

EPO High Deductible Health Plans

Options below are for small groups (2-50). Large groups have additional options. Ask your sales representative for more information.

In-Network Deductible Individual/Family	In-Network Coinsurance	In-Network Out-of-Pocket Max Individual/Family
\$5,600**/ \$11,200	100%	\$5,600/\$11,200

**Also available for sole proprietors.

Annual and lifetime maximums: Unlimited.

Benefit Highlights	In-Network
Annual Physical Checkup (Adult)	Covered in Full
Preventive Mammography, Pap Smear, Prostate Screening, and OB/GYN Services	Covered in Full
Well-Baby and Well-Child Care: Up to age 19, including immunizations	Covered in Full
Inpatient Hospital Coverage* and Inpatient Medical Services*, including surgery, maternity, routine nursery care	Deductible & Coinsurance
Skilled Nursing Facility Care*: 60 days per calendar year	Deductible & Coinsurance
Hospice Care—inpatient and outpatient*: 210 days per lifetime	Deductible & Coinsurance
Pre-Admission Testing	Deductible & Coinsurance
Ambulatory Surgery*	Deductible & Coinsurance
Home Health Care Services*: 200 visits per calendar year	Deductible & Coinsurance
Home and Office Visits, including outpatient clinic visits	Deductible & Coinsurance
Chiropractic Care	Deductible & Coinsurance
Physical Therapy, Osteopathic Manipulation, Occupational Therapy: 30 visits per calendar year	Deductible & Coinsurance
Speech Therapy: 10 visits per calendar year	Deductible & Coinsurance
Lab and Radiology	Deductible & Coinsurance
Emergency—professional charges**	Deductible & Coinsurance
Emergency—facility charges	Deductible & Coinsurance
Inpatient Mental Health*: 30 days per calendar year	Deductible & Coinsurance
Inpatient Chemical Dependency*: Detoxification—7 days per calendar year; Rehab—30 days per calendar year/60 days lifetime	Deductible & Coinsurance
Outpatient Chemical Dependency: 60 visits per calendar year, up to 20 family visits	Deductible & Coinsurance
Outpatient Mental Health*: 30 visits per calendar year	Deductible & Coinsurance
Prescription Drugs	Deductible & Copay
Retail Copay—generic/preferred/non-preferred	\$0/\$20/\$40
Mail Order Copay—generic/preferred/non-preferred	\$0/\$40/\$80

*Pre-certification required.

**For out-of-network providers, paid up to 100% of the HIAA at the 90th percentile, subject to deductible and coinsurance.

The benefits described here are only brief highlights of the coverage available. Other cost-controlling options are available. Some benefits may have calendar year limits and/or maximums. All services must be obtained by GHI Participating Providers. Out-of-network providers are not covered subject to certain limited exceptions. The terms, limitations, conditions, and exclusions of the insurance contract and certificate will govern.

GHI policy form PLH SGC 997/PLH SGC 998