EmblemHealth
WHAT CARE FEELS LIKE.

SUMMARY OF BENEFITS — EmblemHealth Healthy NY HMO

Network: Select Care Network
PCP / Specialist Copays: $25 / $40
Deductible: $600 Individual / $1,200 Family per calendar year
Annual Out-of-Pocket Maximum: $4,000 Individual / $8,000 Family (includes deductible)

Except for preventive care and prescription drugs, the deductible must be satisfied before this plan will provide coverage for covered services. Members are required to choose a Primary Care Physician (PCP) upon enrollment. Services rendered by specialists require a referral by the member's PCP. Note: certain services must be approved in advance by EmblemHealth.

BENEFIT HIGHLIGHTS		
Service	**Comments**	**In-Network**
Inpatient Services Performed and Billed by a Hospital or Facility:		
Inpatient Hospital Admission*		$1,000 copay per admission
Skilled Nursing Facility Care*	200 days per person/calendar year.	$1,000 copay per admission
Medical Rehabilitation* (Physical, Speech, and Occupational Therapies)	One consecutive 60-day period, per condition, per lifetime	$1,000 copay per admission
Maternity - Labor and Delivery, and Routine Nursery Care*	Mother and newborn, combined	$1,000 hospital facility copay
Hospice Care*	210 days per lifetime	$1,000 copay per admission
Outpatient Services Performed and Billed by a Hospital or Facility:		
Pre-Admission Testing*		Covered in full
Ambulatory Surgery Facility Charge Free Standing or Hospital OPD*		$100 facility copay
Home Health Care Services*	40 visits per person, per plan year	$25 copay
Diagnostic Lab/Radiology/Diagnostic Imaging		$40 copay
Hospice Care*	210 days	$25 copay
Dialysis		$25 copay
Rehabilitation/Habilitation (Physical, Speech, or Occupational Therapy)*	60 visits per condition, per lifetime	$30 copay
Chemotherapy		$25 copay
Radiation Therapy*		$25 copay
Medical Services Performed and Billed by a Physician or Other Medical Provider:		
Primary Care Physician Office Visit		$25 copay
Specialist Office Visit		$40 copay
Chiropractic Care*		$40 copay
Allergy Care		$25 PCP or $40 Specialist copay
Maternity Pre and Postnatal Care		Covered in full
Rehabilitation/Habilitation (Physical, Speech, or Occupational Therapy)*	60 visits, per condition, per lifetime	$30 copay
Inpatient Hospital Surgery*		$100 surgeon copay
In-Hospital Maternity Services*	Mother and newborn combined	$100 surgeon copay for delivery
Inpatient Hospital Medical Services*		Covered in full
Outpatient Surgery*	Performed in hospital OPD, free-standing facility	$100 surgeon copay
Provider's Office Surgery		$40 copay
Diagnostic Lab / Radiology (X-Rays)		$25 PCP or $40 Specialist copay
Diagnostic Imaging Services (CAT Scan / PET Scan / MRI)*		$40 copay

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BENEFIT HIGHLIGHTS		
Service	**Comments**	**In-Network**
Medical Services Performed and Billed by a Physician or Other Medical Provider (continued):		
Home Infusion Therapy*	Counts toward Home Health Care limit if administered by Home Health Care.	$25 copay
Anesthesia (all settings)		Covered in full
Chemotherapy		$25 copay
Radiation Therapy*		$25 copay
Dialysis Treatment		$25 copay
Emergency Coverage		
Emergency Room professional charges		Covered in full
Emergency Room facility copay		$150 ER copay (waived if admitted)
Urgent Care Centers or Facilities	In-network coverage only	$60 Urgent Care copay
Emergency Ambulance - Ground, Air or Water		$150 Ambulance Copay
Preventive Care Performed and Billed by a Medical Provider or Outpatient Facility		
Well-Baby and Well-Child Care (including immunizations)		Covered in full
Annual Adult Physical Examination		Covered in full
Preventive Mammography, Pap Smear, Prostate or Bone Density Screening		Covered in full
Mental Health and Substance Abuse Disorder Services		
Inpatient Mental Health Care*		$1,000 copay per admission
Outpatient Mental Health*		$25 copay
Inpatient Chemical Dependency*		$1,000 copay per admission
Outpatient Chemical Dependency*	Includes 20 family counseling visits	$25 copay
Medical Equipment/Devices/Hearing Services		
Durable Medical Equipment (DME)*	Excludes orthotics	20% coinsurance
External Prosthetic Devices*	One (1) per limb, per lifetime	20% coinsurance
Hearing Evaluation & testing		$40 copay
Hearing Aids*	Single purchase, one or both ears, every three years	20% coinsurance
Pediatric Vision — coverage up to end of month in which child turns age 19		
Exam for corrective lenses	One exam per 12-month period	$25 copay
Prescription lenses / standard frames	One exam, lenses and frames once in any 12-month period	20% coinsurance
Contact lenses	In lieu of frames only when medically necessary	20% coinsurance

Prescription Drugs (No annual or lifetime maximum)	
Retail:	Generic - $10 copay / Formulary Brand - $35 copay / Non-Formulary Brand - $70 copay. Copays are per prescription, per 30-day supply.
Mail Order:	Generic - $25 copay / Formulary Brand - $88 copay / Non-Formulary Brand - $175 copay. Copays are per prescription, per 90-day supply.
Deductible:	None. Prescription drugs are **not** subject to overall plan deductible. There is no separate Rx deductible. Prescription drugs **are** included in the overall plan out-of-pocket maximum.

* These services require precertification from EmblemHealth.

The EmblemHealth Healthy NY Plan is an HMO plan underwritten by HIP Health Plan of New York ("HIP") and provides in-network benefits only. Except for emergency hospital care, no out-of-network services are covered. Coverage is subject to all terms, conditions, limitations and exclusions set forth in the Contract and Certificate of Coverage. Refer to HIP policy form number 155-23-SGOFFHIXHNYCERT (04/13), et al.