



PPO 30/300/2000A

RX: \$0 Generic; \$25 Brand; \$50 Non-Preferred; \$50 Brand deductible; Retail Threshold \$1000, then 50% coinsurance. Mail order unlimited.

NATIONAL NETWORK

**Benefit Summary EmblemHealth PPO
\$30/\$300x5/\$2,000/70%**

BENEFIT HIGHLIGHTS

	Comments	In-network	Out-of-network
Office Visits and Diagnostic Services for Dependent Children		\$0 Copay per visit	Deductible and coinsurance
Office Visit, Including Outpatient Clinic Visits		\$30 Copay per visit	Deductible and coinsurance
Emergency Room Care Facility Copay		\$100 Copay per visit	\$100 Copay per visit
Ambulatory Surgery Facility Copay		\$250 Copay per visit	Deductible and coinsurance
Coinsurance		N/A	70%/30%
Annual Deductible (Individual/Family)		N/A	\$2,000/\$6,000
Annual Maximum Benefit per Individual		Unlimited	Unlimited
Annual Coinsurance Maximum (Individual/Family)		N/A	\$3,000/\$9,000
Lifetime Maximum		Unlimited	Unlimited
Dependent Children	Coverage effective until end of month	Eligible to age 26	Eligible to age 26

INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL

Inpatient Hospital Admission	PRECERTIFICATION: YES 365 days per confinement	\$300 Copay per day up to a maximum of \$1,500 per single confinement	Deductible and coinsurance
Skilled Nursing Facility Care	PRECERTIFICATION: YES	Covered in full	Deductible and coinsurance
Inpatient Admission for Medical Rehabilitation (i.e. Physical Therapy, Physical Medicine and Rehabilitation)	PRECERTIFICATION: YES 30 days per calendar year	\$300 Copay per day up to a maximum of \$1,500 per single confinement	Deductible and coinsurance
Hospice Care - Inpatient and Outpatient	PRECERTIFICATION: YES 210 days per lifetime	Covered in full	Covered in-network only

OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY

Pre-Admission Testing		Covered in full	Deductible and coinsurance
Ambulatory Surgery Facility Charge (Free-standing and outpatient hospital)	PRECERTIFICATION: YES	\$250 Copay per visit	Deductible and coinsurance
Home Health Care Services	PRECERTIFICATION: YES 200 visits per calendar year	Covered in full	Deductible and coinsurance
Diagnostic Laboratory /Radiology	PRECERTIFICATION: YES Required for in-network radiology services	\$30 Diagnostic copay per visit; No copay for dependent children	Deductible and coinsurance
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full	Deductible and coinsurance

MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN OR OTHER MEDICAL PROVIDER

Office Visits and Diagnostic Services for Dependent Children		No copay for dependent children	Deductible and coinsurance
Office Visit, Including Outpatient Clinic Visits		\$30 Copay per visit	Deductible and coinsurance
Specialist Office Visits		\$30 Copay per visit; No copay for dependent children	Deductible and coinsurance
Maternity Pre-Postnatal Care		Covered in full	Deductible and coinsurance

MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN (Continued)

	Comments	In-network	Out-of-network
Annual Physical Check-up (Adult)		Covered in full	Deductible and coinsurance
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full	Deductible and coinsurance
Chiropractic Care		\$30 Copay per visit; No copay for dependent children	Deductible and coinsurance
Allergy Care		\$30 Copay per visit; No copay for dependent children	Deductible and coinsurance
Physical Therapy, Osteopathic Manipulation, Occupational Therapy	30 Visits per calendar year	\$30 Copay per visit; No copay for dependent children	Deductible and coinsurance
Speech Therapy	10 Visits per calendar year	\$30 Copay per visit; No copay for dependent children	Deductible and coinsurance
Outpatient Surgery	Office	Covered in full	Deductible and coinsurance
	Outpatient hospital	Covered in full	Deductible and coinsurance
	Ambulatory free-standing	Covered in full	Deductible and coinsurance
Inpatient Surgery		Covered in full	Deductible and coinsurance
Durable Medical Equipment (DME)	PRECERTIFICATION: YES when amount >\$2,000	Covered in full	Covered in-network only
Diabetic Management: Education		\$30 Copay per visit; No copay for dependent children	Deductible and coinsurance
Prescriptions	Covered when using a participating pharmacy	\$5 Copay	Covered in-network only
Supplies	Covered under DME benefit	Covered in full	Deductible and coinsurance
Diagnostic Laboratory	Performed in provider's office/free-standing facility	\$30 Diagnostic copay per visit; No copay for dependent children	Deductible and coinsurance
Diagnostic Radiology	PRECERTIFICATION: YES Performed in provider's office/free-standing facility (applies to in-network services only)	\$30 Diagnostic copay per visit; No copay for dependent children	Deductible and coinsurance

WELL BABY AND CHILD CARE

Well Baby and Well Child Care, including Immunizations		Covered in full	Deductible and coinsurance
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EMERGENCY ROOM COVERAGE

Emergency Room Care Facility Copay	ER copay, waived if admitted	\$100 Copay per visit	\$100 Copay per visit
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INPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

Inpatient Mental Health	PRECERTIFICATION: YES 30 days per calendar year; No visit limits for biologically-based mental illness and children with serious emotional disturbances	\$300 Copay per visit up to a maximum of \$1,500 per single confinement	Deductible and coinsurance
Chemical Dependency: Detoxification	PRECERTIFICATION: YES 7 days per calendar year	\$300 Copay per visit up to a maximum of \$1,500 per single confinement	Deductible and coinsurance
Chemical Dependency: Rehabilitation	PRECERTIFICATION: YES 30 days per calendar year	\$300 Copay per visit up to a maximum of \$1,500 per single confinement	Deductible and coinsurance

OUTPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

Outpatient Chemical Dependency	PRECERTIFICATION: YES 60 visits per calendar year	Covered in full	Deductible and coinsurance
Outpatient Mental Health	PRECERTIFICATION: YES 30 days per calendar year; No visit limits for biologically-based mental illness and children with serious emotional disturbances	\$30 Copay per visit; No copay for dependent children	Deductible and coinsurance

VISION

	Comments	In-network	Out-of-network
Exam	Performed by Davis Vision providers only; One eye exam every 24 months; Eligibility: all ages	\$10 Office visit copay for adults; No copay for dependent children	Covered through Davis Vision providers only
Frames, Lenses, Contacts	Eligibility: Children under the age of 26; every 24 months	Lenses, frames, contacts (in lieu of frames and lenses) \$20 copay	Covered through Davis Vision providers only

The EmblemHealth PPO is underwritten by Group Health Incorporated ("GHI"). Coverage is subject to all terms, conditions, limitations and exclusions set forth in the contract and certificate of insurance. Refer to policy form number PLH-SGC-976-2, et.al. For out-of-network services, you are responsible to pay any difference between the plan's payment and the provider's charge.

EmblemHealth provides health benefit coverage and services through its subsidiary companies in New York State: Group Health Incorporated, HIP Health Plan of New York, The PerfectHealth Insurance Company, HIP Insurance Company of New York, GHI HMO Select, Inc., ConnectiCare of New York, Inc. and EmblemHealth Services Company LLC.