

GHP Out-of-Area Plan – Summary of Benefits

Benefits and Services	Member Responsibility	
	In-Network	Out-of-Network
Annual Deductible Total amount a plan member is required to pay each calendar year before he or she is eligible for certain health services. The Annual Deductible need only be met once per plan member per calendar year.	Individual \$250 Family \$500	Individual \$500 Family \$1,000
Annual Out-of-Pocket Maximum Copayments, annual deductible and coinsurance apply to the out-of-pocket maximum. The annual out-of-pocket maximum need only be met once per plan member per calendar year.	Individual \$1,500 Family \$3,000	Individual \$3,000 Family \$6,000
Maximum Lifetime Benefit Combined total of all benefits	Unlimited	Unlimited
PCP/Preventive Care Office Visits Services include routine health assessment, well-child care, child health supervision services, immunizations and injections, vision examination and refraction, hearing test, annual self-referred gynecological examination and pap smear and mammogram screening.	\$10 Copay per visit	40% per visit after deductible
Specialist/Outpatient Office Visits Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, surgery, allergy tests and treatment.	\$20 Copay per visit	40% per visit after deductible
Chiropractic Services Coverage is provided for chiropractic services up to 26 visits; treatment plan is required.	\$20 Copay per visit	40% per visit after deductible
Emergency Room Services Coverage is provided for worldwide emergency health services as defined in the COC.	\$75 per visit (waived if patient is admitted)	\$75 per visit (waived if patient is admitted)
Emergency Ambulance Services Coverage is provided for Emergencies as defined in the COC.	20% per occurrence After deductible	40% per occurrence After deductible
Urgent Care Services Urgent care services at participating alternate facilities both in and out of the service area are covered when authorized in advance by the plan.	\$50 copay per visit	\$50 copay per visit
Maternity Care Office Visits Covered services include pre-natal and post-natal care, examinations, tests and educational services.	\$10 first visit only	40% first visit only after deductible

GHP Out-of-Area Plan – Summary of Benefits *(continued)*

Benefits and Services	Member Responsibility	
	In-Network	Out-of-Network
<p>Maternity Care, Inpatient Hospital Covered services include all physician services for mother and newborn(s), delivery, newborn nursery services and semi-private room.</p>	20% per admission after deductible	40% per admission after deductible \$1,000 penalty for failure to pre-certify
<p>Outpatient Services and Diagnostic Procedures and Tests Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient Surgery section.</p>	20% per visit after deductible	40% per visit after deductible 20% penalty for failure to pre-certify
<p>Outpatient Surgery Benefits are provided for covered services rendered at an outpatient hospital or free standing surgery center.</p>	20% per visit after deductible	40% per visit after deductible 20% penalty for failure to pre-certify
<p>Inpatient Hospital Services Unlimited coverage is provided for medically necessary physician and surgeon services, semi-private rooms, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.</p>	20% per admission after deductible	40% per admission after deductible \$1,000 penalty for failure to pre-certify
<p>Skilled Nursing Facility Coverage is provided in lieu of an inpatient hospital admission when approved by the Plan. Coverage is provided for a semi-private room.</p>	20% per admission after deductible Limited to 45 days per calendar year.	40% per admission after deductible Limited to 45 days per calendar year. \$1,000 penalty for failure to pre-certify
<p>Home Health Care and Hospice Coverage is provided when services are authorized in advance by the Plan.</p>	20% per visit after deductible	40% per visit after deductible 20% penalty for failure to pre-certify
<p>Durable Medical Equipment Coverage is provided when services authorized in advance by the Plan.</p>	20% per visit after deductible	40% per visit after deductible 20% penalty for failure to pre-certify

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Benefits and Services	Member Responsibility	
	In-Network	Out-of-Network
<p>Orthotics and Prosthetics Coverage is provided when services authorized in advance by the Plan.</p>	20% of covered expenses after deductible (covers initial placement only)	40% of covered expenses after deductible (covers initial placement only) 20% penalty for failure to precertify
<p>Physical, Occupational and Speech Therapy Coverage is provided for medically necessary inpatient or outpatient physical, occupational and speech therapy when authorized in advance by the Plan. Limited to 60 combined visits.</p>	20% per visit after deductible	40% per visit after deductible 20% penalty for failure to pre-certify
<p>Mental Health/Substance Abuse-Inpatient All mental health services must be prior authorized in advance by calling the GHP behavioral health line toll free at 877-227-3520.</p>	20% per admission after deductible	40% of covered expenses after deductible
<p>Mental Health/Substance Abuse-Outpatient All mental health services must be prior authorized in advance by calling the GHP behavioral health line toll free at 877-227-3520.</p>	\$20 copayment per visit	40% of covered expenses after deductible