Summary of Benefits –POS QA1500-20 IND

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.	**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 $1,500	Individual $4,500
2.	**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 $2,000	Individual $10,500
3.	**Maximum Lifetime Benefit** Combined total of all benefits.	$5,000,000	$1,000,000
4.	**Physician Office Visits- Preventive Care** Services include routine health assessment, well-child care, child health supervision services, immunizations and injections, hearing test, annual self-referred gynecological examination and pap smear and mammogram screening.	For Primary Care Services $25 Copay per visit For Specialty Care Services $25 Copay per visit	For Primary Care Services 40% Coinsurance per visit after Deductible For Specialty Care Services 40% Coinsurance per visit after Deductible
5.	**Physician Office Visits – Medical Services** Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, adult immunizations and injections, surgery, vision examination, allergy tests and treatment.	For Primary Care Services $25 Copay per visit after deductible For Specialty Care Services $25 Copay per visit after deductible	For Primary Care Services 40% Coinsurance per visit after deductible For Specialty Care Services 40% Coinsurance per visit after deductible
6.	**Chiropractic Services** Services include treatment that is Medically Necessary, clinically appropriate, and within the chiropractor's scope of practice. Coverage is provided for chiropractic services up to 26 visits. Maximum benefit is an In-Network and Out-of-Network combined limit.	$25 Copay per visit after deductible	40% per visit after deductible
7.	**Emergency Room Services** Coverage is provided for worldwide emergency health services as defined in the COC.	$200 Copay per visit after deductible	$200 Copay per visit after deductible
8.	**Emergency Ambulance Services** Coverage is provided for Emergencies as defined in the COC.	0% Coinsurance per occurrence after deductible	40% per occurrence after deductible

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
9.	**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 after deductible	$50 Copay per visit after deductible
10.	**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.	0% Coinsurance per visit after deductible	40% per visit after deductible 20% penalty for failure to precertify
11.	**High Technology Diagnostic Services, Tests, and Procedures** Including, but not limited to: MRI, MRA, CT Scans, Thallium Scans, Nuclear Stress Tests, PET Scans, Echocardiograms, Ultrasounds (regardless of where service is performed)	0% Coinsurance per visit after deductible	40% per visit after deductible 20% penalty for failure to precertify
12.	**Outpatient Surgery** Benefits are provided for covered services rendered at an outpatient hospital or free standing surgery center.	0% Coinsurance per visit after deductible	40% per visit after deductible 20% penalty for failure to precertify
13.	**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.	0% Coinsurance per admission after deductible	40% per admission after deductible $1,000 penalty for failure to precertify
14.	**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.	0% Coinsurance per admission after deductible (Limited to 30 days per benefit period)	40% per admission after deductible (Limited to 30 days per benefit period) $1,000 penalty for failure to precertify
15.	**Home Health Care** Coverage is provided when services are authorized in advance by the Plan.	0% Coinsurance per occurrence after deductible (Limited to 40 days per benefit period)	40% per visit after deductible (Limited to 40 days per benefit period) 20% penalty for failure to precertify
16.	**Hospice** Coverage is provided when services are authorized in advance by the Plan.	0% Coinsurance per occurrence after deductible (Limited to 90 days per benefit period)	40% per visit after deductible (Limited to 90 days per benefit period) 20% penalty for failure to precertify

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
17.	**Durable Medical Equipment and Orthotics and Prosthetics** Coverage is provided when services authorized in advance by the Plan.	0% Coinsurance per occurrence after deductible (Limited to a benefit maximum of $4,000 year) (covers initial placement only)	40% of covered expenses after deductible (Limited to a benefit maximum of $4,000 year) (covers initial placement only) 20% penalty for failure to precertify
18.	**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.	0% Coinsurance per occurrence after deductible	40% per visit after deductible 20% penalty for failure to precertify
19.	**Mental Health/Substance Abuse - Inpatient** All mental health services must be prior authorized in advance by calling the GHP behavior health line toll free at 877-227-3520	0% Coinsurance per admission after deductible	40% of covered expenses after deductible $1,000 penalty for failure to precertify
20.	**Mental Health/Substance Abuse - Outpatient** All mental health services must be prior authorized in advance by calling the GHP behavior health line toll free at 877-227-3520	$25 Copay per visit after deductible	40% of covered expenses after deductible 20% penalty for failure to precertify
21.	**Hearing Aid** Coverage is provided for hearing aids.	$500 Copay per hearing aid; after deductible limited to a benefit maximum of $2,600.	40% Coinsurance per hearing aid; after deductible limited to a benefit maximum of $2,600.