BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
ACUPUNCTURIST/ ACUPRESSURE	Not a covered hospital charge. See Major Medical columns for coverage.	Services of a Network provider when prescribed by a doctor are covered after you pay the copayment. Benefits are available during the active phase of treatment. Benefits are terminated in the maintenance phase when no further improvement in the condition can be reasonably expected.	Services of a duly licensed acupuncturist when prescribed by a doctor during the active phase of treatment are covered at 80% of reasonable and customary, after the deductible. There are no benefits for the maintenance phase when no further improvement in the condition can be reasonably expected.
AMBULANCE 			
AIR AMBULANCE SERVICE  **(*MUST BE CERTIFIED WITHIN 48 HOURS OF TRANSPORT WHEN AIR AMBULANCE IS USED TO TRANSPORT FROM ONE FACILITY TO ANOTHER – ALL COVERAGE IS SUBJECT TO MEDICAL NECESSITY.)*** **Coverage is provided to the nearest available facility able to provide the required medical treatment.**	Not a covered hospital charge. See Major Medical columns for coverage.	The traditional major medical benefit applies whether you use an air or ground ambulance.	Air ambulance is covered in full if use of land transport would pose a threat to health or cannot be provided due to distance. Use of an air ambulance for purposes of transporting from one facility to another must be pre-certified within 48 hours of services. To pre-certify, call EBCBS at 1-800-939-7515.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
GROUND AMBULANCE SERVICE	Not a covered hospital charge. See Major Medical columns for coverage.	The traditional major medical benefit applies whether you use an air or ground ambulance.	The cost of local, professional ambulance services in excess of $35.00 are covered. The cost of an organized voluntary ambulance service is covered for up to a maximum of $50.00 for under fifty (50) miles and $75.00 for over fifty (50) miles. This benefit is not subject to the deductible or 20% copayment.
ALLERGY TESTING & TREATMENT	Not a covered hospital charge. See Major Medical columns for coverage.	There is no copayment for professional services for allergy immunization or allergy serum when billed by a participating provider. If there is an associated office visit, a copayment will apply.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are also responsible for the charges above reasonable and customary fees.
AMBULATORY SURGERY	**In-network Hospital** Covered in full subject to $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Surgery performed at a Network Ambulatory Surgery Center is subject to a $15.00 copayment, which covers the facility, same-day on-site testing and anesthesiology charges.	After the deductible, EMHP pays 80% of reasonable and customary facility charges. You are also responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
ANESTHESIA			
ANESTHESIA (in-hospital)	**In-network Hospital** Covered in full **Out-of-Network Hospital** Not a covered hospital charge. See Major Medical columns for coverage.	In-hospital anesthesia for surgery or maternity care is covered in full, as long as the anesthesiologist is either a Network provider or the services are rendered at an in-network hospital. If not, the anesthesiologist's charges should be submitted under the traditional major medical coverage.	After the deductible, EMHP pays 80% of reasonable and customary charges of a non-participating anesthesiologist in an out-of-network hospital. You are also responsible for the charges above reasonable and customary fees.
ANESTHESIA (in-office)	Not a covered hospital charge. See Major Medical columns for coverage.	Certain minor surgical procedures can be performed in a doctor's office and will be paid in full. When an anesthesiologist's services are used, their charges are typically included in the doctor's fees for the procedure. You must confirm this directly with your doctor, however.	After the deductible, EMHP pays 80% of reasonable and customary charges by a non-participating anesthesiologist. You are also responsible for the charges above reasonable and customary fees.
ANNUAL MAXIMUM	**Not applicable**	When you use an in-network provider, there is no annual or lifetime maximum on the benefits available.	The traditional major medical coverage has an annual maximum benefit of $ 1,250,000 for calendar year 2012. Each covered family member has a separate annual maximum benefit. There is no lifetime maximum.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
ANNUAL PHYSICAL	Not a covered hospital charge. See Major Medical Columns for coverage.	Annual physical exams performed by a Network provider are covered in full after you pay the copayment.	If you or your enrolled spouse/domestic partner are age fifty (50) and older, you will be reimbursed up to $250.00 once every calendar year for physical exams. This benefit is not subject to the deductible or copayment. No coverage for physical exams is provided for retirees or enrollees under age fifty (50) except as otherwise specifically covered.
