

**Comparison between East End Health Plan and the Empire Plan Effective January 1, 2007**

<b>I. General Conditions</b>				
<b>Benefit</b>	<b>East End Health Plan</b>		<b>Empire Plan</b>	
	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
Lifetime Maximum	Unlimited		Unlimited	
Calendar Year Maximum	\$1,000,000		Unlimited	
Deductible	N/A	\$350 enrollee; \$700 accumulative maximum per family	N/A	\$350 enrollee; \$350 enroled spouse; \$350 all dependent children combined (Effective 1/1/07)
Maximum Out-of-Pocket Expense	N/A	\$1,500	N/A	\$1,650 per employee and covered dependents combined (Effective 1/1/07)
<b>II. Hospital Services</b>				
<b>Benefit</b>	<b>East End Health Plan</b>		<b>Empire Plan</b>	
	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
Hospital In-Patient	Covered in full.		Covered in full for 365 days of care per illness. Pre-certification or notification required.	10% Coinsurance up to a combined inpatient/outpatient max of \$1,500 per enrollee/\$1,500 per spouse/\$1,500 all dependent children combined.
Hospital Out-Patient	\$35 copayment. No copay for physical therapy.		\$35 Copayment (waived if admitted) for minor surgery and diagnostic testing. No Copay for certain procedures.	10% Coinsurance or \$75 (whichever is greater) up to a combined inpatient/outpatient max of \$1,500 per enrollee/\$1,500 per spouse/\$1,500 all dependent children combined.
Emergency Room	\$50 Copayment (waived if admitted)		\$60 Copayment (waived if admitted)	
Pre-Admission Testing	\$15 copayment		Paid at 100%	
Laboratory & X-Ray	Covered in full		\$35 Copayment (waived if admitted) for all lab and x-ray services during office visit or freestanding center. <i>Pre-Certification required for MRI test.</i>	
Routine Nursery	100% No Copayment Applies		Paid at 100% for care in-hospital.	Doctors' services for the routine care of a newborn child are covered up to a total maximum payment of \$150. Not subject to copayment or deductible.
Cardiac Rehabilitation / Physical Therapy	\$15 Copayment	80% R&C after deductible	\$15 Copayment	10% Coinsurance or \$75 (whichever is greater) up to a combined inpatient/outpatient max of \$1,500 per enrollee/\$1,500 per spouse/\$1,500 all dependent children combined.

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<b>III. Physician Services</b>				
<b>Benefit</b>	<b>East End Health Plan</b>		<b>Empire Plan</b>	
	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
Office Visits	\$15 Copayment	80% R&C after deductible	\$18 Copayment	80% R&C after deductible
Routine Adult Physical Exams (including Adult immunizations)	\$15 Copayment. Influenza, pneumonia, MMR, varicella and tetanus immunizations are covered as part of the Physical Exam. When shots are administered outside of the Physical Exam there is a \$15 co-payment.	80% R&C after deductible	\$18 Copayment. Influenza, pneumonia, MMR, varicella and tetanus immunizations are covered at \$18 Copayments.	Up to \$250 once every two calendar years for actives age 50 or older and up to \$250 once every two calendar years for an active's spouse age 50 or older. Not subject to deductible or coinsurance. Immunizations are not covered.
Gynecology (including PAP smear, related lab tests)	\$15 Copayment	80% R&C after deductible	\$18 Copayment	80% R&C after deductible
Mammography	\$15 Copayment	80% R&C after deductible	\$18 Copayment	80% R&C after deductible
Well-Baby and Well-Child Care	100% No Copayment	Covered up to a maximum of \$100. Not subject to deductible and coinsurance.	100% up to age 19. No Copayment Applies.	80% R&C after deductible
Diagnostic Tests & X-Ray	\$15 Copayment	80% R&C after deductible	\$18 Copayment	80% R&C after deductible
Laboratory Services	No copayment if participating lab is used.	\$15 Copayment	\$18 Copayment	80% R&C after deductible
Surgery	\$15 Copayment	80% R&C after deductible	\$18 Copayment	80% R&C after deductible
Anesthesiology	\$15 Copayment	80% R&C after deductible	\$18 Copayment for facility charges at a participating ambulatory surgical center.	80% R&C after deductible
Maternity	\$15 Copayment for initial visit. 100% thereafter.	80% R&C after deductible	No Copayment for prenatal visits, delivery and six-week check-up after delivery.	80% R&C after deductible
Allergy Testing/Treatment	\$15 Copayment	80% R&C after deductible	\$18 Copayment	80% R&C after deductible
Specialists	\$15 Copayment	80% R&C after deductible	\$18 Copayment	80% R&C after deductible
<b>IV. Mental Health/Substance Abuse Services</b>				
<b>Benefit</b>	<b>East End Health Plan</b>		<b>Empire Plan</b>	
	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
Mental Health Inpatient	Covered in Full. 120 day maximum benefit. Pre-Certification is required.	80% R&C after deductible. 120 day maximum benefit. Pre-Certification is required.	Paid at 100%; <i>Managed care program. Pre-Certification required.</i>	Limited to 30 days per year. \$2,000 deductible per enrolled, per spouse, per dependent children combined. After deductible, Plan pays 50% of network allowance.
Mental Health Outpatient	\$15 Copayment. Pre-Certification is required.	Subject to deductible and coinsurance. Benefit capped at \$40 per visit. Pre-Certification is required.	\$18 Copayment. <i>Managed care program. Pre-Certification required.</i>	Limited to 30 visits per year. \$500 deductible per enrolled, per spouse, per dependent children combined. After deductible, Plan pays 50% of network allowance.
Substance Abuse Inpatient	Covered in Full. 1 admit per year, 3 for lifetime. Pre-Certification is required.	Covered in Full. 1 admit per year, 3 for lifetime. Pre-Certification is required. \$450 per day maximum benefit.	Paid at 100%. Limited to 3 stays per lifetime. <i>Managed care program. Pre-Certification required.</i>	\$50,000 Annual maximum. \$250,000 Lifetime maximum. Limited to one stay per year. three stays per lifetime. \$2,000 deductible per enrolled, per spouse, per dependent children combined. After deductible, Plan pays 50% of network allowance.
Substance Abuse Outpatient	\$15 Copayment. 60 visit maximum benefit. 20 of the visits may be used for family counseling. Pre-Certification is required.	80% R&C after deductible. 60 visit maximum benefit. 20 of the visits may be used for family counseling. Pre-Certification is required.	\$18 Copayment. <i>Managed care program. Pre-Certification required.</i>	\$50,000 Annual maximum. \$250,000 Lifetime maximum. Limited to 30 visits per year. \$500 deductible per enrolled, per spouse, per dependent children combined. After deductible, Plan pays 50% of network allowance.

