



## NATIONAL NETWORK

## Benefit Summary EmblemHealth ConsumerDirect EPO Option 5: 100%/\$5,800

**BENEFIT HIGHLIGHTS** EmblemHealth ConsumerDirect EPO provides in-network benefits only. Except for emergency hospital care, no out-of-network services are covered.

	Individual	Family
Aggregate Deductible*	\$5,800	\$11,600
Coinsurance	100% (Member pays 0%)	100% (Member pays 0%)
Out-of-Pocket Maximum	\$5,800	\$11,600
Prescription Coverage: Generic/Preferred/Non-Preferred	After deductible: Covered in full	After deductible: Covered in full
Unmarried Dependent Children/Unmarried Dependent Student - 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

	Comments	In-Network
Inpatient Hospital Admission	PRECERTIFICATION: YES 365 days per confinement	Subject to deductible
Skilled Nursing Facility Care	PRECERTIFICATION: YES	Subject to deductible
Inpatient Admission for Medical Rehabilitation (i.e. Physical Therapy, Physical Medicine and Rehabilitation)	PRECERTIFICATION: YES 30 days per calendar year	Subject to deductible
Hospice Care-Inpatient and Outpatient	PRECERTIFICATION: YES 210 days per lifetime	Subject to deductible

### OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY

Pre-Admission Testing		Subject to deductible
Ambulatory Surgery Facility Charge (free-standing)	PRECERTIFICATION: YES	Subject to deductible
Ambulatory Surgery Facility Charge (Outpatient hospital)	PRECERTIFICATION: YES	Subject to deductible
Home Health Care Services	PRECERTIFICATION: YES 200 visits per calendar year	Subject to deductible
Diagnostic Laboratory /Radiology	PRECERTIFICATION: YES for radiology services	Subject to deductible
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full

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

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

**MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN OR OTHER MEDICAL PROVIDER (Continued)**

Speech Therapy	10 visits per calendar year	Subject to deductible
Outpatient Surgery	Office	Subject to deductible
	Outpatient hospital	Subject to deductible
	Ambulatory free-standing	Subject to deductible
Inpatient Surgery		Subject to deductible
Durable Medical Equipment (DME)	PRECERTIFICATION: YES when amount >\$2,000; \$10,000 calendar year maximum	Subject to deductible
Diabetic Management: Education		Subject to deductible
Prescriptions		After deductible covered in full
Supplies	Covered under DME benefit, DME annual maximum does not apply	Subject to deductible
Diagnostic Laboratory	Performed in provider's office/ free-standing facility	Subject to deductible
Diagnostic Radiology	PRECERTIFICATION: YES Performed in provider's office/ free-standing facility	Subject to deductible

**WELL BABY AND CHILD CARE**

Well Baby and Well Child Care, Including Immunizations	Up to age 19	Covered in full
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**EMERGENCY COVERAGE**

Emergency Room Care Facility Copay		Subject to deductible
Emergency Ground Ambulance		Covered up to 100% of usual and customary amount; subject to deductible

**INPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY**

Inpatient Mental Health	PRECERTIFICATION: YES 30 days per calendar year, no limits for biologically-based mental illness and children with serious emotional disturbances	Subject to deductible
Chemical Dependency: Detoxification	PRECERTIFICATION: YES 7 days per calendar year	Subject to deductible
Chemical Dependency: Rehabilitation	PRECERTIFICATION: YES 30 days calendar year	Subject to deductible

**OUTPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY**

Outpatient Chemical Dependency	PRECERTIFICATION: YES 60 visits per calendar year	Subject to deductible
Outpatient Mental Health	PRECERTIFICATION: YES 30 visits per calendar year, no limits for biologically-based mental illness and children with serious emotional disturbances	Subject to deductible

The EmblemHealth ConsumerDirect EPO is underwritten by Group Health Incorporated ("GHI") and provides in-network benefits only. Except for emergency hospital care, no out-of-network services are covered. Coverage is subject to all terms, conditions, limitations and exclusions set forth in the contract and certificate of insurance. Policy form number PLH-SGC-997, et al.

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.