ASSISTANT SURGEON	Not a covered hospital charge. See Major Medical columns for coverage.	Services will be covered at 100%.	After the deductible, EMHP pays 80% of reasonable and customary charges by a non-participating surgical assistant. You are also responsible for the charges above reasonable and customary fees.
BIRTH CONTROL (insertion of IUD, injections for Dep-Provera and diaphragm fittings)	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	If services are performed in a network provider's office, covered in full after payment of the appropriate copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are also responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
BLOOD TRANSFUSIONS NOTE: EMHP will not pay for services rendered in connection with the drawing, processing, disposal and/or storage of blood drawn from the enrollee, or from a donor selected by the enrollee, for the enrollee's own use unless it is medically documented to the satisfaction of EBCBS that the enrollee's condition requires the use of autologous or directed blood.	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered as out of network benefit only.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are also responsible for the charges above reasonable and customary fees.
BONE DENSITY TEST	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	A bone density test performed by a network provider is covered in full after the appropriate copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are also responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
CARDIAC REHABILITATION  ***(YOU MUST PRE-CERTIFY)***	**In-network Hospital** Covered as outpatient only. **Out-of-Network Hospital** Not covered	If your doctor prescribes cardiac rehabilitation, then you must obtain pre-certification to be covered in full after payment of the copayment for each visit to a participating cardiac rehabilitation center, and you receive the care on an outpatient basis. This copayment includes use of the facility and services you receive from nurses and doctors who monitor the program. You will not be required to pay more than two (2) copayments for multiple services, however. However, there is no copayment for visits to an in-network, hospital-based cardiac rehabilitation center that has an agreement in effect with EBCBS on the date of your visit.	Pre-certified visits for cardiac rehabilitation in facilities that are not hospital-based or do not have an agreement with EBCBS are covered when prescribed by a doctor, subject to deductible, 20% copayment and charges above the plan's reasonable and customary limits. .
CHEMOTHERAPY	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When this service is performed in a Network provider's office, it is covered in full with no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges for chemotherapy. You are also responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
CHIROPRACTIC CARE  ***(YOU MUST PRE-CERTIFY)***	Not a covered hospital charge. See Major Medical columns for coverage.	Services of a Network provider are covered after you pay the copayment. An additional copayment is required for necessary related x-rays done at the time of the visit. There is a maximum of two (2) copayments per visit. Benefits are available during the active phase of treatment. Benefits are terminated in the maintenance phase when no further improvement in the condition can be reasonably expected. For coverage to be extended beyond the 15th visit, it must be a continuation of the active phase AND pre-certified by EBCBS.	Services of a duly licensed chiropractor will be covered for manual manipulation of the spine to correct a subluxation that can be shown by an x-ray and other services prescribed by a doctor during the active phase of treatment. There are no benefits for the maintenance phase when no further improvement in the condition can be reasonably expected. **For coverage to be extended beyond the 15th visit, it must be a continuation of the active phase AND pre-certified by EBCBS.**
CHOLESTEROL SCREENING	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Cholesterol screening performed by a participating provider is covered in full, with no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are also responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
CLINIC	**Not covered unless owned and operated by a Hospital**	There is no in-network coverage for services rendered at a clinic.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are also responsible for the charges above reasonable and customary fees.
COCHLEAR IMPLANTATION	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered in full after the appropriate copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are also responsible for the charges above reasonable and customary fees.
