



SUMMARY COMPARISON OF HEALTH PLANS FOR EMPLOYEES AND THOSE RETIREES NOT ELIGIBLE FOR MEDICARE

TRANSFER PERIOD: FALL 2007 BENEFITS & RATES AS OF JULY 2007. SUBJECT TO CHANGE.

TYPE OF PLAN	PPO/INDEMNITY	HMO	POS	HMO	HMO	POS	HMO	HMO	POS	HMO	HMO	HMO
NAME OF PLAN	GHI-CBP	HIP PRIME	HIP PRIME POS	EMPIRE EPO	EMPIRE HMO	AETNA INC. QUALITY POINT OF SERVICE	AETNA INC.	CIGNA HEALTHCARE	VYTRA	HEALTH NET	GHI/HMO	
MONTHLY COST	BASIC COVERAGE: \$0 EMPLOYEE OPTION Individual: \$6.08 Family: \$15.32 RETIREE OPTION Individual: \$113.15 Family: \$211.60	BASIC COVERAGE: \$0 RETIREE OPTION Individual: \$84.49 Family: \$207.01	BASIC ONLY Individual: \$96.33 Family: \$236.11 BASIC WITH RETIREE OPTION Individual: \$239.23 Family: \$586.16	BASIC ONLY Individual: \$235.63 Family: \$604.46 BASIC WITH RETIREE OPTION Individual: \$310.34 Family: \$787.59	BASIC ONLY Ind.: \$62.45 Fam.: \$213.52 BASIC WITH RETIREE OPTION Ind.: \$137.16 Fam.: \$396.65	BASIC ONLY Individual: \$531.46 Family: \$1,301.05 BASIC WITH RETIREE OPTION Individual: \$678.36 Family: \$1,619.55	BASIC ONLY Individual: \$71.16 Family: \$311.45 BASIC WITH RETIREE OPTION Individual: \$176.06 Family: \$557.25	BASIC ONLY Individual: \$159.96 Family: \$492.11 BASIC WITH RETIREE OPTION Individual: \$300.98 Family: \$865.80	BASIC ONLY Individual: \$68.77 Family: \$229.38 BASIC WITH RETIREE OPTION Ind: \$161.88 Family: \$487.19	BASIC ONLY Individual: \$165.08 Family: \$472.83 BASIC WITH RETIREE OPTION Ind: \$339.44 Family: \$923.57	BASIC ONLY Individual: \$68.64 Family: \$209.09 BASIC WITH RETIREE OPTION Ind: \$149.16 Family: \$414.18	
PHONE	GHI: 212-501-4444 BC: 800-433-9592		800-HIP-TALK	800-767-8672		800-445-USHC		800-244-6224	800-406-0806	800-441-5741	877-244-4466	
WEB SITE	www.ghi.com www.empireblue.com		www.hipusa.com	www.empireblue.com		www.aetna.com		www.cigna.com/healthcare	www.vytra.com	www.healthnet.com	www.ghihmo.com	
MEDICAL/SURGICAL • In-Network or Participating Provider	Participating provider's services provided at no cost except \$15 copayment for office visits to Medical Providers/Practitioners. \$20 for Surgeons, all Surgical Subspecialties and Dermatologists (a full list appears on www.ghi.com).	Covered in full. \$0 co-pay.	In-network: \$0 co-pay. Covered in full. Out-of-network: Covered 80% after deductible.	\$15 copay.	\$15 copay.	Covered in full minus copayments as specified below. Primary Care Physician (PCP) referral required or cost will be subject to deductible and coinsurance as specified below.	Covered in full minus copays as specified below. Primary Care Physician (PCP) referral required.	\$10 per visit.	Full coverage when services are provided or approved by a VYTRA primary physician except for copayments as specified below. No referrals needed for OB/GYN, Podiatrists, Chiropractors, Ophthalmologists and Mental Health Providers.	Full coverage when services are provided or approved by a Health Net primary physician except for copayments as specified below.	Full coverage when services are provided or approved by a GHI/HMO primary physician except for copayments as specified below.	
• Out-of-Network or Non-Participating Provider Deductible	\$200 deductible per person (\$500 per family) per calendar year.	N/A	\$250 annual deductible per person (\$500 for a family).	In-network benefits only.	In-network benefits only.	Single: \$250 Family: \$750	Not applicable.	Emergency care only.				
