

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		25%	
Hospital/facility coinsurance maximum (per calendar year)		\$5,000	
Hospital/facility allowance	GHI contracted fee schedule	GHI's reasonable and customary charges	
Medical copayment/coinsurance	\$30 per office visit and lab services	25%	
Medical allowance	GHI CBP schedule	100% of GHI Medicare based fee schedule	
Medical annual deductible (per calendar year)		\$1,000 per person/ \$3,000 per family	
Medical coinsurance maximum (per calendar year)		\$10,000 per person/ \$30,000 per family	
Annual maximum (combined medical/hospital per calendar year)		\$1,000,000	
Lifetime maximum	None	None	
Drug Program			
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	
Diagnostic lab and radiology procedures	\$30 copayment	Covered in-network only	
Emergency room facility charges	Covered in full after \$100 copayment	Covered up to 100% hospital/facility allowed charge after \$100 copayment	
Emergency room professional charges	Covered in full	Covered up to 100% of Ingenix/HIAA at the 80th percentile	
Mental health treatment (inpatient/outpatient)	Not covered	Not covered	
Chemical dependence treatment. 60 visits per calendar, up to 20 visits for family therapy.	\$30 copayment	25% coinsurance	
Drug Program			
Retail Pharmacy Program (Covered in-network only)	Generic/Preferred/Non-Preferred	Deductible	Annual maximum
30-day supply	Member pays: \$10/50%/50%	\$100 per person, \$300 per family per calendar year	\$3,000 per person per calendar year
Mail Order Pharmacy Program (Covered in-network only)	Generic/Preferred/Non-Preferred		
90-day supply	Member pays: \$20/50%/50%	None	None
Mandatory mail after initial fill and one refill			

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 requiring pre-certification. Note: maternity services do not require pre-certification.

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