	Copay varies by drug based on above	Not covered	Covers up to a 34-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20%	Deductible (if any) applies. Precert/prior auth may be required.
	Physician/surgeon fees	No charge	20%	Deductible (if any) applies. Precert/prior auth may be required.
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Copay waived if admitted to the hospital
	Emergency medical transportation	No charge	No charge	none
	Urgent care	$20 copay/visit	$20 copay/visit	none

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Provider	Your Cost if You Use a Non-Preferred Provider	Limitations
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20%	Deductible (if any) applies. Precert/prior auth required. 90 days/non-par/benefit period.
	Physician/surgeon fee	No charge	20%	Precert/prior auth required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	20%	none
	Mental/Behavioral health inpatient services	No charge	20%	Deductible (if any) applies. 90 days/non-par/benefit period.
	Substance use disorder outpatient services	$20 copay/visit	20%	none
	Substance use disorder inpatient services	No charge	20%	Deductible (if any) applies. 90 days/non-par/benefit period.
If you are pregnant	Prenatal and postnatal care	No charge for prenatal exams	20%	none
	Delivery and all inpatient services	No charge	20%	Deductible (if any) applies. Precert/prior auth required. 90 days/non-par/benefit period.

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Provider	Your Cost if You Use a Non-Preferred Provider	Limitations
If you need help recovering or have other special health needs	Home health care	No charge	20%	none
	Rehabilitation services	$40 copay/visit	20%	none
	Habilitation services	$40 copay/visit	20%	none
	Skilled nursing care	No charge	20%	Deductible (if any) applies. 60 days/period of confinement/person.
	Durable medical equipment	No charge	Not covered	none
	Hospice service	No charge	20%	none
If your child needs dental or eye care	Eye exam	No charge	Not covered	1 exam/member/benefit period.
	Glasses	Not covered	Not covered	none
	Dental check-up	Not covered	Not covered	none

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Infertility treatment	• Private duty nursing
• Cosmetic surgery	• Long term care	• Routine foot care
• Dental care	• Most coverage provided outside the United States	• Weight loss programs
• Hearing aids	• Non-emergency care when traveling outside the U.S.	
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-504-0443 . You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Geisinger Quality Customer Service at: 1-800-504-0443 , Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform and the Pennsylvania Insurance Department at 1-877-881-6388. Additionally, a consumer assistance program can help you file your appeal. Contact 1-877-881-6388.

Language Access Services

To access our Language helpline, please call 1-800-504-0443 .

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $ 6,490
- **Patient pays** $ 1,050

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$1,000
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$30
Total	$1,050

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $ 2,765
- **Patient pays** $ 2,635

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$353
Co-pays	$2,203
Co-insurance	$0
Limits or exclusions	$79
Total	$2,635

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Summary of Benefits and Coverage Disclosure

Minimum essential coverage and minimum value standard

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.** To review the sample or actual Subscription Certificate go to www.thehealthplan.com.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**