

NATIONAL NETWORK

Benefit Summary EmblemHealth PPO
\$40/\$500x3/\$5,000/70%

| BENEFIT HIGHLIGHTS | | | |
|--|---|---|----------------------------|
| | Comments | In-network | Out-of-network |
| Office Visits and Diagnostic Services for Dependent Children | | \$0 Copay per visit | Deductible and coinsurance |
| Office Visit, Including Outpatient Clinic Visits | | \$40 Copay per visit | Deductible and coinsurance |
| Emergency Room Care Facility Copay | | \$200 Copay per visit | \$200 Copay per visit |
| Ambulatory Surgery Facility Copay | | \$300 Copay per visit | Deductible and coinsurance |
| Coinsurance | | N/A | 70%/30% |
| Annual Deductible (Individual/Family) | | N/A | \$5,000/\$15,000 |
| Annual Maximum Benefit per Individual | | Unlimited | Unlimited |
| Annual Coinsurance Maximum (Individual/Family) | | N/A | \$3,000/\$9,000 |
| Lifetime Maximum | | Unlimited | Unlimited |
| Dependent Children | Coverage effective until end of month | Eligible to age 26 | Eligible to age 26 |
| INPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL | | | |
| Inpatient Hospital Admission | PRECERTIFICATION: YES 365 days per confinement | \$500 Copay per day up to a maximum of \$1,500 per single confinement | Deductible and coinsurance |
| Skilled Nursing Facility Care | PRECERTIFICATION: YES | Covered in full | Deductible and coinsurance |
| Inpatient Admission for Medical Rehabilitation (i.e. Physical Therapy, Physical Medicine and Rehabilitation) | PRECERTIFICATION: YES 30 days per calendar year | \$500 Copay per day up to a maximum of \$1,500 per single confinement | Deductible and coinsurance |
| Hospice Care - Inpatient and Outpatient | PRECERTIFICATION: YES 210 days per lifetime | Covered in full | Covered in-network only |
| OUTPATIENT HOSPITAL SERVICES PERFORMED AND BILLED BY A HOSPITAL OR FACILITY | | | |
| Pre-admission Testing | | Covered in full | Deductible and coinsurance |
| Ambulatory Surgery Facility Charge (Freestanding and outpatient hospital) | PRECERTIFICATION: YES | \$300 Copay per visit | Deductible and coinsurance |
| Home Health Care Services | PRECERTIFICATION: YES 200 visits per calendar year | Covered in full | Deductible and coinsurance |
| Diagnostic Laboratory | | \$40 Diagnostic copay per visit; No copay for dependent children | Deductible and coinsurance |
| Diagnostic Radiology | PRECERTIFICATION: YES Required for in-network radiology services | 40% Coinsurance up to \$150 per provider per date of service; No copay for dependent children | Deductible and coinsurance |
| Preventive Mammography, Pap Smear and Prostate Screening | | Covered in full | Deductible and coinsurance |
| MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN OR OTHER MEDICAL PROVIDER | | | |
| Office Visits and Diagnostic Services for Dependent Child(ren) /Student(s) | | No copay for dependent children | Deductible and coinsurance |
| Office Visit, including Outpatient Clinic Visits | | \$40 Copay per visit | Deductible and coinsurance |
| Specialist Office Visits | | \$40 Copay per visit; No copay for dependent children | Deductible and coinsurance |

MEDICAL SERVICES PERFORMED AND BILLED BY A PHYSICIAN (Continued)

