GHI-Small Business Advantage Program

Group Name | **Effective Date:** | **Group Rep**

Rating Structure: ☐ **2-Tier Sole Proprietor** ☐ **4-Tier Groups of 2-50**

		Network	Non-Network
Inpatient hospital *coverage and inpatient medical[1] services		Covered in Full, after $500 copay	25% Coinsurance after $1,000 copay per confinement
Skilled Nursing Facility Care*	**60** days per calendar year	Covered in Full	25% coinsurance (copay waived)
Hospice Care * (inpatient/in-home)	**210** days per lifetime	Covered in Full	Covered in-network only
Inpatient Maternity , routine Nursery Care		Covered in Full, after $500 copay	25% Coinsurance after $1,000 copay per
Inpatient Admission* for Medical Rehabilitation (i.e. PT, Physical Medicine and Rehabilitation)		Not Covered	Not Covered
Pre-Admission Testing		Covered in Full	25% Coinsurance
Ambulatory Surgery *		Covered in Full after $100 copay	25% Coinsurance after $100 copay
Outpatient (hospital) Diagnostic Lab & Radiology	Place of Service: hospital	Covered in Full after $50 copay	25% Coinsurance
Home Health Care Services*	**200** visits per cal yr	Covered in Full	Covered In-Network Only
Office visits, including allergy care, Chiropractic Care ,OB/GYN care, Out of Hospital Specialist Consultation		$30 copay	Covered In-Network Only
Maternity Pre-Postnatal Care		Covered in Full	Covered In-Network Only
Annual Physical Check-up (Adult)		$30 copay	Covered In-Network Only
Preventive Mammography and Pap Smear & Prostate Screening		$30 copay	Covered In-Network Only
Physical Therapy, Osteopathic Manipulation, Occupational Therapy	**30** visits per calendar year	$30 copay	Covered In-Network Only
Speech Therapy	**10** visits per calendar year	$30 copay	Covered In-Network Only
Well baby and Well Child Care, including Immunizations	up to **age 19**	Covered in Full	25% Coinsurance after deductible
Diagnostic Lab and Radiology billed by a provider	Place of Service: office	$30 copay	Covered In-Network Only
		Covered in Full	Covered up to 100% of HIAA at the 80th%ile
Emergency Care facility	ER Copay, waived if admitted	Covered in Full after $100 Copay charge (waived if admitted)	Covered up to allowed charge, after $100 copay (waived if admitted)
Emergency Admission professional charges		Covered in Full	Covered up to 100% of HIAA at the 80th%ile
DME: (*Precert required when the amt is > $2000)		$100 deductible, $1,500 annual max	Covered In-Network Only
Ground Ambulance		N/A	Covered up to UCR , subject to deductible and coinsurance
Air Ambulance		N/A	Covered up to $10,000 per occurrence
Home Infusion Therapy*		Covered in Full	Covered In-Network Only
Inpatient Mental Health	**30** days per calendar year	Covered in Full, after $500 copay	25% Coinsurance after $1,000 copay per confinement
Inpatient Chemical Dependency: Detox & Rehab		Not Covered	Not Covered
Outpatient Chemical Dependency	**60** visits per calendar year, up to 20 family visits	$30 copay	25 % Coinsurance
Outpatient Mental health			
Professional Services	**20** days per calendar year	$30 Copay	Not Covered
Hospital based facility services		Covered in Full	25% coinsurance

[1] Non participating providers (anesthesiologist, radiologist. pathologist, asst surgeon) in a network Hospital is covered up to 100% of HIAA at the 80th%ile .
*Pre-certification Required

Prescription Coverage Retail	Prescription Coverage Mail Order	
___ $10/50%/50%/$100 ded/$3000 annual retail max	$20/50%/50%	Mandatory Mail

The benefits described here in are only brief highlights of the coverage available. The terms, limitations, conditions, and exclusions of the insurance contract and certificate will govern.

Available Optional Riders (additional cost):

☐ Skilled Nursing Facility Care PLH-5005 ☐ Alcoholism and Substance Abuse Hospital coverage PLH-5008 ☐ Nursing Services PLC-1094B

Dependent/Student **19/23**

Financial	Network	Non-Network
Hospital Copay	$500	$1,000
Hospital Coinsurance	None	25%
Hospital Coinsurance Max	None	$5,000
Hospital Allowed Charge	GHI's Fee Schedule	150% of Medicare
Office Visit Copay/Coinsurance	$30, unless otherwise indicated	25%, unless otherwise indicated
Medical Deductible	None	$1000/$3000
Medical Coinsurance Max	None	$10,000 pp/$30,000 family
Medical Allowed Charge	GHI's Fee scheduled	100% of Medicare
Annual OON Max	Unlimited	$1,000,000
Lifetime Max	None	None