



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 1-800-447-4000.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Referred providers \$0 person/ \$0 family; self-referred providers \$2,500 person/ \$5,000 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 st). 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?	No.	There are no other specific <u>deductibles</u> .
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For participating providers \$2,000 person/ \$4,000 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 www.thehealthplan.com or call 1-800-447-4000 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 specialist 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> .

Questions: Call 1-800-447-4000 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. view the Glossary at www.thehealthplan.com or call 1-800-447-4000 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 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 PHN copay/visit \$50 Non-PHN copay/visit	20% after deductible	None
	Specialist visit	\$50 copay/visit	20% after deductible	None
	Other practitioner office visit	\$25 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)	No charge	20% after deductible	Deductible (if any) applies
	Imaging (CT/PET scans, MRIs)	\$250 after deductible	20% after deductible	Deductible (if any) applies. Precert / prior auth required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.thehealthplan.com	Generic (preferred) drugs	\$3	Not covered	Covers up to a 31-day supply. Mail order 2x copayment.
	Generic (non-preferred) drugs	\$15	Not covered	Covers up to a 31-day supply. Mail order 2x copayment.
	Brand (preferred) drugs	\$35	Not covered	Covers up to a 31-day supply. Mail order 2x copayment.
	Brand (non-preferred) drugs	\$55	Not covered	Covers up to a 31-day supply. Mail order 2x copayment.

Questions: Call 1-800-447-4000 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.
view the Glossary at www.thehealthplan.com or call 1-800-447-4000 to request a copy.

Geisinger Health Plan: Solutions POS Extra

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: POS

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
	Specialty (preferred)	40% up to \$150	Not covered	No mail order option.
	\$0 Tier	No charge	Not covered	MediBenNC vaccines (flu and zostavax) and oral contraceptives.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250/day (max \$1250 admission)	20% after deductible	Copayment/deductible (if any) applies
	Physician/surgeon fees	No charge	20% after deductible	None
If you need immediate medical attention	Emergency room services	\$200 copay/visit	\$200 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)	\$250/day (max \$1250 admission) after deductible	20% after deductible	Copayment/deductible (if any) applies. Precert/prior auth required.
	Physician/surgeon fee	No charge	20% after deductible	None

Questions: Call 1-800-447-4000 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. view the Glossary at www.thehealthplan.com or call 1-800-447-4000 to request a copy.

Geisinger Health Plan: Solutions POS Extra

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: POS

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Individual therapy: \$25 copay/visit	20% after deductible	None
		Group therapy: \$25 copay/visit		
	Mental/Behavioral health inpatient services	\$250/day (max \$1250 admission) after deductible	20% after deductible	Copayment/deductible (if any) applies. Precert/prior auth required.
	Substance use disorder outpatient services	Individual therapy: \$50 copay/visit	20% after deductible	None
		Group therapy: \$50 copay/visit		
	Substance use disorder inpatient services	\$250/day (max \$1250 admission) after deductible	20% after deductible	Copayment/deductible (if any) applies. Precert/prior auth required.
If you are pregnant	Prenatal and postnatal care	No charge	20% after deductible	None
	Delivery and all inpatient services	\$250/day (max \$1250 admission) after deductible	20% after deductible	Copayment /deductible applies to vaginal delivery, cesarean delivery and each newborn admission.

Questions: Call 1-800-447-4000 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. view the Glossary at www.thehealthplan.com or call 1-800-447-4000 to request a copy.

Geisinger Health Plan: Solutions POS Extra

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: POS

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 \$25 copay/visit	20% after deductible	Limited to 60 visits/member/ benefit period.
		Specialist \$50 copay/visit		
		Other professional \$50 copay/visit		
	Rehabilitation services	Physical: \$50 copay/visit	20% after deductible	Combined maximum of 30 visits/member/benefit period.
		Speech: \$50 copay/visit		
		Occupational: \$50 copay/visit		
	Habilitation services	\$50 copay/visit	20% after deductible	Combined maximum of 30 visits/member/benefit period.
	Skilled nursing care	\$50 / day after deductible	20% after deductible	120 days/member/benefit period.
	Durable medical equipment	20% after deductible	Not covered	Deductible (if any) applies
	Prosthetic Devices	20% after deductible		
	Orthotic Devices	50% after deductible		
If you need eye care and eyewear	Hospice service	Residential: \$50 copay/visit	20% after deductible	None
		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%	Not covered	Up to age 19 only. 1 frame every 24 months.

Questions: Call 1-800-447-4000 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. view the Glossary at www.thehealthplan.com or call 1-800-447-4000 to request a copy.

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

Questions: Call 1-800-447-4000 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. view the Glossary at www.thehealthplan.com or call 1-800-447-4000 to request a copy.

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 1-800-447-4000. 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, 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.**

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.

Questions: Call 1-800-447-4000 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. view the Glossary at www.thehealthplan.com or call 1-800-447-4000 to request a copy.

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 \$6,504
- Patient pays \$1,036

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	\$0
Copays	\$1,006
Coinsurance	\$0
Limits or exclusions	\$30
Total	\$1,036

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

- Amount owed to providers: \$5,400
- Plan pays \$5,009
- Patient pays \$391

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	\$0
Copays	\$312
Coinsurance	\$0
Limits or exclusions	\$79
Total	\$391

Questions: Call 1-800-447-4000 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. view the Glossary at www.thehealthplan.com or call 1-800-447-4000 to request a copy.

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.

Questions: Call 1-800-447-4000 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. view the Glossary at www.thehealthplan.com or call 1-800-447-4000 to request a copy.