COLON CANCER SCREENING (lab tests)	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Colon cancer screening performed by a participating provider is covered in full, with no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are also responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
COLON CANCER SCREENING (surgical procedure, i.e., routine sigmoidoscopy and colonoscopy)	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Colon cancer screening performed by a participating provider is covered in full, after payment of the applicable copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are also responsible for the charges above reasonable and customary fees.
DIABETIC SUPPLIES	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	The cost of diabetic supplies such as syringes, lancets and test strips are covered in full after you pay a copayment equal to 10% of the cost.	The cost of diabetic supplies such as syringes, lancets and test strips are covered in full after you pay a copayment equal to 10% of the cost.
DIAGNOSTIC X-RAY **Payment of benefits is subject to the Program Requirements. (See page 70.)**	**In-network Hospital** Inpatient: Not Covered Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Diagnostic x-ray examinations performed in a Network doctor's office are paid in full after you pay the copayment. There is a maximum of two (2) copayments for multiple x-ray services performed during one office visit.	After the deductible, EMHP pays 80% of reasonable and customary charges for the diagnostic x-ray services. You are also responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
DIAGNOSTIC TESTING (Magnetic Resonance Imaging (MRI); Angiography (MRA); CAT-scan; PET-scan; Cardiac computer tomography angiography (CTA or CT Scans); and Nuclear Testing	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Diagnostic testing performed in a Network doctor's office are paid in full after you pay the copayment. There is a maximum of two (2) copayments for multiple services performed during one office visit.	After the deductible, EMHP pays 80% of reasonable and customary charges for diagnostic services. You are also responsible for the charges above reasonable and customary fees.
DURABLE MEDICAL EQUIPMENT	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	The cost of durable medical equipment is paid in full after you pay a copayment equal to 10% of the cost of purchasing or renting same. Coverage is also provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.	After the deductible, EMHP pays 80% of reasonable and customary cost of purchasing or renting durable medical equipment, whichever is more appropriate. You are also responsible for the charges above reasonable and customary fees. Coverage is also provided for any repairs and necessary maintenance not provided for under a manufacturer's warranty or purchase agreement.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
EMERGENCY ROOM SERVICES			
FOR PPO ENROLLEES AND FOR POS ENROLLEES: ***IN-AREA EMERGENCY ROOM SERVICES*– Includes facility/hospital room use charges; attending ER physician; radiology and pathology charges; and anesthesiology charges** *(See page 65 for important details on limitations of coverage of Emergency Care)*	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered in full for services rendered by attending ER physician, radiology and pathology charges and anesthesiology charges. **Coverage of all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.) depends on the provider's network status.**	Covered in full for services rendered by attending ER physician, radiology and pathology charges and anesthesiology charges only. **Coverage of all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.) depends on the provider's network status.** If non-participating, then plan pays after the deductible, at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
FOR PPO ENROLLEES: ***OUT OF AREA EMERGENCY ROOM SERVICES*** *(See page 65 for important details on limitations of coverage of Emergency Care)*	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered in full for services rendered by attending ER physician, radiology and pathology charges and anesthesiology charges. **Coverage of all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.) depends on the provider's network status.**	Covered in full for services rendered by attending ER physician, radiology and pathology charges and anesthesiology charges only. **Coverage of all other medical service providers, such as specialists (cardiologist, plastic surgeon, orthopedist, etc.) depends on the provider's network status.** If non-participating, then plan pays after the deductible, at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
FOR POS ENROLLEES: ***OUT OF AREA EMERGENCY ROOM SERVICES*** *(See page 66 for important details on limitations of coverage)*	Covered in full	Covered in full	Covered in full
ENTERAL FORMULA  ***(YOU MUST PRE-CERTIFY)***	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100 % with no copayment.	Paid at 50% of in-network cost, after deductible.
