

**Direct Pay Value Plan Benefit Grid**

Value	In-Network	Out-of-Network
<b>Hospital Coverage</b>		
365 days of semi-private room & board in an acute care hospital *	Covered in full	<b>Base Hospital Coverage:</b> Within NYS - Up to 80% of average in-network allowed charge <i>Outside NYS</i> - 100% of hospital's charge
Hospital Deductible	None	None
Hospital Coinsurance	None	None
Maternity *	Covered in full	Base Hospital Coverage
Routine Nursery Care	Covered in full	Base Hospital Coverage
Outpatient Emergency Care (facility charges)	\$50 copay, waived if admitted	\$50 copay, waived if admitted
Freestanding Ambulatory Surgery Center Care *	Covered in full	Base Hospital Coverage
Pre-Admission Testing - no more than 7 days before scheduled surgery	Covered in full	Base Hospital Coverage
Inpatient Psychiatric Care per calendar year*	Not covered	Not covered
Inpatient Substance Abuse Treatment per calendar year*	Not covered	Not covered
Outpatient Substance Abuse Treatment - 60 visits per person, per calendar year (iup to 20 of these may be used for family therapy)*	Covered in full	Base Hospital Coverage
Outpatient Hospital-Based and Free-Standing Facility Dialysis	Covered in full	Base Hospital Coverage
Inpatient Admissions for Physical Therapy, Physical Medicine & Rehabilitation *	Not covered	Not covered
Diagnostic Admissions	Not covered	Not covered
Home Care Visits - Up to 40 visits per person, per calendar year*	Covered in full	Base Hospital Coverage
Hospice Care - 210 days per lifetime (includes 5 bereavement counseling sessions for family members)	Covered in full	80% of GHI Allowed Charge
Skilled Nursing Facility Care	Not covered	Not covered
Managed Care - including Precertification, Voluntary Second Surgical Opinion and Large Case Management (LCM)	Yes	Yes
Centers of Specialized Care - Paid-in-full benefits for select cardiac procedures and heart transplants	Covered in full	Program available in-network only
Outpatient Referred Ambulatory Care: laboratory tests, physical therapy, diagnostic X-rays and radiation therapy and chemotherapy	Diagnostic x-ray & lab subject to \$25 copay, other services covered in full	Base Hospital Coverage
Outpatient Laboratory Test and Diagnostic X-rays	\$25 copay	Base Hospital Coverage
Outpatient Mammography Screening and Pap Smear Screening	Covered in full	Base Hospital Coverage
Air Ambulance	Not covered	Not covered
Dependent Children Coverage		Age 26 EOM
<b>Medical Coverage</b>		
Base Medical Coverage	GHI CBP Schedule of Allowances as payment-in-full except for copay where noted	After satisfaction of deductible, member reimbursed at 100% of GHI CBP Schedule of Allowances
Annual Deductible	None	\$250 per person / \$500 per family
Coinsurance	None	None
Stop Loss Catastrophic Benefit - per individual or family. Subject to \$10,000 OPE ("Out-of-Pocket Expenses") deductible. "OPE" is defined as the difference between GHI Allowed Charge & all payments made under CBP during a given calendar year.	n/a	After member incurs \$10,000 in eligible out-of-pocket expenses, add'l reimbursement for covered services is made at 100% of R & C
Annual Maximum	None	None
Lifetime Maximum	None	None
Home and Office Visits (Adult)	Not covered	Not covered
Annual Adult Physical	Covered in full	Not covered
Preventive Services	Covered in full	Not covered
E.R. Professional Charges	Not covered	Not covered
Chiropractic Care	Not covered	Not covered
PT, OT, & Osteopathic Manipulation	Not covered	Not covered
Allergy Care Visits	Not covered	Not covered
Speech Therapy	Not covered	Not covered
Routine Podiatric Care	Not covered	Not covered
Well Baby Care	Covered in full	Base Medical Coverage
Well Child Care	Covered in full	Base Medical Coverage
Pediatric Immunizations	Covered in full	Base Medical Coverage
Out-of-Hospital Consultations	Not covered	Not covered
Diagnostic X-Rays	Covered subject to \$20 copay per provider, per d.o.s.	Base Medical Coverage

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MRI, Cat Scans & Sonograms*	Covered subject to \$20 copay per provider, per d.o.s.	Base Medical Coverage
Diagnostic Lab Tests	Not covered	Not covered
Mammography Screening (age & frequency per mandate)	Covered in full	Base Medical Coverage
Cervical Cytology (PAP) Screening - Annual, 18 years of age & older	Covered in full	Base Medical Coverage
Diabetes Self-Management (for supplies, see under Equipment)	Not covered	Not covered
In-Hospital and Out of Hospital Surgery	Covered in full	Base Medical Coverage
In-hospital Consultations	Covered in full	Base Medical Coverage
Ambulance - Emergency only, Standard, ground transport	Out-of-network benefit only	Covered up to 100% of UCR
Out-of-Hospital Psychiatric Tx.	Not covered	Not covered
Private Duty Nursing	Out-of-network benefit only	First 96 hours not covered. Then, after satisfaction of plan's annual deductible, member reimbursed 80% of Allowed Charge up to a \$5,000 per person annual maximum.
Durable Medical Equipment (DME) PPO -	After satisfaction of deductible, covered in full for all eligible items. Subject to a \$100 annual per person deductible. Pre-certification required for items \$2,000 & over and for all prosthetic devices, regardless of cost.	No coverage, except <b>Mastectomy bras</b> - 2 per cal.yr at 100% Allowed Charge. <b>Certain Prosthetic &amp; Orthotic devices &amp; Syringes</b> - at 80% Allowed Charge. All subject to satisfaction of DME deductible
<b>Description of Plan Benefit</b>		
Annual Retail Deductible	\$50 per person	No coverage
Retail Generic Copay	\$10	No coverage
Retail Brand Copay	\$10 + difference between Brand & Generic	No coverage
Retail Reimbursement after satisfaction of deductible & copay	Paid in full	No coverage
Retail Pharmacy Supply	Up to 30 days	No coverage
Maintenance Mail Order Program (Voluntary)	Processed through Medco	No coverage
Mail Order Deductible	None	No coverage
Mail Order Generic Copay	\$8	No coverage
Mail Order Brand Copay	\$15	No coverage
Mail Order Supply	Up to 90 days	
Annual Maximum -	None	No coverage

\* Indicates services may be subject to Pre-certification.

Emblem Health  
Direct Pay Individual Plan

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