Co-Insurance/Schedule	After deductible met, GHI pays 100% of the NYC Non-Participating Provider Schedule of Allowances. (Note: Schedule does not represent current provider charges). If you have the Optional Rider, the Rider will provide for a average 75% increase in existing NYC Schedule of Allowances for in-hospital and related procedures.	\$0 co-pay.	80% of the customary charges as determined by HIP. Customary charges are based on nationally recognized fee schedule. Patient responsible for 20% plus charges in excess of customary charge.	Not applicable. In-network benefits only.	Not applicable. In-network benefits only.	80% of reasonable and customary fees as determined by Aetna, unless otherwise specified.	Not applicable.	\$10 per visit. See services listed below.				
Stop Loss/Catastrophic	If you use non-participating physicians for in-hospital care, you may incur catastrophic expenses. GHI Catastrophic Coverage pays additional amounts under such circumstances. When you have, in a calendar year, \$1,500 covered out-of-pocket expenses based upon physicians' usual and customary fees, GHI pays 100% of the reasonable and customary charges. The service to which Catastrophic Coverage applies and also the services which contribute to the \$1,500 deductible are: surgery, anesthesia, maternity care, in-hospital medical care, radiation, chemotherapy and expenses related to in-hospital X-ray and laboratory services.	No limit-in-network.	After \$2,000 co-insurance per person (\$4,000 for family) payment of 100% of customary charges. Charges in excess of covered charges remain the patient's responsibility.	Not applicable. In-network benefits only.	Not applicable. In-network benefits only.	Single: \$2,500, Family: \$7,500. After co-insurance expires, each reach above specified amounts, Aetna will pay 100% of reasonable and customary fees. Excess charges will be the member's responsibility.	Not applicable.	Annual out-of-pocket maximum: Individual: \$2,000. Family: \$4,000.				
Maximums	\$2,000,000 lifetime per person. In-network no maximum.	Unlimited.	In-network: Unlimited. Out-of-network, \$5,000,000 annual per member.	Unlimited.	Unlimited.	\$1,000,000	None.	Unlimited lifetime maximum.				
Notification and/or Approval	No notification or approval required to go out of network.	There is no charge if you are referred by your primary physician and use services in network.	Must contact plan prior to going out of network for certain services (hospital, skilled nursing, ambulatory surgery, home care, MRI's, CAT scans).	Prescription required for inpatient admission; home health care; home infusion therapy; physical therapy; occupational therapy; hospice; skilled nursing; speech therapy; cardiac rehab; MRI; MRA; durable medical equipment; inpatient & outpatient surgery. Maternity; Air Ambulance. In-network benefits only.	Prescription by PCP required for inpatient admission; home health care; home infusion therapy; physical therapy; occupational therapy; hospice; skilled nursing; speech therapy; cardiac rehab; MRI; MRA; durable medical equipment; inpatient & outpatient surgery. Maternity; Air Ambulance. In-network benefits only.	Prescription required for outpatient surgery, physical therapy, occupational therapy, nursing facility care and home care or benefits will be substantially reduced.	PCP referrals required.	Services arranged by primary care physician. Notify Cigna within 48 hours for emergency.				
Sample Restrictions (POS Plan)	Not applicable.	N/A	Adult preventive care not covered outside network. (Preventive care for children covered out of network subject to deductible and coinsurance.)	In-network benefits only.	In-network benefits only.	Routine preventive care is only covered in-network.	Must use in-network PCP to coordinate care and issue referrals.	Not applicable.				
HOSPITALIZATION • In-Network or Participating Provider	After \$300 deductible per admission (\$750 per person per calendar year maximum). For employees and non-Medicare retirees: Full 365 days covered by Blue Cross under basic. New York City Healthplan must be contacted to avoid penalty of \$250 per day to a maximum of \$500 per admission prior to any scheduled hospital admission and within 48 hours of emergency admission.	Covered in full without limit. \$0 co-pay.	In-network: \$0 co-pay. Covered in full. Out-of-network: Covered 80% after deductible.	In-network benefits only.	In-network benefits only.	\$100 hospitalization co-pay when referred by PCP or if admitted after emergency room visit. Without referral, precertification is required in order to avoid substantial reduction in benefits. If admitted after emergency room visit, hospitalization covered in full.	\$100 hospitalization co-pay when referred by PCP or if admitted after emergency room visit.	Primary care physician will arrange for admission to a participating hospital and manage hospital care. \$150 per admission.	Emergency admissions covered in full. Hospital emergency room, \$50 per visit. Waived if admitted. If admitted the \$150 inpatient copay would apply.	Emergency admissions covered in full.	Emergency admissions covered in full.	