EYE CARE/GLASSES FOLLOWING CATARACT SURGERY	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100% with no copayment.	The EMHP covers one pair of prescription eyeglasses or contact lenses and one eye examination within twelve (12) months of cataract surgery. After the deductible, these expenses are reimbursed at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
FOOT ORTHOTICS Orthopedic shoes and other supportive devices, and services are covered when necessary for treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions. Replacements will be allowed, as medically necessary, once every twelve (12) months for enrollees under the age of eighteen (18) and once every twenty-four (24) months for enrollees over the age of eighteen (18). The device must be medically necessary and prescribed by a doctor or podiatrist.	Not a covered hospital charge. See Major Medical columns for coverage.	Foot orthotics dispensed by a participating provider are covered in full, up to $300, with no copayment. The plan benefit provides for one orthotic device per affected body part meeting the individual's functional needs.	After the deductible, foot orthotics are paid at 80% of reasonable and customary charges. The maximum allowable benefit is $300.00.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
HEARING AIDS	Not a covered hospital charge. See Major Medical columns for coverage.	The cost of hearing aids, including examination for and fitting of, are covered. The maximum benefit is up to $3,000.00 per covered individual, payable once during the frequency limitation period, upon the placement of a covered hearing aid appliance. This amount is the total allowance for reimbursement without the per ear limitation. Frequency Limitation: Reimbursement will only be allowed once every thirty-six (36) months; for enrollees twelve (12) and under, once every twenty-four (24) months, if existing hearing aid can no longer compensate for the child's hearing loss. This benefit is not subject to the deductible for copayment.	The cost of hearing aids, including examination for and fitting of, are covered. The maximum benefit is up to $3,000.00 per covered individual, payable once during the frequency limitation period, upon the placement of a covered hearing aid appliance. This amount is the total allowance for reimbursement without the per ear limitation. Frequency Limitation: Reimbursement with only be allowed once every thirty-six (36) months; for enrollees twelve (12) and under, once every twenty-four (24) months, if existing hearing aid can no longer compensate for the child's hearing loss. This benefit is not subject to the deductible or copayment.
HEMO (KIDNEY) DIALYSIS	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered at 100% with no copayment.	After the deductible, these expenses are reimbursed at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
HOME DOCTOR VISITS	Not a covered hospital charge. See Major Medical columns for coverage.	Once you pay the copayment, the EMHP pays the contractual rate for services provided by a Network provider at home. There is a maximum of two copayments for multiple services provided during one visit. Covered services include: • general medical care • diagnostic services • treatment of illness • allergy desensitization • physical exams	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
HOME HEALTH CARE and IN-HOME SERVICES  ***(ALL SERVICES AND SUPPLIES MUST BE PRE-CERTIFIED)***			
Lab and therapy services Laboratory, physical, occupational and/or speech therapy services provided by or on behalf of the home care agency are covered.	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100% with no copayment.	After the deductible, these expenses are reimbursed at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
Medical Supplies	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100% with no copayment.	After the deductible, these expenses are reimbursed at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
Nursing Services Coverage is not provided for assistance with daily living, companionship or care, which a less skilled person such as a home health aide could provide. The first forty-eight (48) hours of service in a calendar year are not covered by the EMHP. This coverage does not include the services of a private duty nurse while hospitalized.	Not a covered hospital charge. See Major Medical columns for coverage.	You are covered in full with no copayment for part-time or intermittent visits by Network nurses or by registered nurses (RNs) from accredited Network nursing agencies.	Services of an R.N. (Registered Nurse) or L.P.N. (Licensed Practical Nurse) if no R.N. is available, are covered if the care is prescribed by your doctor when care is needed to manage medical problems of an acutely ill patient. After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
Prescription Drugs & Home Infusion Therapy	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100% with no copayment.	After the deductible, these expenses are reimbursed at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
HOSPICE  ***(YOU MUST PRE-CERTIFY)*** Covered when provided by a hospice organization certified under New York State law, or comparable certification if outside of NYS.	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Services of a Network doctor given in connection with treatment of the terminally ill are only covered if provided in a Network hospice; services are paid in full, with no copayment.	Benefits for hospice services are not available if provided by an out-of-network provider or facility.
