EmblemHealth
WHAT CARE FEELS LIKE.

SUMMARY OF BENEFITS —EMBLEMHEALTH EPO SELECT 35 / 55 PLAN

	COMMENTS/LIMITATIONS	IN-NETWORK
BENEFIT HIGHLIGHTS		
Primary Care Physician Office Visit		$35 copay
Specialist Office Visit		$55 copay
Emergency Room Facility	Copay waived if admitted to hospital	$200 copay
Urgent Care Facility	In-Network coverage only	$60 copay
Ambulatory Surgery Facility		30% coinsurance after deductible
Coinsurance	See below for applicable services	30%
Annual Deductible (Individual/Family)	Applies to hospital and medical	$2,000 / $4,000
Annual Out-of-Pocket Maximum (Individual/Family)	See footnotes*	$6,000 / $12,000
INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL		
Inpatient Hospital Admission	365 days per calendar year	30% coinsurance after deductible
Skilled Nursing Facility Care	365 days per calendar year	30% coinsurance after deductible
Inpatient Rehabilitation	One consecutive 60-day period, per condition, per calendar year	30% coinsurance after deductible
Hospice Care	210 days per lifetime	30% coinsurance after deductible
OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY		
Pre-admission Testing		Covered in full
Ambulatory Surgery Facility (Freestanding and outpatient hospital)		30% coinsurance after deductible
Home Health Care Services	40 visits per calendar year	$35 copay
Diagnostic Laboratory and Radiology	Advanced radiology requires prior approval	$55 copay
Chemotherapy		$35 copay
MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN OR OTHER MEDICAL PROVIDER		
Primary Care Physician Office Visit		$35 copay
Specialist Office Visit		$55 copay
Maternity Pre- and Postnatal Care		Covered in full
Chiropractic Care		$55 copay
Allergy Care	Copay amount is determined by type of provider visited for service	$35 PCP Copay / $55 Specialist Copay
Physical, Occupational, and Speech Therapy Rehabilitative	90 visits, per condition, per calendar year, combined therapies	$55 copay
Physical, Occupational, and Speech Therapy Habilitative	90 visits, per condition, per calendar year, combined therapies	$55 copay
Surgery: Inpatient/Outpatient		30% coinsurance after deductible
Surgery: Office		$55 copay
Pediatric Vision - Exams	One exam per 12 month period. Coverage up to age 19 end of month	$35 copay
Pediatric Vision - Lenses & Frames	One set of lenses & frames or contacts per 12 month period. Coverage up to age 19 end of month	30% coinsurance
Diagnostic Laboratory and Radiology	Copay amount is determined by type of provider visited for service. Advanced radiology requires prior approval	$35 PCP Copay / $55 Specialist Copay

EMB_MB_OTH_21687_EH-EPOSlect35-55_CCEK1 9/14

SUMMARY OF BENEFITS —EMBLEMHEALTH EPO SELECT 35 / 55 PLAN

	COMMENTS/LIMITATIONS	IN-NETWORK
MEDICAL SUPPLIES/DEVICES/DME		
Durable Medical Equipment (DME)	Standard equipment only; excludes orthotics	30% coinsurance
Hearing Aids	Single purchase, one or both ears, (including repair/ replacement) every three years.	30% coinsurance
Prosthetic Devices-external	One device per limb, per lifetime	30% coinsurance
PREVENTIVE CARE		
Well-Baby and Well-Child Care, including Immunizations		Covered in full
Annual Physical Checkup		Covered in full
Preventive Mammography, Pap Smear, Prostate and Bone Density Screening		Covered in full
Colonoscopy Screenings		Covered in full
EMERGENCY COVERAGE		
Emergency Room Facility	Copay waived if admitted to hospital	$200 copay
Emergency Room Professional		Covered in full
Ambulance		$150 copay
INPATIENT MENTAL HEALTH & SUBSTANCE USE		
Inpatient Mental Health		30% coinsurance after deductible
Inpatient Substance Use Services: Detoxification and Rehabilitation		30% coinsurance after deductible
OUTPATIENT MENTAL HEALTH & SUBSTANCE USE		
Outpatient Mental Health		$35 copay
Outpatient Substance Use Services	Includes 20 family counseling visits	$35 copay
PRESCRIPTIONS DRUGS		
Retail	30-day supply	Each member must meet a $100 deductible or family must meet a $200 deductible for Retail or Mail Order before the following copays apply: $15 / $35 / $75
Mail Order	90-day supply	Each member must meet a $100 deductible or family must meet a $200 deductible for Retail or Mail Order before the following copays apply: $38 / $88 / $188
EXERCISE FACILITY INCENTIVE		
Gym Reimbursement	Incentive only available to Subscriber and Subscriber's Covered Spouse. Incentive is not applied to Out Of Pocket Maximum or Deductible	Subscriber reimbursed up to $200 for completion of 50 exercise facility visits in each six month period. Covered Spouse reimbursed up to $100 per six-month period and 50 exercise facility visits.

The EmblemHealth EPO Select 35/55 Plan is underwritten by HIP Insurance Company of New York. Except for emergency care, the above benefits and services are covered only when provided or by a Prime network physician and/or approved in advance by the EmblemHealth Care Management Program. Participating physicians and providers have contracted with EmblemHealth to provide care to our members; they are not employees, agents, servants or representatives of EmblemHealth. This summary is provided for information only; it does not contain complete details or limitations of the Plan which are available only in the Contract or Certificate of Coverage, and it does not constitute an agreement. Refer to HIP policy form number 151-23-SGOFFHIXCERT (04/14), et al.

Certain services must be approved in advance by EmblemHealth.

*Out Of Pocket max incudes deductible, copays and coinsurance. Gym Reimbursement benefit does not apply towards the OOP max.