• Out-of-Network or Non-Participating Provider		N/A		As many days as medically necessary, semi-private room & board covered in full with prior precertification from Empire's Medical Management and subject to copy of \$250 individual/maximum \$425 per calendar year per contract.	As many days as medically necessary, semi-private room & board covered in full with prior precertification by PCP from Empire's Medical Management and subject to copy of \$250 individual/maximum \$425 per calendar year per contract.	\$100 hospitalization co-pay and coinsurance. Precertification required in order to avoid substantial reduction in benefits. If admitted after emergency room visit, hospitalization covered in full.	\$100 hospitalization co-pay when referred by PCP or if admitted after emergency room visit.	Emergency care only. Hospital emergency room, \$50 per visit. Waived if admitted. If admitted the \$150 inpatient copay would apply.	Emergency admissions covered in full.	Emergency admissions covered in full.	Emergency admissions covered in full.	
IN-HOSPITAL SPECIALIST CONSULTATION	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Limited to one per specialty per confinement for each condition. Covered only upon referral of your provider.	Covered in full.	All services covered in full with prior precertification from Empire's Medical Management and subject to copy of \$250 individual/maximum \$625 per calendar year per contract for any inpatient admission.	All services covered in full with prior precertification from your PCP by Empire's Medical Management and subject to copy of \$250 individual/maximum \$625 per calendar year per contract for any inpatient admission.	In-network covered in full when referred by PCP. Out-of-network or without referral for hospitalization, subject to deductible and coinsurance.	Covered in full.	Covered in full.	Arranged by primary care physician. No charge.	Covered in full.	Covered in full.	Covered in full.	
SURGERY (In or out of hospital)	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Mandatory Health Line notification required for surgical procedures. Blue Cross covers outpatient facility charges after 20% deductible (max. of \$200 per individual) Schedule of Allowances.	Covered in full.			In-network covered in full when referred by PCP. Out-of-network or without referral for surgery, subject to deductible and coinsurance.	Covered in full when referred by PCP.	Arranged by primary care physician. No charge.	Outpatient surgery in provider's office covered in full with \$5 copay.	Covered in full.	Covered in full.	Covered in full.	
ASSISTANT AT SURGERY	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full.	In-network: \$0 co-pay. Covered in full.		In-network covered in full when surgery referred by PCP. Out-of-network or without referral for surgery, subject to deductible and coinsurance.	Covered in full when surgery referred by PCP.	Arranged by primary care physician. No charge.	Covered in full when medically necessary.	Covered in full.	Covered in full.	Covered in full.	
IN-HOSPITAL ANESTHESIA	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full.			In-network covered in full when hospitalization referred by PCP. Out-of-network or without referral for hospitalization, subject to deductible and coinsurance.	Covered in full when hospitalization referred by PCP.	Arranged by primary care physician. No charge.	Covered in full.	Covered in full.	Covered in full.	Covered in full.	
MATERNITY AND RELATED CARE	Blue Cross covers mother's hospital stay after \$300 deductible. For most other charges, GHI payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances. See Newborn Well-Baby Nursery Charges below.	Covered in full.	Out-of-network: Covered 80% after deductible.		In-network: \$20 copay for first OB visit only. \$100 hospitalization co-pay. Out-of-network subject to deductible and coinsurance for OB visits and hospitalization.	In-network: \$20 copay for first OB visit only. \$100 hospitalization co-pay.	First visit to confirm pregnancy, \$10. Per visit thereafter, no charge. Hospital charges per admission, \$150. Delivery charges, none.	\$5 copay first visit only.	Covered in full.	Covered in full.	In-network: First visit \$15 copay OB/GYN visits. Hospital covered in full.	
NEWBORN WELL-BABY NURSERY CHARGES	Initial in-hospital pediatric visit payment in full for participating providers. Reimbursement for non-participating is covered up to a \$60 maximum per confinement.	Covered in full.			In-network covered in full when hospitalization referred by PCP. Out-of-network or without referral for hosp., subject to deductible and coinsurance.	Covered in full when hospitalization referred by PCP.	Covered in full.	Covered in full.	Covered in full.	Covered in full.	Covered in full if added to plan/contract within 30 days.	
