PPO PLAN 9

Description of Medical Benefits

$2,000/$4,000 Deductible, 80% / 70% Coinsurance

		In-Network	Out-Of-Network
Deductible	(single/family)	$2,000/$4,000	
Coinsurance		80%	70%
Coinsurance Maximum OOP (excl. deductible)	(single/family)	$1,000/$1,000	$2,100/$2,100
Calendar Year Maximum Benefit		$5,000,000	

After the Annual Deductible is met, the coinsurance for in-network benefits is 80% (for out-of-network benefits 70%) until the coinsurance maximum out of pocket of $1000 in-network ($2,100 for out-of-network) is reached, then the coinsurance is 100% for in & out-of-network.

Note: *Out of Network Services are subject to additional out of pocket expense as a result of Balance Billing by your Provider of the difference between PerfectHealth's "Allowed Amount" vs "Actual Billed Charges".*

NETWORK PLAN OPTIONS	NETWORK	*Providers*	*Hospitals*
9 D	Diamond	MultiPlan	GHI
9 P	Platinum	MultiPlan	HIP

PREVENTIVE CARE		*After Deductible*	*After Deductible*
Well Child Care (including immunizations)	Benefits are in accordance with the recommendations of the American Academy of Pediatrics and the Advisory Committee on Immunization Practices*	100% Coinsurance (deductible waived)	100% Coinsurance (deductible waived)
Mammography	1 baseline age 35-39 1 screening per year age 40+ Screening at any age with prior history or family history	80%	70%
Routine OB/GYN visits	1 routine exam per year including pap smear	80%	70%
Colorectal Cancer Screening	1 screening per year age 50+	80%	70%
Bone Mineral Density Test		80%	70%
Prostate Cancer Screening	Screening at any age with prior history-1 Screening per year age 40+ with family history- 1 screening per year age 50+	80%	70%
Routine Exams	Up to $250 per year**	Up to $250 per year (deductible waived)**	70%

MEDICAL CARE		*After Deductible*	*After Deductible*
Medical office visits		80%	70%
Specialist consultations		80%	70%
Laboratory		80%	70%
X-ray and diagnostic tests		80%	70%
Rehabilitative services (physical, occupational and speech therapy)		80%	70%
Spinal manipulation		80%	70%
Allergy testing and treatment		80%	70%
Services of the physician, surgeon, anesthesiologist, radiologist, pathologist		80%	70%
Diabetic equipment, supplies, and self-management education		80%	70%
Foot Care, other than routine care	Up to $2,000 per year	80%	70%
Organ Transplant	Up to $250,000 lifetime benefit	80%	70%

HOSPITAL CARE	*******Precertification is required***	*After Deductible*	*After Deductible*
Room and Board	Semi-private room	80%	70%
Intensive Care		80%	70%
Other In-Hospital Services		80%	70%
Outpatient surgery		80%	70%
Preadmission Tests		80%	70%
Maternity and newborn care	Automatic newborn coverage for first 31 days. Service of certified nurse midwife included	80%	70%
Medication dispensed while inpatient		80%	70%
Private duty nurse	Up to $125 per day	80%	70%

*At the present time the benefits are : 11 exams for children between birth and 2 years old, and 1 exam every year from age 2 through 18 years old.

**Benefits are in accordance with the recomendation of the U.S. Preventive Service Task Force for adults age 19 and over, as recommended by a doctor every 1-3 years.

***Precertification is required for hospital admissions, certain elective procedures, and other services as specified by the Plan. Insureds are responsible for obtaining pre-certification for the required services. Non-Compliance Benefit Reduction Penalty applies.

PPO PLAN 9

Description of Medical Benefits

$2,000/$4,000 Deductible, 80% / 70% Coinsurance

Description of Medical Benefits (continued)

After the Annual Deductible is met, the coinsurance for in-network benefits is 80% (for out-of-network benefits 70%) until the coinsurance maximum out of pocket of $1000 in-network ($2,100 for out-of-network) is reached, then the coinsurance is 100% for in & out-of-network.

		In-Network	Out-Of-Network
EMERGENCY CARE		***After Deductible***	***After Deductible***
Emergency Room*		80%	70%
Local Ambulance		80%	70%
Other Transportation	Up to $2,500 for any one hospital confinement, and must be medically necessary	80%	70%

OTHER HEALTH CARE		***After Deductible***	***After Deductible***
Prosthetic devices		80%	70%
Durable medical equipment	Up to $10,000 lifetime benefit	80%	70%
Convalescent Care Facility	50% of hospital semi-private room rate, and up to 90 days for any one injury or sickness	80%	70%
Infertility	Hospital, surgical and medical care for the diagnosis and treatment of correctable medical conditions causing infertility	80%	70%
Hospice Care	Up to 210 days	80%	70%
Home Health Care		80%	70%

MENTAL HEALTH/ALCOHOLISM/SUBSTANCE ABUSE		***After Deductible***	***After Deductible***
Mental health - inpatient	Up to 30 days per year	80%	70%
Mental Health - outpatient	Up to 20 visits per year	80%	70%
Mental Health - treatment for adults and children with biologically based mental illness		80%	70%
Mental Health - treatment for children with serious emotional disturbances		80%	70%
Alcoholism/Substance Abuse - inpatient	Up to 30 days per year. Up to 7 days per year in a detoxification facility	80%	70%
Alcoholism/Substance Abuse - outpatient	Up to 60 visits per year - 20 visits may be for family members	80%	70%

CASE MANAGEMENT
The Case Management Program is available when special assistance is needed. Benefit Reduction Penalty applies for refusal to participate in the Case Management Program.

SERVICES NOT ASSOCIATED WITH A PROVIDER NETWORK	
Prescription Drugs and Medicines	After the ded. is met, paid at 70% up to the OON coinsur max, then paid at 100%

REIMBURSEMENT
PPO: This plan will pay out of network providers a comparable reimbursement level as would have been paid to an in network provider for the same service.

Emergency Room Services provided by non participating Hospital Based Physicians such as Radiologists; Pathologists; Anesthesiologists etc which are performed in an in network participating facility **only will be considered in accordance with your in network deductible and coinsurance (if applicable). In an out of network facility, these services will be considered in accordance with your out of network deductible and coinsurance (if applicable). However, the out of network Facility as well as the Hospital Based Physician may bill you for the difference between our Allowance and their Billed Charges.*

EXCLUSIONS

This plan does not cover expenses for:

- *medical care not recommended and approved by a doctor, or received in an U.S. Government owned and operated facility.*
- *medical care for cosmetic purposes, dental care or treatment.*
- *injury or sickness due to war or armed conflict, or due to taking part in a felony.*
- *injury or sickness received outside the United States, Mexico or Canada, or furnished by the insured's immediate family.*
- *injury or sickness that arises out of or in the course of employment for which Workers' Compensation is paid.*
- *custodial care, and routine foot care.*
- *pre-existing condition. But credit for prior creditable coverage is given.*

This summary of benefits is intended only to highlight the PerfectHealth plan benefits.
A complete listing of all the services, limitations, exclusions, terms and conditions of the plan is contained in the Group Policy and Booklet-Certificate.
If you are interested in any of these plans please contact The PerfectHealth Insurance Company Sales Department at 718-370-6060 or or visit us on the web at www.perfectny.com.

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