

# Geisinger Quality Options: PPO with No Referral Plan

Coverage Period: 01/01/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + 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](http://www.thehealthplan.com) or by calling 1-800-504-0443.

| Important Questions                                       | Answers                                                                                                                                          | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                   | For preferred providers <b>\$3,000</b> person/ <b>\$6,000</b> family. For non-preferred providers <b>\$5,000</b> person/ <b>\$10,000</b> family. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan documents to see when the <u>deductible</u> starts over (usually, but not always, January 1 <sup>st</sup> ). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .                                                                               |
| Are there other <u>deductibles</u> for specific services? | Yes. For participating pharmacies <b>\$250</b> person/ <b>\$500</b> family.                                                                      | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.                                                                                                                                                                                                                                                                                                                          |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | Yes. For participating providers <b>\$6,000</b> person/ <b>\$12,000</b> family. Includes all deductibles, coinsurance and copayments.            | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?  | Premiums, balance-billed charges, and health care this plan doesn't cover.                                                                       | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> 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 <i>specific</i> covered services, such as office visits.                                                                                                                                                                                                                                                                                                                          |
| Does this plan use a <u>network of providers</u> ?        | Yes. See <a href="http://www.thehealthplan.com">www.thehealthplan.com</a> or call 1-800-504-0443 for a list of participating providers.          | If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ?         | No. You don't need a referral to see a specialist.                                                                                               | This plan will pay some or all of the costs to see a <b>specialist</b> for covered services. You can see the <u>specialist</u> 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 5. See your policy or plan document for additional information about <u>excluded services</u> .                                                                                                                                                                                                                                                                                                   |

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Geisinger Choice Marketplace Direct 8

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- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event                                                                                                                                                                                  | Services You May Need                            | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------|
| If you visit a health care <b>provider's</b> office or clinic                                                                                                                                         | Primary care visit to treat an injury or illness | \$30 copay/visit                            | 40% after deductible                            | None                                                                           |
|                                                                                                                                                                                                       | Specialist visit                                 | \$50 copay/visit                            | 40% after deductible                            | None                                                                           |
|                                                                                                                                                                                                       | Other practitioner office visit                  | \$30 copay/visit                            | Not covered                                     | 20 visits/member/benefit period                                                |
|                                                                                                                                                                                                       | Preventive care/screening/immunization           | No charge                                   | Not covered                                     | Adults (22+): Limited to 1 routine exam per year, PCP copay applies thereafter |
| If you have a test                                                                                                                                                                                    | Diagnostic test (x-ray, blood work)              | 30%                                         | 40% after deductible                            | None                                                                           |
|                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                     | 30% after deductible                        | 40% after deductible                            | Deductible (if any) applies. Precert/prior auth required.                      |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.thehealthplan.com">www.thehealthplan.com</a> | Generic (preferred) drugs                        | \$3                                         | Not covered                                     | Covers up to a 31-day supply                                                   |
|                                                                                                                                                                                                       | Generic (non-preferred) drugs                    | \$20                                        | Not covered                                     | Covers up to a 31-day supply                                                   |
|                                                                                                                                                                                                       | Brand (preferred) drugs                          | \$50 after deductible                       | Not covered                                     | Covers up to a 31-day supply                                                   |
|                                                                                                                                                                                                       | Brand (non-preferred) drugs                      | \$85 after deductible                       | Not covered                                     | Covers up to a 31-day supply                                                   |
|                                                                                                                                                                                                       | Specialty (preferred)                            | 50% after deductible up to policy max OOP   | Not covered                                     | No mail order option.                                                          |
|                                                                                                                                                                                                       | \$0 Tier                                         | No charge                                   | Not covered                                     | MediBenNC vaccines (flu and zostavax) and oral contraceptives.                 |