NEWBORN WELL-BABY MEDICAL CARE	Eleven out-of-hospital visits covered from birth through 23 months. Ages 2-19: one out-of-hospital visit per year according to the New York State Department of Health Guidelines. Immunizing agents relative to adult vaccinations for influenza and pneumonia covered in full with \$15 copay for office visit. Covered only when rendered at GHI participating provider. For non-Medicare eligible employees and their eligible dependents age 45 and older, GHI-CBP will provide for annual physical through GHI participating providers only with \$15 copay. No copay for lab and diagnostic radiology services when completed in office. Outside lab or radiological subject to provisions of \$15 copay currently in effect for lab and diagnostic X-rays. Well-child care & immunization; GHI will provide necessary immunizations as recommended by the American Academy of Pediatrics for hepatitis A, varicella and pneumococcal conjugate vaccine (Prevnar).	Covered in full, including routine physicals.			In-network: Covered in full. Out-of-network: Adult preventive care not covered. Preventive care for children covered 80% after deductible.	Covered in full to age 19.	Covered in full to age 19.	Dependent preventive care (birth to age 19), well-child care physical exams, routine immunizations and injections; NY residents; no charge. NJ residents: \$10 copay per visit.	\$5 copay. Copay is waived for well-child visits if it meets standard set by the American Academy of Pediatrics.	Covered in full. Nutritional counseling: \$15 copay, two visits. Acupuncture: \$15 copay, up to six visits.	Covered in full.	
PREVENTIVE CARE (Including Well-Child Care & Immunization)	Payment in full for participating providers. \$15 copayment for office visits to Medical Providers/Practitioners. \$20 for Surgeons, all Surgical Subspecialties and Dermatologists (a full list appears on www.ghi.com). Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full. \$0 co-pay.			In-network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$15 copay for PCP.	In-network: \$15 copay to PCP. \$20 specialties when seen with referral from PCP. Out-of-network or without referral subject to deductible and coinsurance.	\$15 copay to PCP. \$20 specialties when seen with referral from PCP.	\$10 per visit.	Covered in full with \$5 copay.	Covered in full with \$15 cop. \$20 specialist copay.	Covered in full with \$15 copay.
OFFICE VISIT	Payment in full for participating providers except for \$15 copayment for office visits to Medical Providers/Practitioners. \$20 for Surgeons, all Surgical Subspecialties and Dermatologists (a full list appears on www.ghi.com). Reimbursement for non-participating is covered under NYC Schedule of Allowances. Limited to one per specialty per year for each condition. Covered only upon referral of your provider.	Covered in full. \$0 co-pay.			In-network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$15 copay.	Covered in full in-network with \$15 copay and PCP referral.	Covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance.	\$10 per visit when referred by primary care physician. Women have direct access to a participating OB/GYN for well-woman gynecological care and acute gynecological conditions.	Covered in full with \$5 copay with referral from PCP.	Covered in full.	Covered in full - \$15 copay with a referral from PCP.
SPECIALIST CONSULTATION - OUT-OF-HOSPITAL	Payment in full for participating providers except for \$15 copayment. A maximum of one copayment for these services will apply per date of service, per provider. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full. \$0 co-pay.			In-network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$0 copay.	In-network covered in full with referral from PCP. \$20 copay may apply. Out-of-network or without referral subject to deductible and coinsurance.	Covered in full with referral from PCP. \$20 copay may apply.	Covered in full as part of office visit. Lab tests covered in full. Members must use assigned radiologist.	Covered in full.	Lab tests covered in full. X-rays \$15 copay.	
X-RAYS AND LABORATORY TESTS	In-network: No out-of-pocket expenses for covered services. Precertification by GHI's Managed Care Department is required. Out of network: 80% of participating provider schedule of allowances after \$250 deductible per person per calendar year. \$100,000 maximum per person per year without optional rider; \$200,000 with optional rider.	Supplemental Welfare Fund benefit for employees. No coverage first 72 hours. Reimbursed at 80% for up to 504 subsequent hours in hospital.	Not covered out of network. Supplemental Welfare Fund benefit for employees, as described under HIP Plan.	Not covered.	Not covered.	Not covered.	Not covered.	Referral care covered in full when medically necessary and approved and coordinated through Aetna. Non-referral care subject to deductible & coinsurance. Precertification required or benefits will be substantially reduced.	Referral care covered in full when medically necessary and approved by Cigna.	Covered in full when medically necessary.	Not covered.	Covered in full when approved in advance by medical director.
PRIVATE DUTY NURSING	Coverage at 80% of GHI's schedule of allowances.	Covered in full. \$0 co-pay.			\$0 copay up to allowed amount. You pay difference between allowed amount and total charge.	\$0 copay up to allowed amount. You pay difference between allowed amount and total charge.	Covered in full when medically necessary.	Covered in full when medically necessary.	Emergency care per ride, no charge.	Covered in full when medically necessary.	Covered in full when medically necessary.	Covered in full when medically necessary.