IMMUNIZATIONS – ADULT Covered immunizations include: influenza; pneumonia; measles-mumps-rubella (MMR); varicella (chicken pox); tetanus immunizations; Human Papilloma Virus (HPV) immunizations for cervical cancer prevention(covered between ages 9 through 26); meningitis immunizations (covered for dependent students age 19 and over); Zostavax or Zoster vaccine (available for covered members age 60 and older, for shingles); and LymeRix (Borrelia burgdorferi for Lyme's Disease).	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100% after appropriate copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
IMMUNIZATIONS – CHILDREN (*See also Routine Pediatric Care)* 1) Vaccines and injectable substances for dependent children under the age of nineteen (19) are covered. 2) The cost of oral and injectable substances for routine preventive pediatric immunizations is covered. 3) Influenza vaccine is included in the list of covered pediatric immunizations.	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100% after appropriate copayment. However, if immunizations are received during a well-child office visit, there is no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
INFERTILITY - INVITRO/GIFT/ZIFT AND ARTIFICIAL INSEMINATION  ***(YOU MUST PRE-CERTIFY)*** Benefits are more fully described at page 88.	Not a covered hospital charge. See Major Medical columns for coverage.	Covered in full with no copayment.	No coverage
IN-HOSPITAL DOCTOR VISITS	Not a covered hospital charge. See Major Medical columns for coverage.	Network doctors' visits in the hospital not related to surgery are covered in full with no copayment. (Surgery-related visits are included in the scheduled amount for surgery.)	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
INJECTIONS/BIOLOGICALS	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Injections performed by a Network doctor in his/her office are covered in full, with no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
LABORATORY TESTS	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Diagnostic Laboratory work is covered in full with no copayment, when using a Network provider.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
LIFETIME MAXIMUM	There is no lifetime maximum	There is no lifetime maximum	There is no lifetime maximum

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
MAMMOGRAPHY BENEFIT	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Mammographies performed by a Network provider are covered in full under the following conditions after you pay the copayment: • a doctor recommends a mammogram for a covered person of any age who has a prior history of breast cancer or whose parent or sibling has prior history of breast cancer; • A single base line mammogram for covered persons age thirty-five (35) through thirty-nine (39); or • A mammogram every year for covered persons age forty (40) or older, or more frequently if a doctor recommends.	After the in-network copayment, mammographies are paid at 100% of reasonable and customary charges under the following conditions: • Any time a doctor recommends a mammogram for a covered person of any age who has a prior history of breast cancer or whose parent or sibling has a prior history of breast cancer; • A single baseline mammogram for a covered person age thirty-five (35) through thirty-nine (39); or • A mammogram every year for a covered person age forty (40) or older or more frequently if a doctor recommends.
MASTECTOMY PROSTHESES (EXTERNAL)  **(*YOU MUST PRE-CERTIFY*)** For any single prosthesis costing $1,000 or more. Includes mastectomy sleeves and adhesive skin supports. Covered once each calendar year for one single or double external mastectomy prosthesis, sleeve and/or adhesive skin support. Coverage of mastectomy bras are limited to four (4) per calendar year	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100% with no copayment.	Covered at 100%, with no deductible or copayment.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
MATERNITY CARE  ***(YOU MUST PRE-CERTIFY WITHIN 48 HOURS OF THE BIRTH OF YOUR CHILD)*** *Whether services are provided in-network or out-of-network, call Empire BlueCross BlueShield's Medical Management Program at 1-800-939-7515 within the first three months of a pregnancy. This will ensure that you receive maximum benefits. See page 62 for additional information.*	Includes in-patient hospital coverage for mother and for newborn for at least forty-eight (48) hours after childbirth for any delivery other than a cesarean section, and for at least ninety-six (96) hours following a cesarean section. **In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network** 10% of billed charges or $75 (whichever is greater); Up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	The care you receive from a Network provider in connection with pregnancy before and after childbirth including complications is covered in full, after the appropriate copayment payable only at the initial visit. Care may be provided by a Network doctor or a certified nurse midwife whose license or certificate allows for the practice as a nurse midwife under the laws of the state in which services are provided.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
MEDICAL REHABILITATION  ***(YOU MUST PRE-CERTIFY)***	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Not covered	Covered @ 80%, Subject to deductible when benefits are exhausted under the hospital benefits program

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
MEDICAL SUPPLIES	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered at 90% of cost.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
MODIFIED SOLID FOOD PRODUCTS 1) Must be prescribed by a physician. 2) Total maximum reimbursement is $2500 per covered person per calendar year.	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100% with no copay, up to annual maximum of $2,500 per covered per calendar year.	Covered at 100% with no deductible or copay, up to an annual maximum of $2,500 per covered per calendar year.
