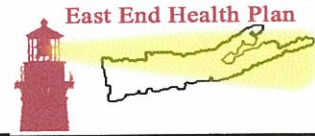


# EAST END HEALTH PLAN BENEFIT SUMMARY



**\*\* 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.**

## SECTION I - GENERAL CONDITIONS

<b>Lifetime Maximum Benefit</b>	Unlimited
<b>Calendar Year Maximum Benefit</b>	\$1,000,000

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<b>Deductible</b>	N/A	\$350 per individual up to \$700 accumulative maximum per family
<b>Maximum Out-of-Pocket Expense</b>	N/A	\$1,500

## SECTION II - HOSPITAL SERVICES

**Hospital Inpatient Services**                      Covered in full.  
(Including Maternity care and Newborn care from birth on)

**Hospital Outpatient Services**                      \$35 Co-payment.

**Emergency Room**                      \$50 Co-payment. 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.

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<b>Pre-Admission Testing</b>	\$15 co-pay	80% of R&C after deductible
<b>Diagnostic Tests &amp; X-Ray</b> (Including mammography screening)	\$15 co-pay	80% of R&C after deductible



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	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<b>Laboratory Services</b>	Covered in Full - No co-pay if in-network lab is used	\$15 Co-pay All other lab providers
<p>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 claims to the TPA for reimbursement.</p>		
<b>Physical Therapy (Inpatient Only)</b>	Covered in Full - No co-pay	80% of R&C after deductible
<b>Hemodialysis</b>	\$15 co-pay	80% of R&C after deductible
<b>Chemo Therapy</b>	\$15 co-pay	80% of R&C after deductible

### SECTION III - PHYSICIAN SERVICES

	<u>IN-NETWORK BENEFIT PAYMENT</u>	<u>OUT-OF-NETWORK BENEFIT PAYMENT</u>
<b>Physician Office Visits</b>	\$15 co-pay	80% of R&C after deductible
<b>Specialist Office Visits</b>	\$15 co-pay	80% of R&C after deductible
<b>Gynecology Office Visits (Including PAP Smear and related lab tests subject to lab benefit)</b>	\$15 co-pay	80% of R&C after deductible
<b>Diagnostic Tests &amp; X-Ray (Including mammography screening)</b>	\$15 co-pay	80% of R&C after deductible
<b>Laboratory Services</b>	Covered in Full - No co-pay if in-network labs are used	\$15 Co-pay All other lab providers
<p>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 claims to the TPA for reimbursement.</p>		
<b>Well Child/Baby Care (Including Immunizations)</b>	Covered in Full - No co-pay	Covered up to a maximum of \$100. Not subject to deductible and co-insurance.
<b>Routine Adult Physical Exams</b>	\$15 co-pay. One exam per year	80% of R&C after deductible
<b>Surgery</b>	\$15 co-pay	80% of R&C after deductible
<b>Anesthesiology</b>	\$15 co-pay	80% of R&C after deductible
<b>Maternity</b>	\$15 co-pay for initial visit. Covered in Full thereafter.	80% of R&C after deductible
<b>Allergy Testing</b>	\$15 co-pay	80% of R&C after deductible



**EAST END HEALTH PLAN BENEFIT SUMMARY**

**SECTION IV - MENTAL HEALTH/SUBSTANCE ABUSE SERVICES**

	<b><u>IN-NETWORK BENEFIT PAYMENT</u></b>	<b><u>OUT-OF-NETWORK BENEFIT PAYMENT</u></b>
<b>Substance Abuse Inpatient</b>	Covered in Full. One admission per year is covered up to a 7 week maximum stay per admission. Three admissions per lifetime are covered. Pre-Certification of the admission is required.	Covered in Full. One admission per year is covered up to a 7 week maximum stay per admission. Three admissions per lifetime are covered. Pre-Certification of the admission is required. There is a \$450 per day maximum benefit for out-of-network services
<b>Substance Abuse Outpatient</b>	\$15 Co-pay. 60 visit maximum benefit. 20 of the visits may be used for family counseling. Pre-Certification of the service is required.	80% of R&C after deductible. 60 visit maximum benefit. 20 of the visits may be used for family counseling. Pre-Certification of the service is required
	<b><u>IN-NETWORK BENEFIT PAYMENT</u></b>	<b><u>OUT-OF-NETWORK BENEFIT PAYMENT</u></b>
<b>Mental Health Inpatient</b>	Covered in full up to 120 days. Pre-certification of the admission is required.	80% of R&C after deductible. 120 day maximum benefit applies. Pre-Certification of the admission is required.
<b>Mental Health Outpatient</b>	\$15 co-pay	80% of R&C after deductible. Benefit capped at \$40 per visit.

**SECTION V - PRESCRIPTION DRUGS**

<b>Prescription Drug Retail Benefit</b>	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):	
	Generic Drugs:	\$5
	Preferred Brand Name Drugs	\$15
	Non-Preferred Brand Name Drugs	\$30
<b>Prescription Drug Mail Order Benefit</b>	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:	\$5
	Preferred Brand Name Drugs	\$20
	Non-Preferred Brand Name Drugs	\$40



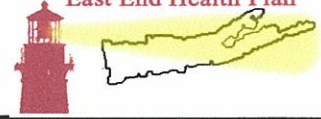
**SECTION VI - OTHER BENEFITS**

<b>Hospice Care</b>	Covered in full. Life expectancy must be six months or less. Service must be provided by a certified Hospice organization.
<b>Skilled Nursing Facility</b>	Covered in full. Maximum benefit is 90 days per year.
<b>Home Health Care</b>	Covered in full. Maximum benefit is 100 days per year.
<b>Ambulance</b>	Ambulance is paid at 100% up to \$50. Remaining balance over \$50 is paid at 80% after deductible.
<b>Hearing Aid</b>	Paid at 100% up to a total maximum reimbursement of \$1,200 per ear once every four years. Children of the age 12 and under are covered up to a total maximum reimbursement of \$1,200 per ear once every two years. These benefits are not subject to deductible or co-insurance.

	<b><u>IN-NETWORK BENEFIT PAYMENT</u></b>	<b><u>OUT-OF-NETWORK BENEFIT PAYMENT</u></b>
<b>Chiropractic Services</b>	\$15 co-pay	80% of R&C after deductible
<b>Physical, Occupational &amp; Speech Therapy</b>	\$15 co-pay	80% of R&C after deductible
<b>Durable Medical Equipment</b>	Plan pays 90% of the purchase cost or rental expense of equipment.	80% of R&C after deductible

**Vision Plan**  
**In-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 warranty is given on all Plan-supplied eyeglasses.

Any frame from the special selection of designer frames displayed on the “Tower Collection” in every participating doctor’s office is available under the Plan with no co-payment. 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 are available under the Plan and require either a \$25.00 or \$45 co-payment toward standard, soft, daily-wear disposable or planned replacement contact lenses. New disposable contact lens wearers will receive an initial supply (two multi-packs) of lenses along with all necessary visits for proper fitting and recommended follow-up care. Existing contact lens wearers will receive four multi-packs of lenses.



## EAST END HEALTH PLAN BENEFIT SUMMARY

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### Vision Plan (Continued)

**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.

	<u>Benefit</u>
Eye examination	\$30.00
Single vision lenses with frames	\$30.00
Bifocal lenses and frames	\$60.00
Trifocal lenses and frames	\$110.00
Contact lenses	\$110.00