

		<b>In-Network Coverage</b>		
<b>Plan facts</b>	Member services Member services hours Web address Product name	(800) 447-4000 Mon-Fri: 8:00 AM-6:00 PM ET www.thehealthplan.com Geisinger Custom Solutions HMO	Annual enrollment information:	(800) 631-1656
<b>Your medical expenses</b>	Annual deductible Out-of-pocket maximum (does not include deductible) Office visits Maternity care prenatal office visits Inpatient hospitalization Outpatient surgical care Outpatient lab and X-ray Emergency room care Urgent care facility	\$500 (individual) / \$1,000 (family max) \$2,500 (individual) / \$5,000 (family max) per calendar year (excludes deductible) Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible. Certain preventive tests covered at 100% \$100 copay/visit (waived if admitted) Covered at 90% after deductible		
<b>Your prescription drug expenses</b>	Retail	\$10 copay (generic), \$20 copay (preferred brand), \$40 copay (non-preferred brand) per prescription up to 34-day supply		
	Mail order	\$20 copay (generic), \$40 copay (preferred brand name), \$80 copay (non-preferred brand name) per prescription up to 90-day supply		
<b>Preventive care</b>	Routine physical and GYN exam Routine vision exam Well-child care and immunizations Routine mammography	Covered at 100%, no deductible Covered at 100%, no deductible. Limit 1 exam per 24 months Covered at 100%, no deductible Covered at 100%, no deductible		
<b>Mental health</b>	Inpatient Outpatient	Covered at 90% after deductible Covered at 90% after deductible		
<b>Substance abuse</b>	Inpatient detoxification Inpatient rehabilitation Outpatient detoxification Outpatient rehabilitation	Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible Covered at 90% after deductible		
<b>Other professional care</b>	Outpatient physical/speech/occupational therapy Chiropractic care Infertility	Covered at 90% after deductible. Limit 45 visits per calendar year for all therapies combined Covered at 90% after deductible. Limit 15 visits per year Covered at 90% after deductible for diagnosis only. Procedures are not covered. Contact Plan for details		
<b>Out-of-network coverage</b>	Out-of-network non-emergency care	Not covered		
<b>Key facts</b>	NCQA status: PCP referral required for specialist: Lifetime maximum benefit: Provider network:	Excellent Yes NA See website for details	Domestic partner coverage available: Domestic partner children coverage avail.:	Yes Yes

\* Indicates a benefit change

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions.