

**Benefit Summary EmblemHealth CompreHealth
\$30/\$50/\$1,000**

NYC METRO NETWORK

BENEFIT HIGHLIGHTS

EmblemHealth CompreHealth provides in-network benefits only. Except for emergency hospital care, no out-of-network services are covered.

	Comments	In-network
Office Visit and Diagnostic Services for Dependent Children		\$0 Copay per visit
Office Visit, Including Outpatient Clinic Visits		\$30 Copay per visit
Specialist Office Visits		\$50 Copay per visit; No copay for dependent children
Inpatient Hospital Admission		\$1,000 Copay per single confinement
Emergency Room Care Facility Copay		\$150 Copay per visit
Ambulatory Surgery Facility		\$75 Copay per visit
Dependent Children	Coverage effective until end of month	Eligible to age 26
INPATIENT HOSPITAL SERVICES		
Inpatient Hospital Admission		\$1,000 Copay per single confinement
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 Laboratory Tests		Included in hospital admission copay
Short-term Speech, Physical, Occupational and Respiratory Therapy (when part of an acute admission)	Short-term only	Included in hospital admission copay
Speech, Physical, Occupational and Respiratory Therapy (when part of a rehabilitation admission)	30 days per calendar year	\$1,000 Copay per single confinement
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		
PCP Office Visits		\$30 Copay per visit; No copay for dependent children
Specialists Office Visits		\$50 Copay per visit; No copay for dependent children
Preventive Care (i.e. Adult Annual Physical Exam, Pap Smear, Mammography, Prostate Screening, etc.)		Covered in full
Well-Child Care Including Immunizations		Covered in full
Diagnostic Services Including X-Ray, Laboratory Tests, EKG's		Included in Office Visit Copay
Prenatal, Postnatal Care	Performed in physician's office	Covered in full
Ambulatory Surgery		\$75 Copay per visit
Second Medical and Surgical Opinion		Covered in full
Wheelchairs	Covered under Durable Medical Equipment (DME) Rider	Subject to DME deductible
Routine Foot Care		Not covered
Chiropractic Services		\$50 Copay per visit; No copay for dependent children

MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE

	Comments	In-network
Mental Health Care: Inpatient Treatment of Illness	30 days per calendar year; No visit limits for biologically-based mental illness and children with serious emotional disturbances	\$1,000 Copay per single confinement
Outpatient Treatment of Illness	20 visits per calendar year; No visit limits for biologically-based mental illness and children with serious emotional disturbances	\$50 Copay per visit; No copay for dependent children
Alcohol and Substance Abuse Care:		
Inpatient Detoxification	7 days per calendar year	\$1,000 Copay per single confinement
Inpatient Rehabilitation Treatment		Not covered
Outpatient Rehabilitation Treatment	60 visits per calendar year	\$25 Copay per visit; No copay for dependent children

SPECIAL KINDS OF CARE

Emergency and Urgent Care:		
In Hospital Emergency Room		\$150 Emergency Room Copay per visit
In Urgent Care Facility		\$30 Copay per visit
In Physician's Office		\$30 Copay per visit
Ambulance Service to the Hospital		Covered in full
Home Health Care	40 visits per calendar year	Covered in full
Hospice Care	210 days per lifetime	Covered in full
Skilled Nursing Facility Care	30 days per calendar year	Covered in full
Diabetes Equipment, Supplies and Education		\$25 Copay per month
Outpatient Physical, Speech, Occupational and Respiratory Therapy	30 visits per calendar year	\$50 Copay per visit; No copay for dependent children
Family Planning Services		Covered in full
Infertility Diagnosis and Treatment		Subject to applicable copays
In-Vitro Fertilization		Not covered
Dental Care: General		Covered at reduced member fee schedule
Preventive Dental Care: Oral Exam	One every 6 months	\$5 Copay per visit
Cleaning	One every 6 months	\$10 Copay per visit
Topical Application of Fluoride	Eligible: children under 16 years old	\$5 Copay per visit
Fluoride Applications	One every 6 months for persons age 17 and over	Copay to be determined by zip code
Durable Medical Equipment		\$500 Annual deductible
Private Duty Nursing		Not covered
Hearing Aids		Not covered; Cochlear implants covered
Optical Care: Refractive Eye Exams		\$50 Copay per visit
Eyeglasses	Every 24 months	\$45 for a complete pair

The EmblemHealth CompreHealth is underwritten by HIP Health Plan of New York. Except for emergency care, the above benefits and services are covered only when provided or referred by an 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.

Refer to HIP policy form number PLH-SGC-1000, et. al. 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.

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.

EmblemHealth Prescription Drug Options

EmblemHealth CompreHealth

Retail Copay Generic/Preferred/ Non-Preferred	Annual Deductible Per Individual* (Retail & Mail-Order)	Threshold	Mail-Order Copay For 90 day Supply
\$15/\$35/\$75	\$100 brand only	None	\$22.50/\$52.50/\$225

- 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.

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

For more information, contact your EmblemHealth Sales Representative.

* EmblemHealth combined Rx deductible per individual covers retail (30-day supply) and home delivery (90-day supply) for preferred and non-preferred drugs. The deductible does not apply to generic drugs.



EmblemHealth[™]

EmblemHealth insurance plans are underwritten by Group Health Incorporated (GHI), HIP Health Plan of New York (HIP) and HIP Insurance Company of New York. GHI, HIP and HIP Insurance Company of New York are EmblemHealth companies. EmblemHealth Services Company LLC provides administrative services to EmblemHealth companies. Refer to HIP policy form 155-23-EMRX (5/08).