



# GHI-Small Business Advantage Plan PPO 30/1000

For Sole Proprietors

## 4th Quarter 2009 Rates

**Employee:           \$ 747.58**  
**Family:               \$ 1890.83**

**DATED: 8/6/09**

		Network	Non-Network
Inpatient hospital *coverage and inpatient medical <sup>1</sup> services		Covered in Full, after \$500 copay	25% Coinsurance after \$1,000 copay per confinement
Skilled Nursing Facility Care*	60 days per calendar year	Covered in Full	25% coinsurance (copay waived)
Hospice Care * (inpatient/in-home)	210 days per lifetime	Covered in Full	Covered in-network only
Inpatient Maternity , routine Nursery Care		Covered in Full, after \$500 copay	25% Coinsurance after \$1,000 copay per confinement
Inpatient Admission* for Medical Rehabilitation (i.e. PT, Physical Medicine and Rehabilitation)		Not Covered	Not Covered
Pre-Admission Testing		Covered in Full	25% Coinsurance
Ambulatory Surgery *		Covered in Full after \$100 copay	25% Coinsurance after \$100 copay
Outpatient (hospital) Diagnostic Lab & Radiology	Place of Service: hospital	Covered in Full after \$50 copay	25% Coinsurance
Home Health Care Services*	200 visits per cal yr	Covered in Full	Covered In-Network Only
Office visits, including allergy care, Chiropractic Care ,OB/GYN care, Out of Hospital Specialist Consultation		\$30 copay	Covered In-Network Only
Maternity Pre-Postnatal Care		Covered in Full	Covered In-Network Only
Annual Physical Check-up (Adult)		\$30 copay	Covered In-Network Only
Preventive Mammography and Pap Smear & Prostate Screening		Covered in Full	Covered In-Network Only
Physical Therapy, Osteopathic Manipulation, Occupational Therapy	30 visits per calendar year	\$30 copay	Covered In-Network Only
Speech Therapy	10 visits per calendar year	\$30 copay	Covered In-Network Only
Well baby and Well Child Care, including Immunizations	up to age 19	Covered in Full	25% coinsurance after deductible
Diagnostic Lab and Radiology billed by a provider	Place of Service: office	\$30 copay	Covered In-Network Only
		Covered in Full	Covered up to 100% of HIAA at the 80th%ile
Emergency Care facility	ER Copay, waived if admitted	Covered in Full after \$100 copay charge	Covered up to allowed charge after \$100 copay
Emergency Admission professional charges		Covered in Full	Covered up to 100% of Ingenix/HIAA at the 80th%ile
DME: (*Precert required when the amt is > \$2000)		\$100 deductible, \$1,500 annual max	Covered In-Network Only
Ground Ambulance		See out of network	GHI's reasonable and customary charge after medical deductible and coinsurance
Air Ambulance		See out of network	Covered up to \$10,000 per occurrence
Home Infusion Therapy*		Covered in Full	Covered In-Network Only
Inpatient Mental Health		Not Covered	Not Covered
Inpatient Chemical Dependency: Detox & Rehab		Not Covered	Not Covered
Outpatient Chemical Dependency	60 visits per calendar year, up to 20 family visits	\$30 copay	25 % coinsurance
Outpatient Mental Health		Not Covered	Not Covered

<sup>1</sup> Non participating providers (anesthesiologist, radiologist, pathologist, asst surgeon) in a network Hospital is covered up to 100% of HIAA at the 80th%ile .

\*Pre-certification Required

Prescription Coverage Retail	Prescription Coverage Mail Order
\$10/50%/50%/\$100 ded/\$3000 annual retail max	\$20/50%/50% Mandatory Mail

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.

**Available Optional Riders :**

(additional cost)  Alcoholism and Substance Abuse Hospital coverage PLH-5008  Skilled Nursing Facility Care PLH-5005  Nursing Services PLC-1094B

Dependent/Student	19/23	Network	Non-Network
Financial			
Hospital Copay		\$500	\$1,000
Hospital Coinsurance		None	25%
Hospital Coinsurance Max		None	\$5,000
Hospital Allowed Charge		GHI contracted rate	GHI's reasonable and customary charge
Office Visit Copay/Coinsurance		\$30	Covered in-network only
Medical Deductible		None	\$1000/\$3000
Medical Coinsurance Max		None	\$10,000 pp/\$30,000 family
Medical Allowed Charge		GHI CBP fee schedule	GHI Medicare based fee schedule
Annual OON Max		None	\$1,000,000
Lifetime Max		None	None

Rates are subject to New York State Insurance Department approval.

**Note: All GHI prescriptions are Voluntary Home Delivery and are NO LONGER mandatory generic.**

**A \$10 monthly billing fee has been added to your premium.**