NEWBORN (ROUTINE CARE OF NEWBORN)	**In-network Hospital** Covered during the mother's stay **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children.	Covered at 100% with no copay. Doctor services for routine care of newborns in a hospital are reimbursed up to $150.00 with no deductible or copayment.	Doctor services for routine care of newborns in a hospital are reimbursed up to $150.00 with no deductible or copayment.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
NEWBORN (SICK)  ***(YOU MUST PRE-CERTIFY)***	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered at 100% after appropriate copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
NURSE PRACTITIONERS A nurse practitioner is a person legally licensed as a Nurse Practitioner (NP) or Registered Nurse Practitioner (RNP) and authorized to examine patients; and establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who: 1. Acts within the scope of his or her license; and 2. Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.	Not a covered hospital charge. See Major Medical columns for coverage.	Services performed by a Network nurse practitioner are paid in full after you pay the copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
NURSE MIDWIFE SERVICES	Not a covered hospital charge. See Major Medical columns for coverage.	The care you receive from a Network provider in connection with pregnancy before and after childbirth including complications is covered in full. Care may be provided by a Network doctor or a certified nurse midwife whose license or certificate allows for the practice as a nurse midwife under the laws of the state in which services are provided.	Care you receive from a certified nurse midwife whose license or certificate allows for the practice of nurse midwife under the laws of the state in which services are provided is covered. After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
NUTRITIONAL COUNSELING The Plan will pay for covered health services for medical education services provided in a physician's office by an appropriately licensed or healthcare professional when: - education is required for a disease in which patient self-management is an important component of treatment; and - there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.	Not a covered hospital charge. See Major Medical columns for coverage.	Nutritional counseling performed by a participating provider is covered in full, after payment of the applicable copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
OFFICE DOCTOR VISITS	Not a covered hospital charge. See Major Medical columns for coverage.	Once you pay the copayment, the EMHP pays the contractual rate for services provided by a Network provider in the office. There is a maximum of two copayments for multiple services provided during one visit. Covered services include: • general medical care • diagnostic services • treatment of illness • allergy desensitization • physical exams	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
PAP SMEAR (Cervical Cytology Screenings)	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Covered once per calendar year in full, with no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
PHYSICAL THERAPY ***(See Therapy – Physical)***			

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
PODIATRY Services of a duly licensed podiatrist are covered for treatment of diseases, injuries and malformations of the foot. Services and supplies for treatment of corns, calluses or toenails, including cutting or removal, are covered only if prescribed by a doctor who is providing treatment for a metabolic disease.	Not a covered hospital charge. See Major Medical columns for coverage.	You are covered in full after you pay the copayment for services of a Network provider. Benefits are not available for routine foot care.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
PRE-SURGICAL TESTING ***(Surgery must take place within 14 days after the tests are performed.)***	**In-network Hospital** Covered in full **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Not covered. See out of network major medical column for coverage.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
PROSTATE CANCER SCREENING (PSA)	Not a covered hospital charge. See Major Medical columns for coverage.	Covered in full, with no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
PROSTHETICS	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100% with no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
RADIATION THERAPY **(*See Therapy – Radiation)***			

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
