** **THIS SECTION PROVIDES A SUMMARY OF THE PLAN BENEFITS. PLEASE BE SURE TO REFER TO ALL APPROPRIATE SECTIONS IN THE ATTACHED PLAN DOCUMENT FOR A COMPLETE DESCRIPTION OF THE BENEFITS PROVIDED BY THE EAST END HEALTH PLAN.**

GENERAL CONDITIONS

Lifetime Maximum Benefit (per person)	Unlimited
Calendar Year Maximum Benefit (per person)	$2,000,000

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Deductible	N/A	$1,000 per individual; $1,000 per spouse; $1,000 for all dependent children combined
Maximum Out-of-Pocket Expense	N/A	$3,000 per individual; $3,000 per spouse; $3,000 for all dependent children combined

HOSPITAL SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Hospital Inpatient Services (Including Maternity care and Newborn care from birth on; and mental health, and substance abuse services)	Covered in full.	80% of Reasonable and Customary (R&C) after deductible
Hospital Outpatient Services (Includes Same Day Surgery and Ambulatory Surgical Centers)	$35 Co-payment.	80% of Reasonable and Customary (R&C) after deductible
Emergency Room	$50 Co-payment. Co-payment is waived if the patient is admitted into an inpatient setting in the hospital. For an injury or the sudden onset of a medical or behavioral condition. The symptoms of an emergency condition (e.g. severe pain) must be serious enough that a prudent layperson with average knowledge of medicine and health could reasonably believe that, if not immediately treated; • The person's health, or, in the case of a behavioral condition, the person's health or the health of others, could reasonably be in danger; • The person's bodily functions could be seriously impaired; • One of the organs or other parts of the body could be seriously harmed; or • The person could be seriously disfigured.	
Urgent Care Facilities	$20 co-pay	80% of Reasonable and Customary (R&C) after deductible

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Pre-Admission Testing	$20 co-pay	80% of Reasonable and Customary (R&C) after deductible
Diagnostic Tests & X-Ray (Including mammography screening) (Tests and X-Rays that are performed in an outpatient setting)	$20 co-pay	80% of R&C after deductible
Laboratory Services	Covered in Full - No co-pay if in-network lab is used	$20 Co-pay All other lab providers
LabCorp is the in-network laboratory provider. Note that if an out-of-network lab is used, the patient may have to pay the full cost of the lab up front and then submit a paper claim to the Third Party Administrator (TPA) for reimbursement.		
Physical Therapy (Inpatient Only)	Covered in Full - No co-pay	80% of R&C after deductible
Physical Therapy (Outpatient)	$20 co-pay	80% of R&C after deductible
Hemodialysis	$20 co-pay	80% of R&C after deductible
Chemotherapy	$20 co-pay	80% of R&C after deductible

PHYSICIAN SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Physician Office Visits	$20 co-pay	80% of R&C after deductible
Specialist Office Visits	$20 co-pay	80% of R&C after deductible
Gynecology Office Visits **(Including PAP Smear and related lab tests subject to lab benefit)**	$20 co-pay	80% of R&C after deductible
Diagnostic Tests & X-Ray	$20 co-pay	80% of R&C after deductible
Laboratory Services	Covered in Full - No co-pay if in-network labs are used	$20 Co-pay All other lab providers
LabCorp is the in-network laboratory provider. Note that if an out-of-network lab is used, the patient may have to pay the full cost of the lab up front and then submit a paper claim to the TPA for reimbursement.		
Well Baby/Child Care (up to age 19) (Including Immunizations)	Covered in Full - No co-pay	Covered up to a maximum of $100. Not subject to deductible and Coinsurance
Preventive Services (Including Immunizations) (Including mammography screening and pap smears	$0 co-pay.	Covered up to a maximum of $100. Not subject to deductible and coinsurance

PHYSICIAN SERVICES (CONT.)

