

**EPO Diamond**  
**Description of Medical Benefits**  
**\$10,000/\$20,000 Deductible**



|                   |                 | <b>In-Network</b> |
|-------------------|-----------------|-------------------|
| Annual Deductible | (single/family) | \$10000/\$20000   |
| Coinsurance       |                 | 100%              |
| Lifetime Maximum  |                 | Unlimited         |

| <b>PREVENTIVE CARE</b>                    |   | <b>After Annual Deductible</b>       |
|---|---|--------------------------------------|
| Well Child Care (including immunizations) | Benefits are in accordance with the standards established by the American Academy of Pediatrics*                            | 100% Coinsurance (deductible waived) |
| Mammography                               | 1 baseline age 35-39<br>1 screening per year age 40+<br>Screening at any age with prior history or family history           | 100%                                 |
| Routine OB/GYN visits                     | 1 routine exam per year including pap smear   | 100%                                 |
| Colorectal Cancer Screening               | 1 screening per year age 50+  | 100%                                 |
| Bone Mineral Density Test                 |   | 100%                                 |
| Prostate Cancer Screening                 | Screening at any age with prior history<br>1 screening per year age 40+ with family history<br>1 screening per year age 50+ | 100%                                 |
| Routine Exams                             | Up to \$250 per year  | 100%                                 |

| <b>MEDICAL CARE</b>  |                        | <b>After Annual Deductible</b> |
|--|------------------------|--------------------------------|
| Medical office visits  |                        | 100%                           |
| Specialist consultations   |                        | 100%                           |
| Laboratory   |                        | 100%                           |
| X-ray and diagnostic tests   |                        | 100%                           |
| Rehabilitative services (physical, occupational and speech therapy)            |                        | 100%                           |
| Spinal manipulation  |                        | 100%                           |
| Allergy testing and treatment  |                        | 100%                           |
| Services of the physician, surgeon, anesthesiologist, radiologist, pathologist |                        | 100%                           |
| Diabetic equipment, supplies, and self-management education                    |                        | 100%                           |
| Foot Care, other than routine care   | Up to \$2,000 per year | 100%                           |

| <b>HOSPITAL CARE</b>                 | <b>**Precertification is required</b>   | <b>After Annual Deductible</b> |
|--------------------------------------|---|--------------------------------|
| Room and Board                       | Semi-private room   | 100%                           |
| Intensive Care                       |   | 100%                           |
| Other In-Hospital Services           |   | 100%                           |
| Outpatient surgery                   |   | 100%                           |
| Preadmission Tests                   |   | 100%                           |
| Maternity and newborn care           | Automatic newborn coverage for first 31 days. Service of certified nurse midwife included | 100%                           |
| Medication dispensed while inpatient |   | 100%                           |
| Private duty nurse                   | Up to \$125 per day   | 100%                           |

\*At the present time the benefits are : 11 exams for children between birth and 2 years old, and 1 exam every year from age 2 through 18 years old.

\*\*Precertification is required for hospital admissions, certain elective procedures, and other services as specified by the Plan. Insureds are responsible for obtaining pre-certification for the required services. Non-Compliance Benefit Reduction Penalty applies.

**EPO Diamond**  
**Description of Medical Benefits**  
**\$10,000/\$20,000 Deductible**



**Description of Medical Benefits (continued)**

|                       |   | <b>In-Network</b>              |
|-----------------------|---|--------------------------------|
| <b>EMERGENCY CARE</b> |   | <i>After Annual Deductible</i> |
| Emergency Room        |   | 100%                           |
| Local Ambulance       |   | 100%                           |
| Other Transportation  | Up to \$2,500 for any one hospital confinement, and must be medically necessary | 100%                           |

| <b>OTHER HEALTH CARE</b>   |   | <i>After Annual Deductible</i> |
|----------------------------|---|--------------------------------|
| Prosthetic devices         |   | 100%                           |
| Durable medical equipment  | Up to \$10,000 lifetime benefit   | 100%                           |
| Convalescent Care Facility | 50% of hospital semi-private room rate, and up to 90 days for any one injury or sickness                    | 100%                           |
| Infertility                | Hospital, surgical and medical care for the treatment of correctable medical conditions causing infertility | 100%                           |
| Hospice Care               | Up to 210 days  | 100%                           |
| Home Health Care           |   | 100%                           |

| <b>MENTAL HEALTH/ALCOHOLISM/SUBSTANCE ABUSE</b> |  | <i>After Annual Deductible</i> |
|---|--|--------------------------------|
| Mental health - inpatient                       | Up to 30 days per year   | 100%                           |
| Mental Health - outpatient crisis intervention  | 3 visits per year - \$60 or actual charge, if less, per visit              | 100%                           |
| Mental Health - outpatient                      | 52 visits per year - \$40 or actual charge, if less, per visit             | 100%                           |
| Alcoholism/Substance Abuse - inpatient          | Up to 30 days per year. Up to 7 days per year in a detoxification facility | 100%                           |
| Alcoholism/Substance Abuse - outpatient         | Up to 60 visits per year - 20 visits may be for family members             | 100%                           |

| <b>SERVICES NOT ASSOCIATED WITH A PROVIDER NETWORK</b> |  |     |
|--|--|-----|
| Prescription Drugs and Medicines                       |  | 70% |

| <b>NETWORK</b>   |  |                            |
|------------------|--|----------------------------|
| Provider Network |  | MultiPlan                  |
| Hospital Network |  | HIP (subject to approvals) |

**EXCLUSIONS**

This plan does not cover expenses for:

- medical care not recommended and approved by a doctor, or received in an U.S. Government owned and operated facility.
- medical care for cosmetic purposes, dental care or treatment.
- injury or sickness due to war or armed conflict, or due to taking part in a felony.
- injury or sickness received outside the United States, Mexico or Canada, or furnished by the insured's immediate family.
- injury or sickness that arises out of or in the course of employment for which Workers' Compensation is paid.
- custodial care, and routine foot care.

*This summary of benefits is intended only to highlight the PerfectHealth plan benefits. A complete listing of all the services, limitations, exclusions, terms and conditions of the plan is contained in the Group Policy and Booklet-Certificate.*