



GHI-Small Business Advantage Plan PPO 30/1000

For Sole Proprietors

3rd Quarter 2011 Rates

Employee: \$ 1011.55

Family: \$ 2905.01

DATED: 6/1/11

	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 Max (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	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	\$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 confinement	
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	<u>Generic/Preferred/Non-preferred</u>	<u>Deductible</u>	<u>Annual Maximum</u>
Retail Pharmacy Program (Covered In-Network Only)	Member pays: \$10/50%/50/50%	None	None
30 day supply			
Home Delivery Pharmacy Program (Covered In-Network Only)	<u>Generic/Preferred/Non-preferred</u>	<u>Deductible</u>	<u>Annual Maximum</u>
	Member pays: \$20/50%/50/50%	\$100 Ind/\$300 Fam	None
90 day supply			
Mandatory mail-in after initial fill and one refill for maintenance medications.			

The benefits described herein 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 \$15 monthly billing fee has been added to your premium.