



NATIONAL NETWORK

Benefit Summary EmblemHealth EPO \$40/\$1,000

BENEFIT HIGHLIGHTS

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

| | Comments | In-network |
|--|---------------------------------------|--|
| Office Visits and Diagnostic Services for Dependent Children | | \$0 Copay per visit |
| Office Visit, Including Outpatient Clinic Visits | | \$40 Copay per visit |
| Specialist Office Visits | | \$40 Copay per visit; No copay for dependent children |
| Inpatient Hospital Admission | | \$1,000 Copay per single confinement |
| Emergency Room Care Facility Copay | | \$100 Copay per visit |
| Ambulatory Surgery Facility | | \$750 Copay per visit |
| Skilled Nursing Facility Care | | \$200 Copay per visit up to a maximum of \$600 per confinement |
| Dependent Children | Coverage effective until end of month | Eligible to age 26 |

INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL

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| Inpatient Hospital Admission | PRECERTIFICATION: YES 365 days per confinement | \$1,000 Copay per single confinement |
| Skilled Nursing Facility Care | PRECERTIFICATION: YES | \$200 Copay per day up to a maximum of \$600 per confinement |
| Inpatient Admission for Medical Rehabilitation (i.e. Physical Therapy, Physical Medicine and Rehabilitation) | PRECERTIFICATION: YES 30 days per calendar year | \$1,000 Copay per single confinement |
| Hospice Care - Inpatient and Outpatient | PRECERTIFICATION: YES 210 days per lifetime | Covered in full |

OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY

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| Pre-Admission Testing | | Covered in full |
| Ambulatory Surgery Facility Charge (Free-standing) | PRECERTIFICATION: YES | \$750 Copay per visit |
| Ambulatory Surgery Facility Charge (Outpatient hospital) | PRECERTIFICATION: YES | \$750 Copay per visit |
| Home Health Care Services | PRECERTIFICATION: YES 200 visits per calendar year | Covered in full |
| Diagnostic Laboratory/Radiology | PRECERTIFICATION: YES Required for radiology services | \$40 Diagnostic copay per visit; No copay for dependent children |
| Preventive Mammography, Pap Smear and Prostate Screening | | Covered in full |

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

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| Physician Office Visits | | \$40 Copay per visit; No copay for dependent children |
| Specialist Office Visits | | \$40 Copay per visit; No copay for dependent children |
| Maternity Pre-Postnatal Care | | Covered in full |
| Annual Physical Check-up (Adult) | | Covered in full |
| Preventive Mammography, Pap Smear and Prostate Screening | | Covered in full |
| Chiropractic Care | | \$40 Copay per visit; No copay for dependent children |
| Allergy Care | | \$40 Copay per visit; No copay for dependent children |
| Physical Therapy, Osteopathic Manipulation, Occupational Therapy | 30 visits per calendar year | \$40 Copay per visit; No copay for dependent children |

MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN (Continued)

| | Comments | In-network |
|---------------------------------|--|--|
| Speech Therapy | 10 visits per calendar year | \$40 Copay per visit; No copay for dependent children |
| Outpatient Surgery | Office | Covered in full |
| | Outpatient hospital | Covered in full |
| | Ambulatory free-standing | Covered in full |
| Inpatient Surgery | | Covered in full |
| Durable Medical Equipment (DME) | PRECERTIFICATION: YES when amount >\$2,000 | Covered in full |
| Diabetic Management: Education | | \$40 Copay per visit; No copay for dependent children |
| Prescriptions | Covered when using a participating pharmacy | \$5 Copay |
| Supplies | Covered under DME benefit | Covered in full |
| Diagnostic Laboratory | Performed in provider's office/ free-standing facility | \$40 Diagnostic copay per visit; No copay for dependent children |
| Diagnostic Radiology | PRECERTIFICATION: YES Performed in provider's office/ free-standing facility | \$40 Diagnostic copay per visit; No copay for dependent children |

WELL BABY AND CHILD CARE

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| Well Baby and Well Child Care, Including Immunizations | | Covered in full |
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EMERGENCY ROOM COVERAGE

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| Emergency Room Care Facility Copay | ER copay, waived if admitted | \$100 Copay per visit |
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INPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

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|-------------------------------------|---|--------------------------------------|
| Inpatient Mental Health | PRECERTIFICATION: YES 30 days per calendar year; No visit limits for biologically-based mental illness and children with serious emotional disturban ces | \$1,000 Copay per single confinement |
| Chemical Dependency: Detoxification | PRECERTIFICATION: YES 7 days per calendar year | \$1,000 Copay per single confinement |
| Chemical Dependency: Rehabilitation | PRECERTIFICATION: YES 30 days calendar year | \$1,000 Copay per single confinement |

OUTPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

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| Outpatient Chemical Dependency | PRECERTIFICATION: YES 60 visits per calendar year | Covered in full |
| Outpatient Mental Health | PRECERTIFICATION: YES 30 visits per calendar year; No visit limits for biologically-based mental illness and children with serious emotional disturbances | \$40 Copay per visit; No copay for dependent children |

VISION

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| Exam | Performed by Davis Vision provid- ers only; One eye exam every 24 months; Eligibility: all ages | \$10 Office visit copay for adults; No copay for dependent children |
| Frames, Lenses, Contacts | Eligibility: Children under the age of 26; every 24 months | Lenses, frames, contacts (in lieu of frames and lenses) \$20 copay |

The EmblemHealth 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. Refer to GHI policy form numbers PLH-EPO-100A, 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 Ingenix Prevailing Healthcare Charges System. 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.