Summary of Benefits

GHI HEALTHY NY EPO HDHP

This is a high deductible health plan. With the exception of (1) well-baby and well-child care (up to the age of 19) including immunizations; (2) adult preventive services (including a physical examination once every three years, mammography, pap smear, prostate screening exam and immunizations); and (3) prenatal care, **the deductible must be satisfied before the plan will provide coverage for covered services**.

The individual deductible amount for 2012* is $1,200; the family deductible amount for 2012* is $2,400. Family coverage applies if the policy covers more than one person. The family deductible may be satisfied by one individual family member or by expenses incurred by various family members. However, the entire plan year deductible must be satisfied before services will be covered for any member of the family.

The out-of-pocket maximum amount for an individual for 2012 is $6,050; the out-of-pocket maximum amount for a family for 2012 is $12,100. Family coverage applies if the policy covers more than one person. Out-of-pocket expenses include the deductible and copayments paid for Healthy NY benefits covered by this plan. Once the out-of-pocket maximum for the plan year is reached, no further copayments will apply and covered benefits will be covered in full. For more information about high deductible plans, please see your certificate.

COST SHARING	
Annual Plan Deductible	$1,200 Individual for plan year 2012* $2,400 Family for plan year 2012* *Treasury guidelines indicate that each year, the deductible amounts required for a high deductible health plan may be increased to reflect a cost-of-living adjustment. In order for this plan to continue to meet Healthy NY high deductible health plan requirements, and for this plan to continue to qualify as a high deductible health plan for use with a health savings account, the deductible amounts set forth above for plan years 2012 – 2021 may automatically increase to the new deductible amounts established in the Treasury guidelines.
Annual Out-of-Pocket Maximum	$6,050 individual $12,100 family
PHYSICIANS SERVICES	
Primary Care Physician/Specialist Office Visit	$20 copayment per visit
Diagnostic & treatment services	$20 copayment per visit
Consultant & referral services	
Anesthesia services	
Second surgical opinion	
Second opinion for cancer	
Physical therapy and occupational therapy (Covered only in connection with a post-hospital or post-surgical episode.)	
Surgical services (including breast reconstruction following a mastectomy)	20% or $200, whichever is less
EMERGENCY SERVICES	
	$50 copayment per visit (waived if hospital admission results from visit)

Refer to GHI policy form number HNY PLA 90-10, et al.

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ADULT PREVENTIVE HEALTH CARE**	
Mammography screening Cervical cytology screening Prostate screening Periodic physical examinations Adult immunizations	Covered in full
MATERNITY CARE	
Prenatal care	$10 copayment per visit (prenatal)
Postnatal care	$10 copayment per visit (postnatal)
Delivery	20% or $200, whichever is less
Home visit	No copayment
CHILD PREVENTIVE HEALTH SERVICES**	
Preventive and primary care immunization	Covered in full
Scheduled well-care visits	Covered in full
PRE-ADMISSION TESTING	
	$20 copayment per visit
INPATIENT HOSPITAL SERVICES (INCLUDING INPATIENT MATERNITY CARE)	
Daily room & board General nursing care Special diets Miscellaneous hospital services & supplies	$500 copayment per continuous confinement
OUTPATIENT HOSPITAL SERVICES	
Diagnostic & treatment services Home Health Care (Covered only in connection with a post-hospital or post-surgical episode.)	$20 copayment per visit
Outpatient surgery	$75 facility copayment
DIABETIC EQUIPMENT & SUPPLIES AND SELF-MANAGEMENT EDUCATION	
	$20 copayment per visit for self-education $20 copayment per each item of equipment $20 copayment per 34-day supply of insulin, hypoglycemics and supplies
DIAGNOSTIC X-RAY & LAB SERVICES	
	$20 copayment per visit
THERAPEUTIC SERVICES	
Radiological services Chemotherapy Renal Dialysis	$20 copayment per visit
BLOOD AND BLOOD PRODUCTS	
	$20 copayment per visit
PRESCRIPTION DRUGS (OPTIONAL)	
	Copayment: $10 per generic drug per 34-day supply $20 per brand name drug plus difference in cost between the brand name drug and its generic equivalent per 34-day supply Mail order program: $20 per generic drug per 90-day supply $40 per brand name drug per 90-day supply plus the difference in cost between the brand name drug and its generic equivalent Benefit Maximum: Unlimited

NOT COVERED: Ambulance, bariatric surgery, chiropractic care, cosmetic surgery, dental care, durable medical equipment, external prosthetics, hearing care (examinations for hearing aids and the fitting of same), hospice care, infertility services (advanced), mental health services, ostomy supplies, private duty nursing, skilled nursing facility, substance abuse diagnoses, detoxification treatment, rehabilitation, reversal of voluntary sterilization, routine foot care, speech therapy, transsexual surgery (unless medically necessary), vision care (eyeglasses, contact lenses and examinations for such), weight reduction surgery, and other services not listed as covered in the GHI HNY Certificate of Coverage.

**Preventive Care Services mandated by Patient Protection and Affordable Care Act are covered in full in network.

This chart is intended to provide a general outline of GHI EPO Healthy NY HDHP/HSA benefits.
Certain services must be approved in advance by the Care Management program or Emblem Behavioral Health Services department.