



GHI-Small Business Advantage Plan

PPO 30/1000

For Sole Proprietors

4th Quarter 2010 Rates

Employee: \$ 893.10

Family: \$ 2563.41

DATED: 12/7/10

		Network	Non-Network
Hospital/facility copayment per admission	(single hospital confinement)	\$500	\$1,000
Hospital/facility coinsurance		None	25%
Hospital/facility coinsurance maximum	(per calendar year)	None	\$5,000
Hospital/facility allowance		GHI Contracted fee Schedule	150% of Medicare-based fee schedule
Medical copayment/coinsurance		\$30 per office visit	25%
Medical Allowance		GHI Contracted fee Schedule	100% of Medicare-based fee schedule
Medical annual deductible	(per calendar year)	None	\$1,000 per person/\$3,000 per family
Annual Maximum (combined medical/hospital per calendar year)		None	Unlimited
Lifetime Maximum		None	Unlimited
Inpatient hospital acute care services, including maternity and routine nursery care*	365 days per single hospital confinement.	Covered in Full after \$500 copayment	25% coinsurance after \$1,000 copay per single hospital 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
Outpatient/Ambulatory Surgery *		Covered in Full after \$100 copay	25% Coinsurance after \$100 copay
Physician and Specialist Office visits, including Chiropractic Care		\$30 copay	Covered In-Network Only
Annual Adult Physical Check-up including OB/GYN		Covered in full	Covered In-Network Only
Well baby and Well Child Care	up to age 26	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
Emergency room facility charges		Covered in Full after \$100 copay	Covered in Full after \$100 copay
Emergency room professional charges		Covered in Full	Covered up to 100% Ingenix at the 80th percentile
Inpatient Mental Health	30 days per calendar year	Covered in full, after \$500 copay	25% Coinsurance after \$1,000 copay per
Inpatient chemical dependency		Not Covered	Not Covered
Outpatient Mental Health - professional services		\$30 Copay	Not Covered
Outpatient Mental Health -hospital based services (combined 20 days per calendar year)		Covered in full	25% coinsurance
Outpatient chemical dependency treatment --	60 visits per calendar year, up to 20 visits for family therapy	\$30 Copayment	\$25% coinsurance
DRUG PROGRAM			
Retail Pharmacy Program	Generic/Preferred/Non-preferred	Deductible	Annual Maximum
(Covered In-Network Only)			
30 day supply	Member pays: \$10/50%/50/50%	None	None
Home Delivery Pharmacy Program	Generic/Preferred/Non-preferred	Deductible	Annual Maximum
(Covered In-Network Only)			
90 day supply	Member pays: \$20/50%/50/50%	\$100ind/\$300fam	None
Mandatory mail in after initial fill and one refill for maintenance medications.			
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.			

Rates are subject to New York State Insurance Department approval.

* Services require pre-approval. Note: maternity services do not require pre-approval.

A \$14 monthly billing fee has been added to your premium.