



GHI-Small Business Advantage Program

Group Name

Effective Date:

Group Rep

Rating Structure:

2-Tier Sole Proprietor

4-Tier Groups of 2-50

		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
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)		Covered in Full	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
Emergency Room professional charges		Covered in Full	Covered up to 100% of FAIR Health Benchmarks at the 80th%ile
Emergency Care facility	ER Copay, waived if admitted	Covered in Full after \$100 Copay charge (waived if admitted)	Covered up to allowed charge, after \$100 copay (waived if admitted)
Emergency Admission professional charges		Covered in Full	Covered up to 100% of FAIR Health Benchmarks at the 80th%ile
DME: (*Precert required when the amt is > \$2000)		\$100 deductible	Covered In-Network Only
Ground Ambulance		N/A	Covered up to UCR , subject to deductible and coinsurance
Air Ambulance		N/A	Covered up to \$10,000 per occurrence
Home Infusion Therapy*		Covered in Full	Covered In-Network Only
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: 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 Professional Services Hospital based facility services	20 days per calendar year	\$30 Copay	Not Covered
		Covered in Full	25% coinsurance

¹ Non participating providers (anesthesiologist, radiologist, pathologist, asst surgeon) in a network Hospital is covered up to 100% of FAIR Health Benchmarks at the 80th%ile .
*Pre-certification Required

Prescription Coverage Retail \$10/50%/50%/\$100 ded	PLHSGC1005	Prescription Coverage Mail Order \$20/50%/50% Mandatory Mail
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Required Rx Riders: **PLA 66C** **PLA 102**

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.

Required Certs/Riders:	PLH SGC 1003 certificate	PLH SGC 1004 attachment
HCR-CAGP-2011 Grievance and Appeals	HCR-2010 GHI PPACA Rider	PLA 130 Dep Student Medical LOA *Michelle's Law
PLA 107 Mental Health	PLA 122 EAP Rider	PLA 139 NYS COBRA ext & Age 29 YAO
PLA 121 Medicare language	PLA 138-A Wellness Programs	PLA 66C
PLHSGC1005 RX	PLA 16A Domestic Partners	PLA 102

Available Optional Riders (additional cost):

- Skilled Nursing Facility Care PLH-5005
- Nursing Services PLC-1094B
- PLA 131 MH Parity (adds IP chem dep, No limits IP MH & CD, and OP MH CD)
- PLA 110 Unlimited visits Biological Based MH for children
- PLA 140 Age 29 Law

Dependent/Student	26/26	
Financial	Network	Non-Network
Hospital Copay	\$500	\$1,000
Hospital Coinsurance	None	25%
Hospital Coinsurance Max	None	\$5,000
Hospital Allowed Charge	GHI's Fee Schedule	150% of Medicare
Office Visit Copay/Coinsurance	\$30, unless otherwise indicated	25%, unless otherwise indicated
Medical Deductible	None	\$1000/\$3000
Medical Coinsurance Max	None	\$10,000 pp/\$30,000 family
Medical Allowed Charge	GHI's Fee scheduled	100% of Medicare
Annual OON Max	Unlimited	Unlimited
Lifetime Max	None	None