

## GHI Small Business Advantage Program

Covered Services	In-Network	Out-of-Network	
Hospital/facility copayment per admission (single hospital confinement)	\$500	\$1,000	
Hospital/facility coinsurance	None	25%	
Hospital/facility coinsurance maximum (per calendar year)	None	\$5,000	
Hospital/facility allowance	GHI contracted fee schedule	150% of Medicare based fee schedule	
Medical copayment/coinsurance	\$30 per office visit	25%	
Medical allowance	GHI contracted fee schedule	100% of Medicare based fee schedule	
Medical annual deductible (per calendar year)	None	\$1,000 per person/\$3,000 per family	
Medical coinsurance maximum (per calendar year)	None	\$10,000 per person/30,000 per family	
Annual maximum (combined medical/hospital per calendar year)	None	\$1,000,000	
Lifetime maximum	None	None	
Inpatient hospital acute care services, including maternity and routine nursery care.* 365 days per single hospital confinement.	Covered in full after \$500 copayment	25% coinsurance after \$1,000 copayment per single hospital confinement	
Skilled nursing facility care.* 60 days per person per calendar year.	Covered in full	25% coinsurance (copayment waived)	
Hospice care* – inpatient and outpatient. 210 days per person per lifetime.	Covered in full	Covered in-network only	
Outpatient/ambulatory surgery*	Covered in full after \$100 copayment	25% coinsurance after \$100 copayment	
Physician and specialist office visits	\$30 copayment	Covered in-network only	
Chiropractic care	\$30 copayment	Covered in-network only	
Annual adult physical examination, including OB/GYN	\$30 copayment	Covered in-network only	
Well baby & well child care up to age 19	Covered in full	25% coinsurance after deductible	
Diagnostic lab and radiology procedures performed in physician's office	\$30 copayment	Covered in-network only	
Emergency room facility charges	Covered in full after \$100 copayment	Covered up to 100% allowed charge after \$100 copayment	
Emergency room professional charges	Covered in full	Covered up to 100% of Ingenix at the 80th percentile	
Inpatient Mental Health 30 days per calendar year	Covered in full after \$500 copayment	25% coinsurance after \$1,000 copayment per single hospital confinement	
Outpatient Mental Health – professional services Outpatient Mental Health – hospital based facility services Combined 20 days per calendar year	\$30 copayment Covered in Full	Not Covered 25% coinsurance	
Outpatient Chemical dependency treatment. 60 visits per calendar year, up to 20 visits for family therapy.	\$30 copayment	25% coinsurance	
<b>Drug Program</b>			
<b>Retail Pharmacy Program</b> (Covered in-network only)	<b>Generic/Preferred/Non-Preferred</b>	<b>Deductible</b>	<b>Annual maximum</b>
30-day supply	Member pays: \$10/50%/50%	\$100 per person, \$300 per family per calendar year	\$3,000 per person per calendar year
<b>Home Delivery Pharmacy Program</b> (Covered in-network only)	<b>Generic/Preferred/Non-Preferred</b>	<b>Deductible</b>	<b>Annual maximum</b>
90-day supply	Member pays: \$20/50%/50%	None	None
Mandatory mail after initial fill and one refill for maintenance medications.			

This brochure is not a complete benefit description or contract and should only be viewed as a summary to assist you in understanding this program. Coverage is subject to all terms, conditions, limitations and exclusions of the Certificate of Insurance. In the event of any inconsistency between this brochure and the Certificate of Insurance, the Certificate of Insurance shall govern.

\*Services require pre-certification. Note: maternity services do not require pre-certification.

Policy form numbers PLH-SGC-1003, PLH-SGC-1004, PLH-SGC-1005, et al.