AMBULANCE SERVICE	After \$50 copayment, emergency room covered by Blue Cross for sudden or serious illness or accidental injury. Copay waived if admitted to hospital. Empire also covers the emergency room physicians and non-invasive pathology, radiology and cardiology services rendered in the emergency room.	Covered in full. \$0 co-pay.			\$35 copay waived if admitted within 24 hours.	\$35 copay waived if admitted within 24 hours.	Covered anytime, anywhere in the world, 24 hours a day, 7 days a week. \$35 copay for emergency room visit (waived if admitted). \$100 hospitalization co-pay.	Covered anytime, anywhere in the world, 24 hours a day, 7 days a week. \$35 copay for emergency room visit (waived if admitted). \$100 hospitalization co-pay.	\$5 copay for emergency care or participating urgent center. \$25 copay for emergency care at hospital. Waived if admitted.	\$15 copay for emergency care in doctor's office. \$25 copay for urgent care at urgent care center. \$50 copay at hospital. Waived if admitted.	\$35 copay. Waived if admitted. Must notify GHI/HMO within 48 hours.	
EMERGENCY SERVICE	Benefits are paid without regard to any geographical limitations.	Out-of-area care applies to emergency service only. Call 1-800-HIP-TALK.	Out-of-area care applies to emergency service only. Call 1-800-HIP-TALK.	Urgent and emergency care is available to members nationwide through Empire's BlueCard® program's traditional provider network. Guest membership is available to HMO members living in another city for at least 90 days through local Blue Cross and/or Blue Shield plans.	Worldwide emergency care coverage as described above.	Worldwide emergency care coverage as described above.	Worldwide emergency care coverage as described above.	Emergency room care as previously described. Emergency hospitalization is covered. \$150 copay.	Emergency room care as previously described. Emergency hospitalization is covered. \$150 copay.	Covered in full for medically necessary emergency room care, less \$50 copay.	Covered in full for medically necessary emergency room care, less \$50 copay.	Covered in full for medically necessary emergency room care, less \$50 copay.
OUT-OF-AREA CARE AND/OR TRAVEL COVERAGE	Covered by Blue Cross subject to NYC Healthplan pre-authorization. A maximum of 90 days to receive for skilled nursing facility care which may include 30 inpatient days in a rehabilitation hospital primarily for physical therapy, physical rehabilitation or physical medicine.	Covered in full unlimited days. \$0 copay.	In-network: Covered in full. Out-of-network: Not covered.	In-network: Covered in full up to 60 days per calendar year. Precertification by Empire's Medical Management Program is required.	Covered in full up to 60 days per calendar year. Precertification by PCP from Empire's Medical Management Program is required.	Covered in full when medically necessary in lieu of hospitalization. In-network covered in full when approved and coordinated through Aetna. Out-of-network subject to deductible and coinsurance. Covered at 240 days and 35 physician visits per calendar year. Precertification required or benefits will be substantially reduced.	Covered in full when medically necessary in lieu of hospitalization and when coordinated through Aetna.	Inpatient skilled services such as physical, occupational therapy and skilled nursing care covered in full to a combined maximum of 90 consecutive days per calendar year when medically necessary and approved in advance by PHS medical director.	Covered in full when medically necessary. 45 days per calendar year. Must be admitted within three days of inpatient hospital stay.	Covered in full for medically necessary emergency room care, less \$50 copay.	Covered in full for medically necessary emergency room care, less \$50 copay.	Covered in full for medically necessary emergency room care, less \$50 copay.
SKILLED NURSING FACILITY	Not covered except as prescribed for metabolic diseases, such as diabetes, than payment in full for participating providers except for \$20 copayment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Not covered.	Not covered.	Not covered.	Not covered.	In-network covered in full with \$20 copay and referral from PCP. For diabetics only. Out-of-network or without referral subject to deductible and coinsurance. For diabetics only.	Covered in full with \$20 copay and referral from PCP. For diabetics only.	Routine care of the feet not covered.	Routine footwear not covered except when patient is diabetic.	Routine care of the feet not covered.	Routine care of the feet not covered.	
