



NATIONAL NETWORK

**Benefit Summary EmblemHealth ConsumerDirect PPO
Option 4: 100%/80%/\$5,000**

BENEFIT HIGHLIGHTS

	Comments	In-Network (Individual/Family)	Out-of-Network (Individual/Family)
Aggregate Deductible*		\$5,000 /\$10,000	\$10,000/\$20,000
Coinsurance		100%	80%
Out-of-Pocket Maximum		\$5,000/\$10,000	\$12,000/\$24,000
Prescription Coverage		After deductible covered in full	After deductible covered in full
Annual Maximum		None	\$1,000,000
Lifetime Maximum		None	None
Unmarried Dependent Children/Unmarried Dependent Students	Coverage effective until end of calendar year	Eligible to age 19/25	Eligible to age 19/25

INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL

Inpatient Hospital Admission	PRECERTIFICATION: YES 365 days per confinement	Deductible and coinsurance	Deductible and coinsurance
Skilled Nursing Facility Care	PRECERTIFICATION: YES	Deductible and coinsurance	Deductible and coinsurance
Inpatient Admission for Medical Rehabilitation (i.e. Physical Therapy, Physical Medicine and Rehabilitation)	PRECERTIFICATION: YES 30 days per calendar year	Deductible and coinsurance	Deductible and coinsurance
Hospice Care - Inpatient and Outpatient	PRECERTIFICATION: YES 210 days per lifetime	Deductible and coinsurance	Covered in-network only

OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY

Pre-Admission Testing		Deductible and coinsurance	Deductible and coinsurance
Ambulatory Surgery Facility Charge (Free-standing)	PRECERTIFICATION: YES	Deductible and coinsurance	Deductible and coinsurance
Ambulatory Surgery Facility Charge (Outpatient hospital)	PRECERTIFICATION: YES	Deductible and coinsurance	Deductible and coinsurance
Home Health Care Services	PRECERTIFICATION: YES 200 visits per calendar year	Deductible and coinsurance	Deductible and coinsurance
Diagnostic Laboratory /Radiology	PRECERTIFICATION: YES Radiology services (applies to in- network only services)	Deductible and coinsurance	Deductible and coinsurance
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full	Deductible and coinsurance

MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN OR OTHER MEDICAL PROVIDER

Office Visits and Diagnostic Services for Dependent Child(ren)/Students		Deductible and coinsurance	Deductible and coinsurance
Office Visit Copay, Including Outpatient Clinic Visits		Deductible and coinsurance	Deductible and coinsurance
Specialist Office Visits		Deductible and coinsurance	Deductible and coinsurance
Maternity Pre-Postnatal Care		Deductible and coinsurance	Deductible and coinsurance
Annual Physical Check-up (Adult)		Covered in full	Deductible and coinsurance
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full	Deductible and coinsurance
Chiropractic Care		Deductible and coinsurance	Deductible and coinsurance
Allergy Care		Deductible and coinsurance	Deductible and coinsurance
Physical Therapy, Osteopathic Manipulation, Occupational Therapy	30 visits per calendar year	Deductible and coinsurance	Deductible and coinsurance

Speech Therapy	10 visits per calendar year	Deductible and coinsurance	Deductible and coinsurance
Outpatient Surgery	Office	Deductible and coinsurance	Deductible and coinsurance
	Outpatient hospital	Deductible and coinsurance	Deductible and coinsurance
	Ambulatory free-standing	Deductible and coinsurance	Deductible and coinsurance
Inpatient Surgery		Deductible and coinsurance	Deductible and coinsurance
Durable Medical Equipment (DME)	PRECERTIFICATION: YES when amount >\$2,000; \$10,000 calendar year maximum	Deductible and coinsurance	Deductible and coinsurance
Diabetic Management: Education		Deductible and coinsurance	Deductible and coinsurance
	Prescriptions	\$0 Generics/\$5 Brand	Deductible and coinsurance
	Supplies	Covered under DME benefit; DME annual maximum does not apply	Deductible and coinsurance
Diagnostic Laboratory	Performed in providers office/free-standing facility	Deductible and coinsurance	Deductible and coinsurance
Diagnostic Radiology	PRECERTIFICATION: YES Performed in provider's office/free-standing facility (applies to in-network only services)	Deductible and coinsurance	Deductible and coinsurance

WELL BABY AND CHILD CARE

Well Baby and Well Child Care, Including Immunizations	up to age 19	Covered in full	Deductible and coinsurance
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EMERGENCY COVERAGE

Emergency Room (ER) Care Facility Copay		Deductible and coinsurance	Allowed charge, subject to the in-network deductible and coinsurance
Emergency Ground Ambulance		N/A	Covered up to 100% of usual and customary amount; subject to in-network deductible and coinsurance

INPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

Inpatient Mental Health	PRECERTIFICATION: YES 30 days per calendar year. No visit limits for biologically-based mental illness and children with serious emotional disturbances	Deductible and coinsurance	Deductible and coinsurance
Chemical Dependency: Detoxification	PRECERTIFICATION: YES 7 days per calendar year	Deductible and coinsurance	Deductible and coinsurance
Chemical Dependency: Rehabilitation	PRECERTIFICATION: YES 30 days calendar year	Deductible and coinsurance	Deductible and coinsurance

OUTPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

Outpatient Chemical Dependency	PRECERTIFICATION: YES 60 visits per calendar year	Deductible and coinsurance	Deductible and coinsurance
Outpatient Mental Health	PRECERTIFICATION: YES 30 days per calendar year. No visit limits for biologically-based mental illness and children with serious emotional disturbances (applies to in-network only services)	Deductible and coinsurance	Deductible and coinsurance

The EmblemHealth ConsumerDirect PPO is underwritten by Group Health Incorporated ("GHI"). Coverage is subject to all terms, conditions, limitations and exclusions set forth in the contract and certificate of insurance. Policy form number PLH-SGC-1000, et. al. For out-of-network services, you are responsible to pay any difference between the plan's payment and the provider's charge.

EmblemHealth provides health benefit coverage and services through its subsidiary companies in New York State: Group Health Incorporated, HIP Health Plan of New York, The PerfectHealth Insurance Company, HIP Insurance Company of New York, GHI HMO Select, Inc., ConnectiCare of New York, Inc. and EmblemHealth Services Company LLC.

*EmblemHealth's aggregate deductible: if you are a single member with no dependents you are required to satisfy your plan's individual deductible, once per calendar and/or policy year before benefits begin. If you are a family member with dependents your entire family is required to satisfy your health plan's aggregate deductible. This means there is one family deductible that must be met once per calendar and/or policy year before anyone in the family is covered.