

TEIGIT EmblemHealth/GHI Plans Comparison

Plan	EPO HSA		PPO HSA		GHI Small Business Advantage Plan	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
In-Network?	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Deductibles:	\$5,800	In-Network Only	\$5,000	\$10,000	\$500	\$1,000
Copay/Coinsurance	100%	In-Network Only	100%	80%/20%	\$30	75%/25%
Inpatient Hospital Services*						
Hospital Coverage	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	Base Hospital Coverage	\$1,000 Hospital Copay and 25% Coinsurance
Skilled Nursing	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	Covered in Full	25% Coinsurance
Maternity and Routine Nursery Care	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	Base Hospital Coverage	\$1,000 Hospital Copay and 25% Coinsurance
Hospice Care	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Covered in network only	Covered in Full	In-Network only
Outpatient Hospital Services*						
Ambulatory Surgery	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	Covered in Full after \$100 copayment	25% Coinsurance after \$100 copayment
Home Health Care	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	Covered in Full	In-Network only
Medical Services						
Home and Office Visits	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	\$30 Copayment	In-Network only
Annual Physical Check-up	Covered in Full	In-Network Only	Covered in Full	Deductible/Coinsurance	\$30 Copayment	In-Network only
Well-baby and Well-child Care up to Age 19	Covered in Full	In-Network Only	Covered in Full	Deductible/Coinsurance	Covered in Full	25% Coinsurance
PT/OT/Speech Therapy	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	\$30 Copayment	In-Network only
Lab and Radiology Services						
Diagnostic Lab Tests and Radiology Procedures	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	\$30 Copayment	In-Network only
Emergency Services						
ER Professional Charge	Deductible/Coinsurance	Up to allowed charge, subj to deductible/ coinsurance	Deductible/Coinsurance	Up to allowed charge, subj to deductible/ coinsurance	Covered in Full	Covered up to Allowed Charge
Emergency Facility Charge (Waived if Admitted)	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Allowed Charge, subject to the in-network Deductible & Coinsurance	\$100 Copayment	\$100 Copayment up to Allowed Charge
Mental Health and Chemical Dependency Services*						
Inpatient/Outpatient Mental Health	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	Not Covered	Not Covered
Outpatient Chemical Dependency Treatment	Deductible/Coinsurance	In-Network Only	Deductible/Coinsurance	Deductible/Coinsurance	\$30 copayment	25% Coinsurance
Pharmacy						
30 days	No charge after deductible	In-Network only	No charge after deductible	In-Network only	\$10/50%/50%	In-Network only
Mail rx (90 days)					\$20/50%/50%	

This chart is not a complete benefit description or contract and should only be viewed as a summary to assist you in understanding these programs. Coverage is subject to all terms, conditions, limitations and exclusions of the Certificate of Insurance. In the event of any inconsistency between this brochure and the Certificate of Insurance, the Certificate of Insurance