EmblemHealth
WHAT CARE FEELS LIKE.

SUMMARY OF BENEFITS — EPO HD6300 (BRONZE)

	COMMENTS/LIMITATIONS	IN-NETWORK
BENEFIT HIGHLIGHTS		
Primary Care Physician Office Visit		0% Coinsurance after deductible
Specialist Office Visit		0% Coinsurance after deductible
Emergency Room Facility	Copay waived if admitted to hospital	0% Coinsurance after deductible
Urgent Care Facility	In-Network coverage only	0% Coinsurance after deductible
Ambulatory Surgery Facility		0% Coinsurance after deductible
Coinsurance		0%
Annual Deductible (Individual/Family)	Applies to hospital, medical and prescription drugs	$6,300 / $12,600
Annual Out-of-Pocket Maximum (Individual/Family)	See footnotes*	$6,300 / $12,600
INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL		
Inpatient Hospital Admission	365 days per calendar year	0% Coinsurance after deductible
Skilled Nursing Facility Care	365 days per calendar year	0% Coinsurance after deductible
Inpatient Rehabilitation	One consecutive 60-day period per condition per calendar year	0% Coinsurance after deductible
Hospice Care	210 days per lifetime	0% Coinsurance after deductible
OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY		
Pre-admission Testing		0% Coinsurance after deductible
Ambulatory Surgery Facility (Freestanding and outpatient hospital)		0% Coinsurance after deductible
Home Health Care Services	60 visits per calendar year	0% Coinsurance after deductible
Diagnostic Laboratory and Radiology	Advanced radiology requires prior approval	0% Coinsurance after deductible
Chemotherapy		0% Coinsurance after deductible
MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN OR OTHER MEDICAL PROVIDER		
Primary Care Physician Office Visit		0% Coinsurance after deductible
Specialist Office Visit		0% Coinsurance after deductible
Maternity Pre- and Postnatal Care		Covered in Full
Chiropractic Care		0% Coinsurance after deductible
Allergy Care		0% Coinsurance after deductible
Physical & Occupational Therapy Rehabilitative and Habilitative	120 visits per calendar year	0% Coinsurance after deductible
Speech Therapy Rehabilitative and Habilitative	60 visits per calendar year	0% Coinsurance after deductible
Surgery: Inpatient/Outpatient		0% Coinsurance after deductible
Surgery: Office		0% Coinsurance after deductible
Pediatric Vision - Exams	One exam per 12 month period. Coverage up to age 19 end of month	0% Coinsurance after deductible
Pediatric Vision - Lenses & Frames	One set of lenses & frames or contacts per 12 month period. Coverage up to age 19 end of month	0% Coinsurance after deductible
Diagnostic Laboratory and Radiology	Advanced radiology requires prior approval	0% Coinsurance after deductible

SUMMARY OF BENEFITS — EPO HD6300 (BRONZE)

	COMMENTS/LIMITATIONS	IN-NETWORK
MEDICAL SUPPLIES/DEVICES/DME		
Durable Medical Equipment (DME)	Prior approval required for item's > $2,000	0% Coinsurance after deductible
Hearing Aids	Single purchase, one or both ears, (including repair/ replacement) every three years.	0% Coinsurance after deductible
Prosthetic Devices-external	One device per limb, per lifetime	0% Coinsurance after deductible
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	0% Coinsurance after deductible
Emergency Room Professional		0% Coinsurance after deductible
Ambulance		0% Coinsurance after deductible
INPATIENT MENTAL HEALTH & SUBSTANCE USE		
Inpatient Mental Health		0% Coinsurance after deductible
Inpatient Substance Use Services: Detoxification and Rehabilitation		0% Coinsurance after deductible
OUTPATIENT MENTAL HEALTH & SUBSTANCE USE		
Outpatient Mental Health		0% Coinsurance after deductible
Outpatient Substance Use Services	Includes 20 family counseling visits	0% Coinsurance after deductible
PRESCRIPTIONS DRUGS		
Retail	30-day supply	0% Coinsurance after deductible
Mail Order	90-day supply	0% Coinsurance after deductible
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 is underwritten by Group Health Incorporated ("GHI") and provides in-network benefits only. Except for emergency care, no out-of-network services are covered. Participating Providers have contracted with GHI to provide care to our members; they are not employees, agents, servants or representatives of GHI. 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 the Certificate of Coverage/Insurance, and it does not constitute an Agreement. Refer to GHI policy form number HCR-OX-100, et al.

Covered services received from non-participating anesthesiologists, radiologists, pathologists and assistant surgeons while receiving covered services in a network hospital, facility, outpatient department, ambulatory facility or office are covered up to 100% of the 90th percentile of FAIR Health Benchmarks. The benefits described herein are only highlights of the coverage available. The terms, limitations, conditions and exclusions of the insurance contract and certificate will govern. 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.