



**EmblemHealth**<sup>®</sup>

GHI and HIP are EmblemHealth companies

## CHOICE PLUS DIRECT PAY SUMMARY OF BENEFITS

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Hospital Services</b>		
Inpatient Admission	No Cost	Subject to deductible and coinsurance
Inpatient Surgery	\$10 copay	Subject to deductible and coinsurance
Outpatient Hospital or Ambulatory Surgery (Facility copay)	\$10 copay	Subject to deductible and coinsurance
Ambulance Services	No Cost	Subject to deductible and coinsurance
Emergency Room Care	\$35 copay	Subject to deductible and coinsurance
<b>Hospital Alternatives</b>		
Skilled Nursing Facility	No Cost	Subject to deductible and coinsurance
Home Health Care (200 visit limit)	\$10 copay	Subject to deductible and coinsurance
Hospice Care- Inpatient (combined benefit of 210 days)	No Cost	Subject to deductible and coinsurance
Hospice Care-Outpatient	\$10 copay	Subject to deductible and coinsurance
<b>Private Duty Nursing</b> (\$5,000 maximum per calendar year (\$10,000 lifetime maximum))	\$10 copay	Subject to deductible and coinsurance
<b>OUTPATIENT MEDICAL CARE</b>		
PCP Office Visits	\$10 copay	Not Covered
Specialist Office Visits	\$10 copay	Subject to deductible and coinsurance
Anesthesia	\$10 copay	Subject to deductible and coinsurance
Delivery of Child	\$10 copay	Subject to deductible and coinsurance
Diagnostic Services and Treatment	\$10 copay	Subject to deductible and coinsurance
Mammography Screening	\$10 copay	Subject to deductible and coinsurance
Pre-and Post-Natal Care	No Cost	Subject to deductible and coinsurance
Radiation Therapy and Chemotherapy	\$10 copay	Subject to deductible and coinsurance
Second Surgical Opinions	No Cost	Subject to deductible and coinsurance
Surgical Services (per occurrence)	\$10 copay	Subject to deductible and coinsurance
Well Child Care (including immunizations)	No Cost	Not Covered
X-ray and Laboratory Services	\$10 copay	Subject to deductible and coinsurance
<b>Rehabilitative Services</b>		
Physical Therapy-Inpatient	No Cost	Subject to deductible and coinsurance
Physical Therapy-Outpatient (Limited to 90 visits per condition per calendar year)	\$10/visit	Subject to deductible and coinsurance
<b>Prescription Drugs</b>		
\$100 deductible per individual per calendar year. \$300 per family per calendar year maximum deductible.		
Retail 34 day supply		
Generic	\$5	Not Covered
Brand Name	\$10	Not Covered
Mail Order- 90 day supply (may not be Included in your plan)		
Generic	\$20	Not Covered
Brand name	\$20	Not Covered

## CHOICE PLUS DIRECT PAY SUMMARY OF BENEFITS

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Alcoholism, Substance Abuse and Mental Nervous Conditions</b> Mental Health-Inpatient Admission (limited to 30 days combined with Inpatient detoxification benefit)	No cost	No cost
Mental Health-Outpatient (limited to 30 visits for regular treatment and 3 visits for crisis intervention)	10%	10%
Inpatient Detoxification (limited to 30 days combined with inpatient mental health benefit)	No cost	No cost
<b>Durable Medical Equipment</b>	No cost	Subject to deductible and coinsurance
Diabetic Equipment and supplies	\$10/item	Subject to deductible and coinsurance
<b>Prosthetic and Orthotic Devices</b> Such as Prosthetic Limbs, Artificial Eyes and external Breast Prostheses	No Cost	Subject to deductible and coinsurance
<b>Deductibles</b>		
Individual per Calendar Year	None	\$1,000
Family per Calendar Year	None	\$2,000
<b>Maximum Out-Of-Pocket Costs</b>		
Individual per Calendar Year	None	\$3,000
Family per Calendar Year	None	\$5,000

*\* Drugs are dispensed in accordance with HIP's Drug Formulary. Please refer to your Prescription Drug Rider for details. Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP Primary Care Physician and/or approved in advance by the HIP Care Management Program. HIP Participating Physicians and Providers have contracted with HIP to provide care to our members; they are not employees, agents, servants or representatives of HIP. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Contract or Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.*

***HIP Health Plan of New York (HIP) and HIP Insurance Company of New York are EmblemHealth companies.***

*Please note that the program benefits described above have been modified as required pursuant to the federal Patient Protection and Affordable Care Act (PPACA) for all policies issued or renewed on or after September 23, 2010. These modifications may include, but not be limited to, elimination of annual and lifetime dollar maximums on essential benefits as defined by PPACA, elimination of pre-existing condition limitations for children under age 19, elimination of in-network cost-sharing for certain preventive care services defined by PPACA, extending coverage of children to age 26 and uniform co-pays and/or coinsurance for in and out of network emergency care*