



NATIONAL NETWORK

Benefit Summary EmblemHealth ConsumerDirect EPO Option 6: 100%/\$10,000

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* | \$10,000 | \$20,000 |
| Coinsurance | 100% (Member pays 0%) | 100% (Member pays 0%) |
| Out-of-Pocket Maximum | \$10,000 | \$20,000 |
| 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 |
|---|--------------|-----------------|

EMERGENCY COVERAGE

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|------------------------------------|--|--|
| 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.

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.

* 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.