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Surgery	$20 co-pay	80% of R&C after deductible
Anesthesiology	Paid in Full	80% of R&C after deductible
Maternity 18 co-pay for initial visit.	$20 co-pay for initial visit Covered in Full thereafter.	80% of R&C after deductible
Allergy Testing	$20 co-pay	80% of R&C after deductible
Allergy Treatment	Paid in Full	80% of R&C after deductible
Chiropractic Services ($20 Co-pay for related radiology)	$20 co-pay	50% of the in-network allowance after deductible
Physical, Occupational & Speech Therapy	$20 co-pay	PT - 50% of in-network allowance after deductible OT & ST - 80% of R&C after deductible
Durable Medical Equipment (Over $1,000 requires prior authorization) (DME can be replaced every three years)	Plan pays 90% of the purchase cost or rental expense of equipment.	80% of R&C after deductible
Prosthetic Devices	Paid in Full	80% of R&C after deductible
Wigs and Cranial Prothetics (For Cancer and Alopecia Diagnosis only – Subject to an annual max of $750)	Paid in Full	80% of R&C after deductible

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES

Substance Abuse Inpatient	Covered in Full. Pre-Certification of the admission is required.	80% of R&C after deductible Pre-Certification of the admission is required
Substance Abuse Outpatient	$20 Co-pay.	80% of R&C after deductible.
Mental Health Inpatient	Covered in full Pre-certification of the admission is required.	80% of R&C after deductible. Pre-Certification of the admission is required.
Mental Health Outpatient	$20 co-pay	80% of R&C after deductible

PRESCRIPTION DRUGS

Prescription Drug Retail Benefit

A 30-day supply of prescription drugs is available at a retail pharmacy subject to the following co-payments (Mandatory generic substitution clause applies to the benefit, please see Part V "Prescription Drug Coverage" of this Plan Document for additional details):

Generic Drugs:	$5
Preferred Brand Name Drugs	$25
Non-Preferred Brand Name Drugs	$45
Specialty Drugs	20% Co-pay

PRESCRIPTION DRUGS (Cont.)

Prescription Drug Mail Order Benefit — A 90-day supply of maintenance prescription drugs is available from the mail order pharmacy subject to the following co-payments (Mandatory generic substitution clause applies to the benefit):

Generic Drugs:	$10
Preferred Brand Name Drugs	$50
Non-Preferred Brand Name Drugs	$90
Specialty Drugs	20% Co-pay

OTHER BENEFITS

Hospice Care — Covered in full. Life expectancy must be six months or less. Service must be provided be a certified Hospice organization.

Skilled Nursing Facility — Covered in full. Maximum benefit is 90 visits per year. **If Medicare Primary, no benefits apply.**

Home Health Care — Covered in full. Maximum benefit is 100 visits per year.

Ambulance — $50 Co-pay. Coverage for Emergency Services Only.

Hearing Aid — Paid at 100% up to a total maximum reimbursement of $1,500 per ear once every four years. Children of the age 12 and under are covered up to a total maximum reimbursement of $1,500 per ear once every two years. These benefits are not subject to deductible or co-insurance.

Vision Plan:

I**n-Network Benefits:** Network providers are an option added to the plan through the Plan's Vision Benefit Administrator. When you use a network participating provider, you can receive a paid-in-full benefit, including a complete eye exam, frame and lenses or contact lenses in lieu of eyeglasses. A one year breakage warranty is provided for all eyeglasses completely supplied by the Plan.

Any frame from the special selection of designer frames displayed on the "Tower Collection" at a participating doctor's office is available under the Plan with no co-payment. If you select a frame other than those available through the Plan, a $45 wholesale allowance will be applied toward their cost. Some spectacle lens types are also available with no co-payment (please note that some lens types are available only at an additional charge). Contact lenses are available in lieu of eyeglasses under the Plan with no co-payment for standard, soft, daily-wear disposable or planned replacement contact lenses or a $75 credit plus 15% discount off any overage towards other types of contact lenses from the provider's own supply. Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.

Out-of-Network Benefits: The Plan pays for vision services based upon a fixed fee schedule. You are responsible for any balance due the provider of the services. To obtain payment for services performed by the Non-Network Provider, please complete a vision claim form and return it with your accompanying receipts to the Plan's Vision Plan Administrator. You will receive a check reimbursing you up to the allowable expense.

	Benefit		Benefit
Eye examination	$30	Contact lenses	$110
Single vision lenses with frame	$30	Medically necessary contact lenses	
Bifocal lenses and frame	$60	for the correction of Keratoconus	$225
Trifocal lenses and frame	$110		