

## NATIONAL NETWORK

## Benefit Summary EmblemHealth EPO \$30/\$500

### 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/Students |   | \$0 Copay per visit  |
| Office Visit, Including Outpatient Clinic Visits                      |   | \$30 Copay per visit   |
| Specialist Office Visits  |   | \$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students |
| Inpatient Hospital Admission  |   | \$500 Copay per single confinement   |
| Emergency Room Care Facility Copay                                    |   | \$100 Copay per visit  |
| Ambulatory Surgery Facility   |   | \$250 Copay per visit  |
| Skilled Nursing Facility Care   |   | \$200 Copay up to a maximum of \$600 per confinement   |
| Unmarried Dependent Children/Students                                 | Coverage effective until end of calendar year | Eligible to age 19/25  |

### INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL

|  |  |  |
|--|--|--|
| Inpatient Hospital Admission   | PRECERTIFICATION: YES                              | \$500 Copay per single confinement                   |
| Skilled Nursing Facility Care  | PRECERTIFICATION: YES                              | \$200 Copay up to a maximum of \$600 per confinement |
| Inpatient Admission for Medical Rehabilitation (i.e. Physical Therapy, Physical Medicine and Rehabilitation) | PRECERTIFICATION: YES<br>30 days per calendar year | Covered in full                                      |
| Hospice Care - Inpatient and Outpatient  | PRECERTIFICATION: YES<br>210 days per lifetime     | Covered in full                                      |

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

|  |   |   |
|--|---|---|
| Pre-Admission Testing                                    |   | Covered in full   |
| Ambulatory Surgery Facility Charge (Free-standing )      |   | \$250 Copay per visit   |
| Ambulatory Surgery Facility Charge (Outpatient hospital) |   | \$250 Copay per visit   |
| Home Health Care Services                                | PRECERTIFICATION: YES<br>200 visits per calendar year | Covered in full   |
| Diagnostic Laboratory/Radiology                          | PRECERTIFICATION: YES                                 | \$30 Diagnostic copay per visit; No copay for unmarried dependent children and unmarried dependent students |
| Preventive Mammography, Pap Smear and Prostate Screening |   | Covered in full   |

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

|  |  |  |
|--|--|--|
| Physician Office Visits  |  | \$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students |
| Specialist Office Visits   |  | \$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students |
| 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  |  | \$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students |
| Allergy Care   |  | \$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students |
| Physical Therapy, Osteopathic Manipulation, Occupational Therapy | PRECERTIFICATION: YES<br>30 visits per calendar year | \$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students |

MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN (Continued)

|                                 | Comments   | In-network  |
|---------------------------------|--|---|
| Speech Therapy                  | 10 visits per calendar year  | \$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students            |
| 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<br>when amount >\$2,000; \$10,000<br>calendar year maximum   | Covered in full, up to calendar year max  |
| Diabetic Management: Education  |  | \$30 Copay per visit; No copay for unmarried dependent children and unmarried dependent students            |
| Prescriptions                   |  | \$5 brand; \$0 generic  |
| Supplies                        | Covered under DME benefit, DME<br>annual maximum does not apply                    | Covered in full   |
| Diagnostic Laboratory           | Performed in provider's office/<br>free-standing facility                          | \$30 Diagnostic copay per visit; No copay for unmarried dependent children and unmarried dependent students |
| Diagnostic Radiology            | PRECERTIFICATION: YES<br>Performed in provider's office/<br>free-standing facility | \$30 Diagnostic copay per visit; No copay for unmarried dependent children and unmarried dependent students |

WELL BABY AND CHILD CARE

|  |              |                 |
|--|--------------|-----------------|
| Well Baby and Well Child Care, Including Immunizations | Up to age 19 | Covered in full |
|--|--------------|-----------------|

EMERGENCY ROOM COVERAGE

|                                    |                              |  |
|------------------------------------|------------------------------|--|
| Emergency Room Care Facility Copay | ER copay, waived if admitted | \$100 ER facility copay per visit                |
| Emergency Ground Ambulance         |                              | Covered up to 100% of usual and customary amount |

INPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

|                                     |  |                 |
|-------------------------------------|--|-----------------|
| Inpatient Mental Health             | PRECERTIFICATION: YES<br>30 days/calendar year; No visit limits for biologically-based mental illness and children with serious emotional disturbances | Covered in full |
| Chemical Dependency: Detoxification | PRECERTIFICATION: YES<br>7 days per calendar year  | Covered in full |
| Chemical Dependency: Rehabilitation | PRECERTIFICATION: YES<br>30 days calendar year   | Covered in full |

OUTPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

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

VISION

|                          |   |  |
|--------------------------|---|--|
| Exam                     | Performed by Davis Vision providers only; One eye exam every 24 months; Eligibility: all ages | \$10 Office visit copay for adults; No copay for dependent children and unmarried dependent students |
| Lenses, Frames, Contacts | Eligibility: Children under the age of 19; every 24 months                                    | Lenses, frames, contacts (in lieu of frames and lenses)<br>\$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 PLS-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.

# EmblemHealth Prescription Drug Options

EmblemHealth EPO and InBalance EPO

| Option R  |                |
|---|----------------|
| Annual deductible per individual.*  | \$50           |
| Retail copayment for generic/preferred brand name/<br>nonpreferred brand name drugs.        | \$0/\$30/\$50  |
| Annual retail maximum per individual (no maximum on<br>home delivery).                      | \$3,000        |
| Home delivery copayment for generic/preferred brand name/<br>nonpreferred brand name drugs. | \$0/\$60/\$100 |

- Covered at EmblemHealth pharmacies only.
- Generic drugs are not mandatory. Other than the applicable copayment, no additional costs apply.
- All prescription drug options include clinical prior authorization and specialty pharmacy programs.
- Rx home delivery is unlimited. The maximum applies to retail Rx purchases only.
- The retail maximum is based on EmblemHealth's discounted rate minus the applicable copay.

All services and benefits are subject to the specific terms and conditions of your Certificate of Insurance and Certificate Attachment and/or riders.

For more information, contact your EmblemHealth Sales Representative.

\* Deductible applies to brand preferred and brand nonpreferred drugs only.

Policy form # PLA-100B



Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.