RECONSTRUCTIVE SURGERY Covered services include: • Reconstructive surgery to restore or improve a body function when the functional impairment is the direct result of one of the following: - Birth defect - Sickness - Accidental injury - Reconstructive breast surgery following a medically necessary mastectomy (including surgery and reconstruction of the remaining breast to produce a symmetrical appearance following the mastectomy: - Reconstructive surgery to remove or revise scar tissue if the scar tissue is due to sickness, accidental injury or any other medically necessary surgery.	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When these services are performed by a Network provider, they are covered in full, after payment of the appropriate co-payment. -	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
RESPIRATORY THERAPY ***(See Therapy – Respiratory)***			
ROUTINE CARE OF NEWBORNS ***(See Newborns)***			

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
ROUTINE PEDIATRIC CARE (a.k.a. WELL CHILD CARE) Covered up to age 19. Vaccines and injectable substances are also covered. Influenza vaccine is included in the list of covered pediatric immunizations.	Not a covered hospital charge. See Major Medical columns for coverage.	There is no copayment for well-child office visits, including routine pediatric examinations, pediatric immunizations and the cost of oral and injectable substances, according to pediatric care guidelines.	Doctor visits for routine pediatric care (well-child care), physical examinations, and immunizations of an enrolled dependent who is under nineteen (19) are covered, after the deductible, at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
SECOND SURGICAL OPINION Patient may seek second opinion for scheduled surgical procedure. Patient must call EBCBS for three doctors and use one of three referred for coverage. If second opinion surgeon performs surgery, patient pays 100% of cost for second opinion. There is NO COVERAGE for inpatient second surgical opinion.	Not a covered hospital charge. See Major Medical columns for coverage.	When provided by a network physician, covered in full, with no copayment.	Covered in full with no deductible or copayment.
SKILLED NURSING FACILITY  **(YOU MUST PRE-CERTIFY)** **Benefits are not available for skilled nursing facilities if Medicare is primary.**	**In-network Hospital** Inpatient: Two (2) days of covered confinement in a skilled nursing facility will count as one (1) day of hospital confinement. **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	The cost of covered Network doctor services while you are confined in a skilled nursing facility are covered in full with no copayment. **Benefits are not available for skilled nursing facilities if Medicare is primary.**	The EMHP covers the cost of doctor services while you are confined in a skilled nursing facility after the deductible, at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees. **Benefits are not available for skilled nursing facilities if Medicare is primary.**

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
SPECIALIST CONSULTATIONS: ***Consultations in the fields of pathology, roentgenology and anesthesiology are not covered.***			
SPECIALIST CONSULTATION (inpatient and office)	Not a covered hospital charge. See Major Medical columns for coverage.	One (1) in-hospital consultation in each specialty per confinement for each condition treated. Covered at 100% after the appropriate copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
SPECIALIST CONSULTATION (outpatient)	Not a covered hospital charge. See Major Medical columns for coverage.	Covered in full, as follows: one outpatient consultation in each specialty per calendar year for each condition being treated.	One outpatient consultation in each specialty per calendar year for each condition being treated is covered after the deductible, at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
SURGERY ***(See section entitled AMBULATORY SURGERY for coverage of surgery performed in an ambulatory surgery center)***			
IN-OFFICE SURGERY	Not a covered hospital charge. See Major Medical columns for coverage.	Surgery performed in a Network doctor's office is covered in full after you pay the copayment. Inpatient surgery is covered in full as long as it is not a surgery which must be done on an outpatient basis. (See Program Requirements, page).	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
IN-PATIENT AND OUTPATIENT SURGERY  ***(YOU MUST PRE-CERTIFY)***	**Facility Charges:** **In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	**Surgeon's charges:** Covered at 100%, with no copayment.	**Surgeon's charges**: After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