ROUTINE PODIATRIC CARE	Payment in full for participating providers except for \$15 copayment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. More than 30 visits subject to medical review by GHI.	Covered in full. \$0 co-pay.	In-network: \$0 co-pay. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$15 copay (waived for treatments).	Covered in full in-network with \$15 copay (waived for treatments).	In-network covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance.	Covered in full with \$20 copay and referral from PCP.	\$10 per visit.	Allergy testing and treatment covered in full with \$5 copay.	Covered in full after \$15 copay office, \$20 specialist office copay.	\$15 copay with PCP referral.	
ALLERGY TESTING AND ALLERGY TREATMENTS	Payment in full for participating providers except for \$15 copayment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Coverage is unlimited, subject to medical review.	Covered in full when services provided through HIP chiropractors.	In-network: \$0 co-pay. Out-of-network: Covered 80% after deductible.	Covered in full in-network with \$15 copay (when medically necessary). PCP referral required.	Covered in full when medically necessary). PCP referral required.	In-network covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance.	Covered in full with \$20 copay and referral from PCP.	\$10 per visit when referred by primary care physician. (See Physical Therapy short-term rehab if NJ residents) \$10 copay per visit in NY.	Covered in full when medically necessary with \$5 copay.	Covered in full when medically necessary. Prior authorization necessary for second and subsequent visits.	\$15 copay with PCP referral when medically necessary.	
CHIROPRACTIC CARE	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full. \$0 co-pay.	In-network: \$0 co-pay. Out-of-network: Covered 80% after deductible.	Covered in full in-network. \$0 copay.	Covered in full in-network. \$0 copay.	In-network covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance.	Covered in full with \$20 copay and referral from PCP.	Outpatient, no charge.	Covered in full.	Covered in full.	Covered in full.	
RADIATION THERAPY	Payment in full for participating providers. Precertification by GHI's Managed Care Department is required. Up to 200 visits per year. Non-participating providers are covered subject to \$20 deductible per episode; 80% of Schedule of Allowances. Maximum of 40 visits per calendar year.	Covered in full. \$0 co-pay.	In-network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network up to 200 visits per calendar year under home health care. Precertification by your PCP through Empire's Medical Management Program is required.	Covered in full in-network up to 200 visits per calendar year under home health care. Precertification by your PCP through Empire's Medical Management Program is required.	Covered when medically necessary. In-network covered in full when coordinated by PCP through Aetna's Patient Management Dept. Out-of-network subject to deductible and coinsurance. Precertification required or benefits will be substantially reduced.	Covered when medically necessary. Coverage by PCP through Aetna's Patient Management Dept.	Home health care per use, no charge. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment. HOSPICE CARE: \$0 copay.	Covered in full. Not subject to copay under Home Health Care. 40 visits per calendar year.	Covered in full under Home Health Care Program when approved in advance by Health Net.	Covered in full for 40 visits only, when medically necessary.	
VISITING NURSE SERVICE	Payment in full for participating providers except for \$15 copayment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. More than 16 visits subject to medical review by GHI.	Outpatient: \$0 co-pay. 90 visits per calendar year.	In-network: Covered in full. Out-of-network: Covered 80% after deductible.	Inpatient covered in network in full up to 30 days per calendar year. Outpatient covered in-network combined 30 visits in home, office, outpatient facility per calendar year. Precertification by Empire's Medical Management is required.	Inpatient covered in network in full up to 30 days per calendar year. Outpatient covered in-network combined 30 visits in home, office, outpatient facility per calendar year. Precertification by Empire's Medical Management is required.	In-network covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance. Treatment covered over 60-day consecutive period or inpatient in-network up to 30 days of treatment.	In-network covered in full when coordinated by PCP through Aetna's Patient Management Dept. Out-of-network or without referral subject to deductible and coinsurance. Treatment covered over 60-day consecutive period or inpatient in-network up to 30 days of treatment.	Short-term rehabilitation and physical therapy combined 60 visits maximum per contract year, \$10 copay. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment.	Short-term rehabilitation only (two consecutive months per diagnosis).	Outpatient physical and occupational therapy up to 30 visits per year with \$20 copay per visit when medically necessary.	\$15 copay, 30 visits per 60-day period.	
