EmblemHealth™

NATIONAL NETWORK

Benefit Summary EmblemHealth ConsumerDirect EPO 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.

	Comments	Individual	Family
Aggregate Deductible+		$5,800	$11,600
Coinsurance		100% (Member pay 0%)	100% (Member pays 0%)
Out-of-Pocket Maximum		$5,800	$11,600
Prescription Coverage Generic/Preferred/Non-Preferred		After deductible is met, covered in full	After deductible is met, covered in full
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 Rehabilition (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	Deductible and coinsurance
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 for radiology services	Deductible and coinsurance	Deductible and coinsurance
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full	Covered in full
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	Covered in full
Preventive Mammography, Pap Smear and Prostate Screening		Covered in full	Covered in full
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

MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN (Continued)

	Comments	Individual	Family
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, covered in full	After deductible is met, covered in full
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	Deductible and coinsurance	Deductible and coinsurance

WELL BABY AND CHILD CARE

Well Baby and Well Child Care, Including Immunizations		Covered in full	Covered in full

EMERGENCY COVERAGE

Emergency Room Care Facility Copay		Deductible and coinsurance	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	Deductible and coinsurance	Deductible and coinsurance

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.

Covered services received from non-participating anesthesiologists, radiologists, pathologists and assistant surgeons while receiving covered services in a network hospital, facility, OPD, ambulatory facility or office is covered up to 100% of the 90th percentile of FAIR Health Benchmarks. The benefits described herein are only highlights of the coverage available. The terms, limitations, conditions and exclusions of the insurance contract and certificate will govern.

[+]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.