| | Comments | In-network | Out-of-network |
|--|---|---|----------------------------|
| Maternity Pre- and Postnatal Care | | Covered in full | Deductible and coinsurance |
| Annual Physical Checkup (Adult) | | Covered in full | Deductible and coinsurance |
| Preventive Mammography, Pap Smear and Prostate Screening | | Covered in full | Deductible and coinsurance |
| Chiropractic Care | | \$40 Copay per visit; No copay for dependent children | Deductible and coinsurance |
| Allergy Care | | \$40 Copay per visit; No copay for dependent children | Deductible and coinsurance |
| Physical Therapy, Osteopathic Manipulation, Occupational Therapy | 30 Visits per calendar year | \$40 Copay per visit; No copay for dependent children | Deductible and coinsurance |
| Speech Therapy | 10 Visits per calendar year | \$40 Copay per visit; No copay for dependent children | Deductible and coinsurance |
| Outpatient Surgery | Office | Covered in full | Deductible and coinsurance |
| | Outpatient hospital | Covered in full | Deductible and coinsurance |
| | Ambulatory freestanding | Covered in full | Deductible and coinsurance |
| Inpatient Surgery | | Covered in full | Deductible and coinsurance |
| Durable Medical Equipment (DME) | PRECERTIFICATION: YES when amount >\$2,000 | Covered in full | Covered in-network only |
| Diabetic Management: Education | | \$40 Copay per visit; No copay for dependent children | Deductible and coinsurance |
| Prescriptions | Covered when using a participating pharmacy | \$5 Copay | Deductible and coinsurance |
| Supplies | Covered under DME benefit | Covered in full | Deductible and coinsurance |
| Diagnostic Laboratory | Performed in provider's office/free-standing facility | \$40 Diagnostic copay per visit; No copay for dependent children | Deductible and coinsurance |
| Diagnostic Radiology | PRECERTIFICATION: YES Performed in provider's office/ freestanding facility (applies to in-network only services) | 40% Coinsurance up to \$150 per provider per date of service; No copay for dependent children | Deductible and coinsurance |

WELL BABY AND CHILD CARE

| | | | |
|--|--|-----------------|----------------------------|
| Well Baby and Well Child Care, including Immunizations | | Covered in full | Deductible and coinsurance |
|--|--|-----------------|----------------------------|

EMERGENCY ROOM COVERAGE

| | | | |
|------------------------------------|------------------------------|-----------------------|-----------------------|
| Emergency Room Care Facility Copay | ER copay, waived if admitted | \$200 Copay per visit | \$200 Copay per visit |
|------------------------------------|------------------------------|-----------------------|-----------------------|

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 disturbances | \$500 Copay per day up to a maximum of \$1,500 per single confinement | Deductible and coinsurance |
| Chemical Dependency: Detoxification | PRECERTIFICATION: YES 7 days per calendar year | \$500 Copay per day up to a maximum of \$1,500 per single confinement | Deductible and coinsurance |
| Chemical Dependency: Rehabilitation | PRECERTIFICATION: YES 30 days per calendar year | \$500 Copay per day up to a maximum of \$1,500 per single confinement | Deductible and coinsurance |

OUTPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY

| | | | |
|--------------------------------|--|---|----------------------------|
| Outpatient Chemical Dependency | PRECERTIFICATION: YES 60 visits per calendar year | Covered in full | Deductible and coinsurance |
| Outpatient Mental Health | PRECERTIFICATION: YES; 30 days 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 | Deductible and coinsurance |

VISION

| | Comments | In-network | Out-of-network |
|--------------------------|---|---|---|
| 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 | Covered through Davis Vision providers only |
| Frames, Lenses, Contacts | Eligibility: Children under the age of 26; every 24 months | Lenses, frames, contacts (in lieu of frames and lenses) \$20 copay | Covered through Davis Vision providers only |

The EmblemHealth PPO is underwritten by Group Health Incorporated ("GHI"). Coverage is subject to all terms, conditions, limitations and exclusions set forth in the contract and certificate of insurance. Refer to policy form number HCR-PPO-100, et al. For out-of-network services, you are responsible to pay any difference between the plan's payment and the provider's charge.

EmblemHealth provides health benefit coverage and services through its subsidiary companies in New York State: Group Health Incorporated, HIP Health Plan of New York, HIP Insurance Company of New York, GHI HMO Select, Inc., ConnectiCare of New York, Inc. and EmblemHealth Services Company LLC.

EmblemHealth Prescription Drug Options

PPO

| Option EH1 | |
|---|--------------------|
| Annual deductible per individual* | \$50 |
| Retail copay for Tier 1/Tier 2/Tier 3 drugs** (30 day supply) | \$10/\$25/\$50 |
| Annual retail threshold per individual (no threshold on home delivery) | None |
| Home delivery copay for Tier 1/Tier 2/Tier 3 drugs** (90 day supply) | \$20/\$62.50/\$125 |

- Covered at EmblemHealth participating pharmacies only.
- Voluntary mail-order program. Other than the applicable copay, no additional costs apply.
- All prescription drug options include clinical prior authorization and specialty pharmacy programs.

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 Tier 2 and Tier 3 drugs only.

**Tier 1 includes multi-source generic drugs. Tier 2 includes single-source generic drugs and brand-name drugs. Tier 3 includes non-formulary brand-name drugs.

Policy form # HCR-Rx-1



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.