



**NATIONAL NETWORK**

**Benefit Summary EmblemHealth ConsumerDirect PPO  
Option 2: 80%/60%/\$3,000**

**BENEFIT HIGHLIGHTS**

	Comments	In-Network (Individual/Family)	Out-of-Network (Individual/Family)
Aggregate Deductible*		\$3,000 /\$6,000	\$6,000/\$12,000
Coinsurance		80% (Member pays 20%)	60% (Member pays 40%)
Out-of-Pocket Maximum		\$5,000/\$10,000	\$10,000/\$20,000
Prescription Rx Coverage		After deductible is met, copay applies	Covered in-network only
Rx Retail Copay Tier 1/Tier 2/Tier 3		\$10/\$25/\$50	Covered in-network only
Rx Mail Order Copay Tier 1/Tier 2/Tier 3		\$20/\$62.50/\$125	Covered in-network only
Annual Maximum		None	None
Lifetime Maximum		None	None
Dependent Children	Coverage effective until end of month	Eligible to age 26	Eligible to age 26

**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 services only)	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**

Physician Office 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

## MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN (Continued)

	Comments	In-Network (Individual/Family)	Out-of-Network (Individual/Family)
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	Deductible and coinsurance	Deductible and coinsurance
Diabetic Management: Education		Deductible and coinsurance	Deductible and coinsurance
Prescriptions	Covered when using a participating pharmacy	After deductible is met, copay applies	Covered in-network only
Supplies	Covered under DME benefit	Deductible and coinsurance	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 services only)	Deductible and coinsurance	Deductible and coinsurance

## WELL BABY AND CHILD CARE

Well Baby and Well Child Care, Including Immunizations		Covered in full	Deductible and coinsurance
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## EMERGENCY COVERAGE

Emergency Room Care Facility Copay		Deductible and coinsurance	In-network deductible and coinsurance
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## INPATIENT MENTAL HEALTH &amp; 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 &amp; 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 services only)	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. Your In-Network deductible is accumulated separate from your Out-of-Network deductible.