PHYSICAL THERAPY	Included in NYC Schedule of Allowances, subject to separate annual deductible of \$100 per person* when using GHI preferred provider. In-network, 50% reimbursement of allowed charge after deductible. Equipment in excess of \$2,000 must be preauthorized by GHI.	Referee: Durable Medical Equipment which includes crutches, canes, wheelchairs, commodes and walkers through rider. In-Service: Additional Welfare Fund benefit reimbursed at 80% of reasonable charge, subject to \$25 deductible, \$1,500 annual maximum and \$2,000 lifetime.	In-network: \$0 co-pay. Out-of-network: Not covered out of network. In-Service: Supplemental Welfare Fund benefit for employees, as described under HIP Plan.	Durable medical equipment, medical supplies, prosthetics, orthotics covered in full. Precertification by Empire's Medical Management is required. In-network provider only.	Durable medical equipment, medical supplies, prosthetics, orthotics covered in full. Precertification by your PCP through Empire's Medical Management is required. In-network provider only.	In-network covered in full with \$20 copay and referral from PCP. Out-of-network or without referral subject to deductible and coinsurance. Treatment covered over 60-day consecutive period or inpatient in-network up to 30 days of treatment.	In-network covered in full when coordinated by PCP through Aetna's Patient Management Dept. Out-of-network or without referral subject to deductible and coinsurance. Treatment covered over 60-day consecutive period or inpatient in-network up to 30 days of treatment.	Short-term rehabilitation and physical therapy combined 60 visits maximum per contract year, \$10 copay. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment.	Short-term rehabilitation and physical therapy combined 60 visits maximum per contract year, \$10 copay. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment.	Health Net pays 50% of cost of durable medical equipment (certain devices require prior authorization) to a maximum benefit payment of \$1,500 per member per calendar year. In-network prosthetics covered in full. External prosthetics covered to \$5,000 maximum.	80% covered to an annual maximum of \$1,500.	
APPLIANCES	Outpatient: In-network covered in full. 60 visits/year combined with non-network visits. Endocrinology/asthma/cancer covered (less than 10 visits per year combined with network visits). Out-of-network treatment covered at 75% of network allowance. 60 visits/year combined with network visits. Inpatient: In-network: Covered in full. 30 days/year, 60 days/year combined with rehabilitation treatment. Out-of-network: Covered in full. 30 days/year, 60 days/year combined with rehabilitation treatment. Optional rider increases network benefit with additional 30 days per year for detoxification and/or rehabilitation covered at 100%. Out of network detoxification covered at 100% of network allowance, no rehabilitation benefits. Optional rider increases benefit with 30 days/years for detoxification and/or rehabilitation, covered at 75% of network allowance. \$1,000 co-insurance maximum per admission, covered at 100% thereafter. Non-network inpatient benefits subject to \$500 penalty if not preauthorized.	Outpatient: In-network covered in full. 60 visits/year combined with non-network visits. Endocrinology/asthma/cancer covered (less than 10 visits per year combined with network visits). Out-of-network treatment covered at 75% of network allowance. 60 visits/year combined with network visits. Inpatient: In-network: Covered in full. 30 days/year, 60 days/year combined with rehabilitation treatment. Out-of-network: Covered in full. 30 days/year, 60 days/year combined with rehabilitation treatment. Optional rider increases network benefit with additional 30 days per year for detoxification and/or rehabilitation covered at 100%. Out of network detoxification covered at 100% of network allowance, no rehabilitation benefits. Optional rider increases benefit with 30 days/years for detoxification and/or rehabilitation, covered at 75% of network allowance. \$1,000 co-insurance maximum per admission, covered at 100% thereafter. Non-network inpatient benefits subject to \$500 penalty if not preauthorized.	In-network: \$0 co-pay. Out-of-network: Not covered out of network. In-Service: Supplemental Welfare Fund benefit for employees, as described under HIP Plan.	In-network: Covered in full up to 60 visits which may include 20 family counseling visits per calendar year. Behavioral health care management must pre-approve all care. In-network inpatient up to 7 days days per calendar year, 30 days which, subject to copy of \$250 individual/\$425 maximum per contract per calendar year. Behavioral Health Care Management must pre-approve all care.	In-network: Covered in full up to 60 visits which may include 20 family counseling visits per calendar year. Behavioral health care management must pre-approve all care. In-network inpatient up to 7 days days per calendar year, 30 days which, subject to copy of \$250 individual/\$425 maximum per contract per calendar year. Behavioral Health Care Management must pre-approve all care.	