TEMPORO MANDIBULAR JOINT DYSFUNCTION (TMJ) In addition to surgery, services for TMJ are covered for the following conditions which are consistent with the diagnosis of organic pathology of the joint and can be demonstrated by x-ray: • degenerative arthritis • osteoarthritis • ankylosis • tumors • infections, or • traumatic injuries. For TMJ, covered services include: diagnostic exams, x-rays, models and testing, injections of medications, and trigger point injection. Appliances related to TMJ are not covered.	Not a covered hospital charge. See Major Medical columns for coverage.	Covered at 100%, after the appropriate copayment. Covered services include diagnostic exams, x-rays, models and testing, injections of medications and trigger point injection. TMJ appliances are not covered.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
THERAPY/REHABILITATION SERVICES (PHYSICAL, OCCUPATIONAL, SPEECH*, VISION#)  ***(YOU MUST PRE-CERTIFY)*** ****Speech therapy is not covered for learning problems or developmental speech impediments with no medical cause*** ***# Routine vision care is not covered***	**Occupational, speech or vision therapy, or any combination of these, are not covered under Hospital benefits** **Physical Therapy Benefits:** **In-network Hospital** Inpatient: Covered in full with no copayment Outpatient*: Subject to $25 copayment. Benefits are available for outpatient physical therapy in a hospital-based facility only when the following conditions are met: • The treatments are ordered by a doctor; **and** • The treatments are in connection with the same illness for which you had previously been hospitalized or related to inpatient or outpatient surgery; **and** • The treatments must start within six (6) months from your discharge from the hospital or within six (6) months from the date surgery was performed: **and** • No payment will be made for physical therapy given after three hundred sixty-five (365) days from the date you were discharged from the hospital or the date of surgery. ****Unless treatment is given at a free standing facility, treatment must start within 6 months of date of discharge from hospital or surgery for duration of no more than 365 days after discharge or surgery.*** **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	Services rendered during the active phase of treatment are covered at 100%, after the appropriate copayment. You must obtain pre-certification for coverage of visits after the 20th. To pre-certify, call EBCBS at 1-800-939-7515.	Charges for physical, occupational and speech therapies and rehabilitation services during the active phase of treatment are covered after the deductible, at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees. You must obtain pre-certification for coverage of visits after the 20th. To pre-certify, call EBCBS at 1-800-939-7515.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
THERAPY – RADIATION	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When these services are performed in a Network provider's office they are covered in full with no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
THERAPY - RESPIRATORY	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When these services are performed in a Network provider's office they are covered in full with no copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.

BENEFIT	HOSPITAL BENEFITS	IN-NETWORK MAJOR MEDICAL	OUT OF NETWORK MAJOR MEDICAL (Traditional Major Medical Coverage)
1/2012			
TRANSPLANTS* (Organ, tissue, bone marrow)  ***(YOU MUST PRE-CERTIFY)*** **** Travel and lodging expenses are not covered***	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	When these services are performed in a Network provider's office they are covered at 100%, after the appropriate copayment.	After the deductible, EMHP pays 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
VOLUNTARY STERILIZATION* **** Reversals are not covered***	**In-network Hospital** Inpatient: Covered in full Outpatient: Covered in full after a $25 copayment **Out-of-Network Hospital** 10% of billed charges or $75 (whichever is greater); up to a combined annual inpatient/outpatient maximum of $1,500 for member; $1,500 for spouse/domestic partner; $1,500 combined for dependent children	In the office covered at 100%, after the appropriate copayment.	Charges for voluntary sterilization are covered after the deductible, at 80% of reasonable and customary charges. You are responsible for the charges above reasonable and customary fees.
WELL CHILD CARE ***(See Routine Pediatric Care)***			
WIGS & TOUPEES (for Chemotherapy patients only)		Covered in full up to a maximum of $300 per calendar year.	After the deductible, EMHP pays 80% of reasonable and customary charges. Maximum benefit is $300 per calendar year. You are responsible for the charges above reasonable and customary fees and $300.