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| Common Medical Event                                                   | Services You May Need                          | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions                                                                              |
|------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| If you have outpatient surgery                                         | Facility fee (e.g., ambulatory surgery center) | 30% after deductible                        | 40% after deductible                            | Deductible (if any) applies                                                                           |
|                                                                        | Physician/surgeon fees                         | 30% after deductible                        | 40% after deductible                            | Deductible (if any) applies                                                                           |
| If you need immediate medical attention                                | Emergency room services                        | \$250 copay/visit                           | \$250 copay/visit                               | Copay waived if admitted to the hospital                                                              |
|                                                                        | Emergency medical transportation               | \$150/ground                                | \$150/ground                                    | None                                                                                                  |
|                                                                        |                                                | \$500/air                                   | \$500/air                                       |                                                                                                       |
|                                                                        | Urgent care                                    | \$50 copay/visit                            | \$50 copay/visit                                | None                                                                                                  |
| If you have a hospital stay                                            | Facility fee (e.g., hospital room)             | 30% after deductible                        | 40% after deductible                            | Deductible (if any) applies. Precert/prior auth required.                                             |
|                                                                        | Physician/surgeon fee                          | 30% after deductible                        | 40% after deductible                            | Deductible (if any) applies                                                                           |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services   | Individual therapy: \$30 copay/visit        | 40% after deductible                            | None                                                                                                  |
|                                                                        |                                                | Group therapy: \$30 copay/visit             |                                                 |                                                                                                       |
|                                                                        | Mental/Behavioral health inpatient services    | 30% after deductible                        | 40% after deductible                            | Deductible (if any) applies. Precert/prior auth required.                                             |
|                                                                        | Substance use disorder outpatient services     | Individual therapy: \$50 copay/visit        | 40% after deductible                            | None                                                                                                  |
|                                                                        |                                                | Group therapy: \$50 copay/visit             |                                                 |                                                                                                       |
|                                                                        | Substance use disorder inpatient services      | 30% after deductible                        | 40% after deductible                            | Deductible (if any) applies. Precert/prior auth required.                                             |
| If you are pregnant                                                    | Prenatal and postnatal care                    | No charge                                   | 40% after deductible                            | None                                                                                                  |
|                                                                        | Delivery and all inpatient services            | 30% after deductible                        | 40% after deductible                            | Deductible applies (as applicable) to vaginal delivery, cesarean delivery and each newborn admission. |

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| Common Medical Event                                           | Services You May Need     | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions                             |
|----------------------------------------------------------------|---------------------------|---------------------------------------------|-------------------------------------------------|------------------------------------------------------|
| If you need help recovering or have other special health needs | Home health care          | PCP \$30 copay/visit                        | 40% after deductible                            | Limited to 60 visits/member/ benefit period.         |
|                                                                |                           | Specialist \$50 copay/visit                 |                                                 |                                                      |
|                                                                |                           | Other professional \$50 copay/visit         |                                                 |                                                      |
|                                                                | Rehabilitation services   | Physical: \$50 copay/visit                  | 40% after deductible                            | Combined maximum of 30 visits/member/benefit period. |
|                                                                |                           | Speech: \$50 copay/visit                    |                                                 |                                                      |
|                                                                |                           | Occupational: \$50 copay/visit              |                                                 |                                                      |
|                                                                | Habilitation services     | \$50 copay/visit                            | 40% after deductible                            | Combined maximum of 30 visits/member/benefit period. |
|                                                                | Skilled nursing care      | 30% after deductible                        | 40% after deductible                            | 120 days/member/benefit period.                      |
|                                                                | Durable medical equipment | 30% after deductible                        | Not covered                                     | Deductible (if any) applies                          |
|                                                                | Prosthetic Devices        | 30% after deductible                        |                                                 |                                                      |
| If you need eye care and eyewear                               | Orthotic Devices          | 50% after deductible                        | 40% after deductible                            | None                                                 |
|                                                                | Hospice service           | Residential: \$50 copay/visit               |                                                 |                                                      |
|                                                                |                           | Facility: \$100 per day                     |                                                 |                                                      |
|                                                                | Pediatric eye exam        | \$50 copay                                  | Not covered                                     | 1 exam/member/benefit period.                        |
|                                                                | Adult eye exam            | \$50 copay                                  | Not covered                                     | 1 exam/member/benefit period.                        |
|                                                                | Hardware (Pediatric)      | 50%                                         | 50%                                             | Up to age 19 only. 1 frame every 24 months.          |

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## 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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside of 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
- Routine eye

## 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.

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For more information on your rights to continue coverage, contact the plan at 1-800-447-4000. 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](http://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](http://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.**

## 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.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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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 \$2,429
- Patient pays \$5,111

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$4,070        |
| Copays               | \$0            |
| Coinsurance          | \$1,011        |
| Limits or exclusions | \$30           |
| <b>Total</b>         | <b>\$5,111</b> |

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

- Amount owed to providers: \$5,400
- Plan pays \$4,332
- Patient pays \$1,068

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$603          |
| Copays               | \$386          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$79           |
| <b>Total</b>         | <b>\$1,068</b> |

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## 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.

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