



## SUMMARY OF BENEFITS FOR COMPREHEALTH HMO

➤ MAJOR COPAYMENT PROVISIONS	CompreHealth
PCP Office visits	\$25 copay per visit with \$0 Child Copay
Specialist Office visits	\$40 copay per visit with \$0 child copay
Hospital admission	\$500 copay per Hospital Admission
Emergency room copay	\$100 copay per visit
Prescription drugs	\$0/\$30, Contraceptives Included, \$50 Non-Formulary, Unlimited Brand Maximum

➤ INPATIENT HOSPITAL SERVICES	CompreHealth
• Hospital and Physician Services	Subject to Hospital admission copay
• Semi-private Room and Board	Included in Hospital Admission copay
• Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia, X-rays and lab tests	Included in Hospital Admission copay
• Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)	Included in Hospital Admission copay Short-term only
• Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)	Subject to Hospital admission copay 30 days per calendar year
• Radiation therapy and chemotherapy	Included in Hospital Admission copay
• Pre-admission testing	Included in Hospital Admission copay
• Human organ transplants	Included in Hospital Admission copay

➤ OUTPATIENT MEDICAL CARE	CompreHealth
• PCP office visits	Subject to PCP office visit copay
• Specialist office visits	Subject to Specialist office visit copay
• Preventive care, including physical exams, ear exams, health education and counseling, pap smear, mammography and immunizations	Included in PCP or Specialist office visit copay
• Well-child care to age 19 including immunizations	No copay
• Diagnostic services including X-ray, lab tests, EKG's	Included in PCP office visit copay
• Prenatal, postnatal care in physician's office	No copay
• Ambulatory surgery	\$50 copay per visit
• Second medical and surgical opinion	No copay
• Wheelchairs	Covered under DME rider
• Routine foot care	Not covered
• Chiropractic services	Subject to Specialist office visit copay



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➤ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE	CompreHealth
<b>Mental Health Care</b>	
• <b>Inpatient</b>	
- Treatment of Mental Illness	Subject to Hospital admission copay; 30 days per calendar year
• <b>Outpatient</b>	
- Treatment of Mental Illness	\$40 copay; 20 visits per calendar year; \$0 Child Copay
<b>Alcohol and Substance Abuse Care</b>	
• Inpatient Detoxification	Subject to Hospital admission copay 7 days per calendar year
• Inpatient Rehabilitation Treatment	Not Covered
• Outpatient Rehabilitation Treatment	\$25 Copay per visit, 60 Visit Limit - per calendar year; \$0 Child Copay

➤ SPECIAL KINDS OF CARE	CompreHealth
<b>Emergency and urgent Care</b>	
• In hospital emergency room	Subject to Emergency room copay
• In urgent care facility	Subject to PCP office visit copay
• In physician's office	Subject to PCP office visit copay
• Ambulance service to the hospital	No copay
<b>Home Health Care</b>	No copay; 40 visits per calendar year
<b>Hospice Care</b>	No copay; 210 days
<b>Skilled Nursing Facility care</b>	\$0 copay; 30 days per calendar year
<b>Dialysis treatment</b>	\$25 copay per visit
<b>Diabetes equipment, supplies and education</b>	\$25 copay per month
<b>Outpatient physical, speech, occupational and respiratory therapy.</b>	Subject to Specialist office visit copay; 30 visits per calendar year; \$0 Child Copay
<b>Family Planning Services</b>	Covered
<b>Infertility Diagnosis and Treatment</b>	Subject to applicable copays
<b>In-vitro Fertilization</b>	Not Covered
<b>Dental Care</b>	
• General dental care	Covered at reduced member fee schedule
• Preventive dental care	
- Oral exam (One every six months)	\$5 copay per visit
- Cleaning (One every six months)	\$10 copay per visit
- Topical application of fluoride for children age 16 and under (One every six months)	\$5 copay per visit
- Fluoride applications age 17 and over (One every six months)	Copay to be determined by zip code
<b>Durable Medical Equipment</b>	\$500 annual deductible
<b>Private Duty Nursing</b>	Not Covered



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<b>Hearing aids</b>	Not covered; Cochlear implants covered
<b>Optical care</b>	
• Refractive Eye Exams	\$40 copay
• Eyeglasses	\$45 for a complete pair every 24 months

### FOOTNOTES

\* *Drugs are dispensed in accordance with EmblemHealth's Drug Formulary. Please refer to your Prescription Drug Rider for details.*

*Except for emergency care, the above benefits and services are covered only when provided or referred by a EmblemHealth Primary Care Physician and/or approved in advance by the EmblemHealth Care Management Program. EmblemHealth Participating Physicians and Providers have contracted with EmblemHealth to provide care to our members; they are not employees, agents, servants or representatives of EmblemHealth. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Contract or Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.*

*EmblemHealth policy forms are subject to the review and approval of the New York State Insurance Department. CompreHealth and CompreHealth EPO premium rates for calendar year 2009 are subject to the review and approval of the New York State Insurance Department. Coverage and/or premium rates will be modified retroactively to meet all requirements of approval.*