GHI-Small Business Advantage Plan
PPO 30/1000

For Sole Proprietors

3rd Quarter 2010 Rates

Employee: $ 851.73
Family: $2443.42

DATED: 5/12/10		Network	Non-Network
Inpatient hospital *coverage and inpatient medical[1] 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

[1] 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**

Financial	**Network**	**Non-Network**
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 $14 monthly billing fee has been added to your premium.