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V. Prescription Drugs			
Benefit	East End Health Plan		Empire Plan
Prescription Drug Copayments- Retail	\$5 Copayment for generic drugs, \$15 for preferred brand name drugs and \$30 for non-preferred brand name drugs (30 day supply). Mandatory generic drug substitution clause applies.		\$5 Copayment for generic drugs, \$15 for preferred brand name drugs and \$30 for non-preferred brand name drugs (30 day supply). \$10 Copayment for generic drugs, \$30 for preferred brand name drugs and \$60 for non-preferred brand name drugs (31-90 day supply). Mandatory generic drug substitution clause applies.
Prescription Drug Copayments- Mail	For maintenance drugs: \$5 Copayment for generic drugs, \$20 for preferred brand name drugs and \$40 for non-preferred brand name drugs (90 day supply). Mandatory generic drug substitution clause applies.		For maintenance drugs: \$5 Copayment for generic drugs, \$20 for preferred brand name drugs and \$55 for non-preferred brand name drugs (up to 90 day supply). Mandatory generic drug substitution clause applies.
VI. Other Benefits			
Benefit	East End Health Plan		Empire Plan
	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u> <u>Out-of-Network</u>
Hospice Care	100% (life expectancy must be 6 months or less). Service must be provided by certified Hospice organization.		Paid at 100% for care in state-certified hospice.      10% Coinsurance up to a combined inpatient/outpatient max of \$1,500 per enrollee/\$1,500 per spouse/\$1,500 all dependent children combined.
Skilled Nursing Facility	Covered in full. Maximum benefit is 90 days per year. Pre-certification required.		Two days for each unused hospital day. Covered in full for medically necessary care in an approved facility (if not Medicare eligible) for each illness. Included in maximum hospitalization benefit of 365 days. <i>Pre-Certification required.</i> 10% Coinsurance up to a combined inpatient/outpatient max of \$1,500 per enrollee/\$1,500 per spouse/\$1,500 all dependent children combined.
Home Health Care	Covered in full. Maximum benefit is 100 days per year. Pre-certification required.		Managed care program. Paid in full if medically necessary. <i>Pre-Certification required.</i> First 48 hours not covered. After deductible 50% of network allowance. No coinsurance maximum.
Chiropractic Services	\$15 Copayment	80% R&C after deductible	\$18 Copayment for visits to a managed physical network provider. \$18 Copayment for related radiology.      Annual maximum benefit of \$1,500 per person with a \$250 deductible for enrollee/\$250 for spouse/ \$250 for dependent children combined. Plan pays up to 50% of network allowance after deductible.
Physical, Occupational & Speech Therapy	\$15 Copayment	80% R&C after deductible	\$18 Copayment for visits to a managed physical network provider. \$18 Copayment for related radiology.      Annual maximum benefit of \$1,500 per person with a \$250 deductible for enrollee/\$250 for spouse/ \$250 for dependent children combined. Plan pays up to 50% of network allowance after deductible.
Ambulance	Paid at 100% up to \$50. Remaining balance over \$50 is paid at 80% after deductible.		Medically necessary services. Local professional ambulance charges except the first \$35. Voluntary ambulance services up to \$50 for under 50 miles and up to \$75 for 50 miles and over. Not subject to deductible and coinsurance.
Durable Medical Equipment	90% covered	80% R&C after deductible	Managed care program; Paid in full if medically necessary. <i>Pre-Certification required.</i> After deductible 50% of network allowance. No coinsurance maximum.
Hearing Aid	Up to a maximum of \$1,200 per ear every 4 years, not subject to deductible or coinsurance. For children, up to \$1,200 per ear every 2 years.		Up to a maximum of \$1,200 per ear every 4 years, not subject to deductible or coinsurance. For children, up to \$1,200 per ear every 2 years.
Vision	Full Vision Benefit under Davis Vision: Exam, Glasses, frames, lenses, contact lenses based on schedule.		Not Covered