



GHI-PPO Community Rated



1-800-427-5358

		In-Network	Out-of-Network
<b>Inpatient Hospital Services*</b>			
Inpatient hospital coverage and inpatient medical services		Covered in Full, may be subject to copay	Deductible & Coinsurance
Skilled Nursing Facility Care	60 days per calendar year	Covered in Full	Deductible & Coinsurance
Hospice Care (inpatient/in-home)	210 days per lifetime	Covered in Full	Covered in-network only
Maternity		Covered in Full, may be subject to copay	Deductible & Coinsurance
Routine Nursery Care		Covered in Full, may be subject to copay	Deductible & Coinsurance
Inpatient Admission for Medical Rehabilitation (i.e. PT, Physical Medicine and Rehabilitation)	30 days per calendar year	Covered in Full, may be subject to copay	Deductible & Coinsurance
<b>Outpatient Hospital Services</b>			
Pre-Admission Testing		Covered in Full	Deductible & Coinsurance
Ambulatory Surgery *		Covered in Full	Deductible & Coinsurance
Home Health Care Services*	200 visits per calendar year	Covered in Full	Deductible & Coinsurance
<b>Medical Services</b>			
<b>Office visits and diagnostic copayment for dependent children/students</b>		<b>\$0 copay</b>	Deductible & Coinsurance
Office visits, including Outpatient clinic visits		Office Visit copay	Deductible & Coinsurance
Maternity Pre-Postnatal Care		Covered in Full	Deductible & Coinsurance
Annual Physical Check-up (Adult)		Office Visit copay	Deductible & Coinsurance
Preventive Mammography and Pap Smear & Prostate Screening		Office Visit copay	Deductible & Coinsurance
OB/GYN check-up (2 visits)		Office Visit copay	Deductible & Coinsurance
Out-of-hospital Specialists Consultation		Office Visit copay	Deductible & Coinsurance
Allergy Care	36 visits per calendar year	Office Visit copay	Deductible & Coinsurance
Chiropractic Care		Office Visit copay	Deductible & Coinsurance
Physical Therapy, Osteopathic Manipulation, Occupational Therapy	30 visits per calendar year	Office Visit copay	Deductible & Coinsurance
Routine Podiatric Care	4 visits per calendar year	Office Visit copay	Covered in-network only
Speech Therapy	10 visits per calendar year	Office Visit copay	Deductible & Coinsurance
<b>Well baby and Child Care</b>			
Well baby and Well Child Care, including Immunizations	up to age 19	Covered in full	Deductible & Coinsurance
<b>Lab and Radiology</b>			
Diagnostic Lab Tests		Office Visit copay	Deductible & Coinsurance
Radiology Procedures (including mammography)		Office Visit copay	Deductible & Coinsurance
<b>Emergency Coverage</b>			
ER professional charges		Covered in Full	Up to 100% of HIAA at the 90th% ile
Emergency Care facility	ER Copay, waived if admitted	Facility Copay	Facility Copay
<b>Other Services</b>			
DME: (*Precert required when the amt is > \$2000)		\$100 deductible, \$10,000 Calendar year max	Covered in-network only
Ground Ambulance		N/A	Covered up to UCR
Home Infusion Therapy*		Covered in full	Covered in-network only
Diabetic Supplies		Copay	Deductible & Coinsurance
<b>Inpatient* Mental Health &amp; Chemical Dependency</b>			
Inpatient Mental Health	30 days calendar year	Covered in Full, may be subject to copay	Deductible & Coinsurance
Chemical Dependency: Detoxification	7 days per calendar year	Covered in Full, may be subject to copay	Covered in-network only
Chemical Dependency: Rehabilitation	30 days cal yr/ 60 days lifetime	Covered in Full, may be subject to copay	Covered in-network only
<b>Outpatient Mental Health &amp; Chemical Dependency*</b>			
Outpatient Chemical Dependency	60 visits per calendar year, up to 20 family visits	Covered in full	Deductible & Coinsurance
Outpatient Mental Health	30 visits per calendar year, up to 20 OON visits	Office visit copay	Deductible & Coinsurance
<b>Vision Services</b>			
Exam	Eligibility : All ages	Davis Vision Providers Only One eye exam biennial, (once every 24 months) for all ages. \$10 copay	Covered through Davis network only
Frames, Lenses, Contacts	Eligibility : Children under the age of 19	Lenses, Frames, contacts (in lieu of frames and lenses), one biennial, (once every 24 months for children under the age of 19. \$20 copay	
<b>Pharmacy Program</b>			
Generic/Brand preferred/Brand non preferred	Voluntary Mail Order, No Mandatory Generic Substitution, Clinical Prior Authorization and Specialty Pharmacy Program	Copay and/or coinsurance	Covered in-network only

\*Pre-certification Required

The benefits described here in are only brief highlights of the coverage available. The terms, limitations, conditions, and exclusions of the insurance contract and certificate will govern.