Inpatient: \$300/\$750 copay max per year with no limit on number of days for biologically based conditions, 30 day limit for non-biologically based conditions. Outpatient: Treatment for biologically based conditions: \$15 copay, unlimited visits. For non-biologically based conditions: \$15 copay, 20 visits max. All mental health substance abuse treatments/hospitalizations are subject to Empire Behavioral Health pre-authorization and approval.	Inpatient: \$300/\$750 copay max per year with no limit on number of days for biologically based conditions, 30 day limit for non-biologically based conditions. Outpatient: Treatment for biologically based conditions: \$15 copay, unlimited visits. For non-biologically based conditions: \$15 copay, 20 visits max. All mental health substance abuse treatments/hospitalizations are subject to Empire Behavioral Health pre-authorization and approval.	Covered in full when coordinated by PCP through Aetna's Patient Management Dept. Out-of-network or without referral subject to deductible and coinsurance. Treatment covered over 60-day consecutive period or inpatient in-network up to 30 days of treatment.	Substance abuse detoxification services available inpatient or outpatient, depending on availability. Services provided by national network of Psychological Management Care Consultants who evaluate patient needs, provide treatment and coordinate counseling and therapy. Inpatient: \$150 copay per admission, up to 30 days per contract year. Outpatient Individual: 40 visits per contract year. Outpatient Group: 60 visits per contract year, \$10 copay per session.	Outpatient drug and alcohol treatment covered in full except for \$5 copay. 40-visit combined annual maximum for drug and/or alcohol treatment. Detoxification covered in full for three periods of detoxification in a calendar year for drug and/or alcohol. Inpatient detoxification not covered.	Outpatient drug and alcohol treatment covered in full except for \$5 copay. 40-visit combined annual maximum for drug and/or alcohol treatment. Detoxification covered in full when approved by Health Net.	Inpatient: Data covered in full, seven-day combined annual maximum for drug and/or alcohol treatment. Outpatient: \$15 copay per visit, 60-visit combined annual maximum for drug/alcohol treatment.
ALCOHOLISM AND DRUG ABUSE (Chemical Dependency)	Outpatient: In-network covered in full. 60 visits/year combined with non-network visits. Endocrinology/asthma/cancer covered (less than 10 visits per year combined with network visits). Out-of-network treatment covered at 75% of network allowance. 60 visits/year combined with network visits. Inpatient: In-network: Covered in full. 30 days/year, 60 days/year combined with rehabilitation treatment. Out-of-network: Covered in full. 30 days/year, 60 days/year combined with rehabilitation treatment. Optional rider increases network benefit with additional 30 days per year for detoxification and/or rehabilitation covered at 100%. Out of network detoxification covered at 100% of network allowance, no rehabilitation benefits. Optional rider increases benefit with 30 days/years for detoxification and/or rehabilitation, covered at 75% of network allowance. \$1,000 co-insurance maximum per admission, covered at 100% thereafter. Non-network inpatient benefits subject to \$500 penalty if not preauthorized.	Outpatient: In-network covered in full. 60 visits/year combined with non-network visits. Endocrinology/asthma/cancer covered (less than 10 visits per year combined with network visits). Out-of-network treatment covered at 75% of network allowance. 60 visits/year combined with network visits. Inpatient: In-network: Covered in full. 30 days/year, 60 days/year combined with rehabilitation treatment. Out-of-network: Covered in full. 30 days/year, 60 days/year combined with rehabilitation treatment. Optional rider increases network benefit with additional 30 days per year for detoxification and/or rehabilitation covered at 100%. Out of network detoxification covered at 100% of network allowance, no rehabilitation benefits. Optional rider increases benefit with 30 days/years for detoxification and/or rehabilitation, covered at 75% of network allowance. \$1,000 co-insurance maximum per admission, covered at 100% thereafter. Non-network inpatient benefits subject to \$500 penalty if not preauthorized.	In-network: \$0 co-pay. Out-of-network: Not covered out of network. In-Service: Supplemental Welfare Fund benefit for employees, as described under HIP Plan.	In-network: Covered in full up to 60 visits which may include 20 family counseling visits per calendar year. Behavioral health care management must pre-approve all care. In-network inpatient up to 7 days days per calendar year, 30 days which, subject to copy of \$250 individual/\$425 maximum per contract per calendar year. Behavioral Health Care Management must pre-approve all care.	In-network: Covered in full up to 60 visits which may include 20 family counseling visits per calendar year. Behavioral health care management must pre-approve all care. In-network inpatient up to 7 days days per calendar year, 30 days which, subject to copy of \$250 individual/\$425 maximum per contract per calendar year. Behavioral Health Care Management must pre-approve all care.	Inpatient: \$300/\$750 copay max per year with no limit on number of days for biologically based conditions, 30 day limit for non-biologically based conditions. Outpatient: Treatment for biologically based conditions: \$15 copay, unlimited						