



Summary of Benefits – Open Access POS Plan*: 749

This Summary of Benefits summarizes your obligation towards the cost of certain covered services. Refer to your Certificate of Coverage for a detailed description of covered services and limitations or exclusions.

To receive In-Network benefits, all covered services, except for Emergency Health Services, must be performed or referred by a participating GHP provider or authorized in advance by the Plan.

All services must be medically necessary as a condition of coverage and not otherwise limited or excluded.

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
1.	<p>Annual Deductible</p> <p>Total amount a plan member is required to pay each benefit period before he or she is eligible for certain health services. The Annual Deductible need only be met once per plan member per calendar year.</p>	<p>Individual \$0</p> <p>Family \$0</p>	<p>Individual \$300</p> <p>Family \$900</p>
2.	<p>Annual Out-of-Pocket Maximum</p> <p>Copayments, annual deductible and coinsurance apply to the out-of-pocket maximum per benefit period. The annual out-of-pocket maximum need only be met once per plan member per calendar year.</p>	<p>Individual \$0</p> <p>Family \$0</p>	<p>Individual \$2,000</p> <p>Family \$6,000</p>
3.	<p>Maximum Lifetime Benefit</p> <p>Combined total of all benefits.</p>	Unlimited	\$1,000,000
4.	<p>PCP/Preventive Care Office Visits</p> <p>Services include routine health assessment, well-child care, child health supervision services, immunizations and injections, hearing test, annual gynecological examination and pap smear and mammogram screening.</p>	\$10 Copay per visit	30% of covered expenses after deductible
5.	<p>Specialist/Outpatient Office Visits</p> <p>Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, surgery, vision examination and refraction, allergy tests and treatment.</p>	\$10 Copay per visit	30% of covered expenses after deductible
6.	<p>Chiropractic Services</p> <p>Coverage is provided for chiropractic services up to 26 visits; treatment plan is required.</p>	\$10 Copay per visit	30% of covered expenses after deductible
7.	<p>Emergency Room Services</p> <p>Coverage is provided for worldwide emergency health services as defined in the COC.</p>	\$100 per visit (waived if patient is admitted)	\$100 per visit (waived if patient is admitted)
8.	<p>Emergency Ambulance Services</p> <p>Coverage is provided for Emergencies as defined in the COC.</p>	0% per occurrence	30% per occurrence after deductible
9.	<p>Urgent Care Services</p> <p>Urgent care services at participating alternate facilities both in and out of the service area are covered when authorized in advance by the Plan.</p>	\$50 Copay per visit	\$50 Copay per visit

BENEFITS AND SERVICES		MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
10.	<p>Maternity Care, Office Visits</p> <p>Covered services include pre-natal and post-natal care, examinations, tests and educational services.</p>	\$10 Copay first visit only	30% of covered expenses after deductible
11.	<p>Maternity Care, Inpatient Hospital</p> <p>Covered services include all physician services for mother and newborn(s), delivery, newborn nursery services and semi-private room.</p>	0% per inpatient admission	30% of covered expenses after deductible \$1,000 penalty for failure to precertify
12.	<p>Outpatient Services and Diagnostic Procedures and Tests</p> <p>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>	0% Coinsurance per visit	30% of covered expenses after deductible 20% penalty for failure to precertify
13.	<p>Outpatient Surgery</p> <p>Benefits are provided for covered services rendered at an outpatient hospital or free standing surgery center.</p>	0% Coinsurance per visit	30% of covered expenses after deductible 20% penalty for failure to precertify
14.	<p>Inpatient Hospital Services</p> <p>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>	0% Coinsurance per inpatient admission	30% of covered expenses after deductible \$1,000 penalty for failure to precertify
15.	<p>Skilled Nursing Facility</p> <p>Coverage is provided in lieu of an inpatient hospital admission when approved by the Plan. Coverage is provided for a semi-private room.</p>	0% Coinsurance per day Limited to 45 days per benefit period	30% of covered expenses after deductible Limited to 45 days per benefit period \$1,000 penalty for failure to precertify
16.	<p>Home Health Care and Hospice</p> <p>Coverage is provided when services are authorized in advance by the Plan.</p>	0% Coinsurance per visit	30% of covered expenses after deductible 20% penalty for failure to precertify
17.	<p>Durable Medical Equipment</p> <p>Coverage is provided when services are authorized in advance by the Plan.</p>	0% of covered expenses	30% of covered expenses after deductible 20% penalty for failure to precertify

		BENEFITS AND SERVICES		MEMBER RESPONSIBILITY	
				IN-NETWORK	OUT-OF-NETWORK
18.	<p>Orthotics and Prosthetics</p> <p>Coverage is provided when services are authorized in advance by the Plan.</p>	0% of covered expenses (covers initial placement only)	30% of covered expenses after deductible (covers initial placement only) 20% penalty for failure to precertify		
19.	<p>Physical, Occupational and Speech Therapy</p> <p>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 per year.</p>	0% per visit	30% of covered expenses after deductible 20% penalty for failure to precertify		
20.	<p>Mental Health/Substance Abuse, Inpatient</p> <p>All mental health services must be prior authorized in advance by calling the GHP behavior health line toll free at 877-227-3520.</p>	0% Coinsurance per admission	30% of covered expenses after deductible \$1,000 penalty for failure to precertify		
21.	<p>Mental Health/Substance Abuse, Outpatient</p> <p>All mental health services must be prior authorized in advance by calling the GHP behavior health line toll free at 877-227-3520.</p>	\$10 Copayment per visit	30% of covered expenses after deductible		
22.	<p>Hearing Aids</p> <p>Coverage is provided for hearing aids.</p>	\$500 Copay per hearing aid limited to a benefit maximum of \$2600.	30% Coinsurance per hearing aid; limited to a benefit maximum of \$2600		