



**EPO 40/1000B**

**RX: \$0 Generic/\$30 Brand/\$50 Non-Formulary; \$50 Brand Deductible. Retail Threshold \$1,000, then 50% coins. Mail order unlimited.**

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

**NATIONAL NETWORK**

**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**

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**

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**

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

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

Emergency Room Care Facility Copay	ER copay, waived if admitted	\$100 Copay per visit
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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 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

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

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.