** **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

Lifetime Maximum Benefit	Unlimited
Calendar Year Maximum Benefit	$1,000,000

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Deductible	N/A	$350 per individual up to $700 accumulative maximum per family
Maximum Out-of-Pocket Expense	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.

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Pre-Admission Testing	$15 co-pay	80% of R&C after deductible
Diagnostic Tests & X-Ray (Including mammography screening)	$15 co-pay	80% of R&C after deductible

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Laboratory Services	Covered in Full - No co-pay if in-network lab is used	$15 Co-pay All other lab providers

Quest Diagnostics 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.

Physical Therapy (Inpatient Only)	Covered in Full - No co-pay	80% of R&C after deductible
Hemodialysis	$15 co-pay	80% of R&C after deductible
Chemo Therapy	$15 co-pay	80% of R&C after deductible

SECTION III - PHYSICIAN SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Physician Office Visits	$15 co-pay	80% of R&C after deductible
Specialist Office Visits	$15 co-pay	80% of R&C after deductible
Gynecology Office Visits (Including PAP Smear and related lab tests subject to lab benefit)	$15 co-pay	80% of R&C after deductible
Diagnostic Tests & X-Ray (Including mammography screening)	$15 co-pay	80% of R&C after deductible
Laboratory Services	Covered in Full - No co-pay if in-network labs are used	$15 Co-pay All other lab providers

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.

Well Child/Baby Care (Including Immunizations)	Covered in Full - No co-pay	Covered up to a maximum of $100. Not subject to deductible and co-insurance.
Routine Adult Physical Exams	$15 co-pay. One exam per year	80% of R&C after deductible
Surgery	$15 co-pay	80% of R&C after deductible
Anesthesiology	$15 co-pay	80% of R&C after deductible
Maternity	$15 co-pay for initial visit. Covered in Full thereafter.	80% of R&C after deductible
Allergy Testing	$15 co-pay	80% of R&C after deductible

SECTION IV - MENTAL HEALTH/SUBSTANCE ABUSE SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Substance Abuse Inpatient	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
Substance Abuse Outpatient	$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
	IN-NETWORK BENEFIT PAYMENT	**OUT-OF-NETWORK BENEFIT PAYMENT**
Mental Health Inpatient	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.
Mental Health Outpatient	$15 co-pay	80% of R&C after deductible. Benefit capped at $40 per visit.

SECTION V - 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):

Generic Drugs:	$5
Preferred Brand Name Drugs	$15
Non-Preferred Brand Name Drugs	$30

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:	$5
Preferred Brand Name Drugs	$20
Non-Preferred Brand Name Drugs	$40

SECTION VI - 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 days per year.	
Home Health Care	Covered in full. Maximum benefit is 100 days per year.	
Ambulance	Ambulance is paid at 100% up to $50. Remaining balance over $50 is paid at 80% after deductible.	
Hearing Aid	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.	
	IN-NETWORK BENEFIT PAYMENT	**OUT-OF-NETWORK BENEFIT PAYMENT**
Chiropractic Services	$15 co-pay	80% of R&C after deductible
Physical, Occupational & Speech Therapy	$15 co-pay	80% of R&C after deductible
Durable Medical Equipment	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.

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.

	Benefit
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