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 1-866-379-4489.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For preferred providers **$7,150** person/**$14,300** family. For non-preferred providers **$10,000** person/**$20,000** 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 documents 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.	There are no other specific **deductibles**.
Is there an out–of–pocket limit on my expenses?	Yes. For preferred providers **$7,150** person/**$14,300** family For non-preferred providers **$15,000** person/**$30,000** family. Includes all deductibles, coinsurance and copayments.	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. See www.thehealthplan.com or call 1-866-379-4489 for a list of participating providers.	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?	Yes. Written approval is needed to see a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-379-4489 **or visit us at** www.thehealthplan.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.thehealthplan.com **or call 1-866-379-4489 to request a copy.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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**, **copayments** and **coinsurance** 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 & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	40% after deductible	None
	Specialist visit	No charge after deductible	40% after deductible	None
	Other practitioner office visit	No charge after deductible	40% after deductible	Chiropractor, Preferred Provider only: 20 visits/member/benefit period
	Preventive care/screening/immunization	No charge	40% after deductible	Adults (22+): Limited to 1 routine exam per year, PCP copay applies thereafter
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	40% after deductible	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	40% after deductible	Precert/prior auth required.
Covers up to a 31-day supply. Mail order 3x copayment.	Generic (preferred) drugs	$0 after deductible	Not covered	Covers up to a 34-day supply.
	Generic (non-preferred) drugs	$0 after deductible	Not covered	
	Brand (preferred) drugs	$0 after deductible	Not covered	
	Brand (non-preferred) drugs	$0 after deductible	Not covered	
	Specialty (preferred)	$0 after deductible	Not covered	No mail order option

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 & Exceptions
	$0 Tier	No charge	Not covered	MediBenNC vaccines (flu and zostavax)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% after deductible	None
	Physician/surgeon fees	No charge after deductible	40% after deductible	None
If you need immediate medical attention	Emergency room services	No charge after deductible	No charge after deductible	None
	Emergency medical transportation	No charge after deductible /ground	No charge after deductible /ground	None
		No charge after deductible /air	No charge after deductible /air	
	Urgent care	No charge after deductible	No charge after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	40% after deductible	Precert/prior auth required. Limited to 90 days out of network.
	Physician/surgeon fee	No charge after deductible	40% after deductible	Precert/prior auth required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after deductible	40% after deductible	None
	Mental/Behavioral health inpatient services	No charge after deductible	40% after deductible	Precert/prior auth required. Limited to 90 days out of network.
	Substance use disorder outpatient services	No charge after deductible	40% after deductible	None
	Substance use disorder inpatient services	No charge after deductible	40% after deductible	Precert/prior auth required. Limited to 90 days out of network.
If you are pregnant	Prenatal and postnatal care	No charge after deductible	40% after deductible	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 & Exceptions
	Delivery and all inpatient services	No charge after deductible	40% after deductible	Deductible applies to vaginal delivery, cesarean delivery and each newborn admission. Limited to 90 days out of network.
If you need help recovering or have other special health needs	Home health care	No charge after deductible	40% after deductible	Limited to 60 visits/member/ benefit period.
	Rehabilitation services	No charge after deductible	40% after deductible	None
	Habilitation services	No charge after deductible	40% after deductible	None
	Skilled nursing care	No charge after deductible	40% after deductible	Limited to 120 days/member/benefit period.
	Durable medical equipment	No charge after deductible	Not covered	None
	Hospice service	No charge after deductible	40% after deductible	None
If you need eye care and eyewear	Pediatric eye exam	No charge after deductible	Not covered	1 exam/member/benefit period.
	Hardware (Pediatric)	No charge after deductible	50% after deductible	Up to age 19 only. 1 frame every 12 months.

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.)**

- Adult Eye Exam
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Long term care
- Non-emergency care when traveling outside of the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs

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.)**

- Chiropractic care
- Infertility Treatment
- Pediatric routine eye exam

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 1-866-379-4489. 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 x 61565 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 may contact the Pennsylvania State Insurance Department at 1-877-881-6388.

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.**

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 page.

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** $70
- **Patient pays** $7,470

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	$7,440
Copays	$0
Coinsurance	$0
Limits or exclusions	$30
Total	**$7,470**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $305
- **Patient pays** $5,095

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	$5,016
Copays	$0
Coinsurance	$0
Limits or exclusions	$79
Total	**$5,095**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Discrimination is Against the Law

Geisinger Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Geisinger Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Geisinger Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Geisinger Health Plan at 800-447-4000 or TTY: 711.

If you believe that Geisinger Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 North Academy Avenue, Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225
GHPCivilRights@thehealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone: 800–368–1019, 800–537–7697 (TDD).
Complaint forms are available at *http:// www.hhs.gov/ocr/office/file/index.html.*

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-447-4000 (رقم هاتف الصم والبكم:711.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-447-4000 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព 800-447-4000 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711)