Comparison between East End Health Plan and the Empire Plan Effective July 1, 2010

I. General Conditions				
Benefit	**East End Health Plan**		**Empire Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Lifetime Maximum	Unlimited		Unlimited	
Calendar Year Maximum	$1,000,000		$1,000,000	
Deductible	N/A	'$350 enrollee; $700 accumulative maximum per family	N/A	$375 enrollee; $375 enroled spouse; $375 all dependent children combined
Maximum Out-of-Pocket Expense	N/A	$1,500	N/A	$1,033 enrollee; $1,033 enroled spouse; $1,033 all dependent children combined

II. Hospital Services				
Benefit	**East End Health Plan**		**Empire Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
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 inpatient physical therapy.		$60 Copayment (waived if admitted) for outpatient surgery. $40 Copayment for diagnostic testing.	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)		$70 Copayment (waived if admitted)	
Pre-Admission Testing	$18 copayment		Paid at 100%	
Laboratory & X-Ray	Covered in full		$35 Copayment (waived if admited) for all lab and x-ray services during office visit or freestanding center. *Pre-Certification required for MRI test.*	

Comparison between East End Health Plan and the Empire Plan Effective July 1, 2010

II. Hospital Services (cont.)				
Benefit	**East End Health Plan**		**Empire Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
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	$18 Copayment	80% R&C after deductible	$20 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.
III. Physician Services				
Benefit	**East End Health Plan**		**Empire Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits	$18 Copayment	80% R&C after deductible	$20 Copayment	80% R&C after deductible
Routine Adult Physical Exams (including Adult immunizations)	$18 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 $18 co-payment.	80% R&C after deductible	$20 Copayment. Influenza, pneumonia, MMR, varicella and tetanus immunizations are covered at $20 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)	$18 Copayment	80% R&C after deductible	$20 Copayment	80% R&C after deductible
Mammography	$18 Copayment	80% R&C after deductible	$20 Copayment	80% R&C after deductible

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III. Physician Services (cont.)				
Benefit	**East End Health Plan**		**Empire Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
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	$18 Copayment	80% R&C after deductible	$20 Copayment	80% R&C after deductible
Laboratory Services	No copayment if participating lab is used.	$18 Copayment	$20 Copayment	80% R&C after deductible
Surgery	$18 Copayment	80% R&C after deductible	$20 Copayment	80% R&C after deductible
Anesthesiology	$18 Copayment	80% R&C after deductible	$20 Copayment for facility charges at a participating ambulatory surgical center.	80% R&C after deductible
Maternity	$18 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	$18 Copayment	80% R&C after deductible	$20 Copayment	80% R&C after deductible
Specialists	$18 Copayment	80% R&C after deductible	$20 Copayment	80% R&C after deductible

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IV. Mental Health/Substance Abuse Services				
Benefit	**East End Health Plan**		**Empire Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health Inpatient	Covered in Full. Pre-Certification is required.	80% R&C after deductible. Pre-Certification is required.	Paid at 100%; *Managed care program. Pre-Certification 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.
Mental Health Outpatient	$18 Copayment.	80% R&C after deductible. Pre-Certification is required.	$20 Copayment. Managed care program. Pre-Certification required.	80% R&C after deductible
Substance Abuse Inpatient	Covered in Full. Pre-Certification is required.	80% R&C after deductible. Pre-Certification is required.	Paid at 100%. *Managed care program. Pre-Certification 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.
Substance Abuse Outpatient	$18 Copayment.	80% R&C after deductible. Pre-Certification is required.	$20 Copayment. Managed care program. Pre-Certification required.	80% R&C after deductible
V. Prescription Drugs				
Benefit	**East End Health Plan**		**Empire Plan**	
Prescription Drug Copayments-Retail	$2 Copayment for generic drugs, $20 for preferred brand name drugs and $40 for non-preferred brand name drugs (30 day supply). Manditory generic drug substitution clause applies.		$5 Copayment for generic drugs, $15 for preferred brand name drugs and $40 for non-preferred brand name drugs (30 day supply). $10 Copayment for generic drugs, $30 for preferred brand name drugs and $70 for non-preferred brand name drugs (31-90 day supply). Manditory generic drug substitution clause applies.	
Prescription Drug Copayments-Mail	For maintenance drugs: $2 Copayment for generic drugs, $25 for preferred brand name drugs and $50 for non-preferred brand name drugs (90 day supply). Manditory generic drug substitution clause applies.		For maintenance drugs: $5 Copayment for generic drugs, $20 for preferred brand name drugs and $65 for non-preferred brand name drugs (up to 90 day supply). Manditory generic drug substitution clause applies.	

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VI. Other Benefits				
Benefit	**East End Health Plan**		**Empire Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
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/$1,5000 per spouse/$1,500 all dependent children combined.
Skilled Nursing Facility	Covered in full. Maximum benefit is 90 days per year (if not Medicare eligible). 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. *Pre-Certification required.*	10% Coinsurance up to a combined inpatient/ outpatient max of $1,500 per enrollee/$1,5000 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. *Pre-Certification required.*	First 48 hours not covered. After deductbile 50% of network allowance. No coinsurance maximum.
Chiropractic Services	$18 Copayment	80% R&C after deductible	$20 Copayment for visits to a managed physical network provider. $20 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.

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VI. Other Benefits (cont.)				
Benefit	**East End Health Plan**		**Empire Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physical, Occupational & Speech Therapy	$18 Copayment	80% R&C after deductible	$20 Copayment for visits to a managed physical network provider. $20 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	
Durable Medical Equipment	90% covered. Pre-Cert is required for DME Equipment that is over $1,000. DME can be replaced every three years.	80% R&C after deductible. Pre-Cert is required for DME Equipment that is over $1,000. DME can be replaced every three years.	Managed care program; Paid in full if medically necessary. *Pre-Certification required.*	After deductbile 50% of network allowance . No coinsurance maximum.
Hearing Aid	Up to a maximum of $1,500 per ear every 4 years, not		Up to a maximum of $1,500 per ear every 4 years, not	
Vision	Full Vision Benefit under Davis Vision: Exam, Glasses, frames, lenses, contact lenses based on schedule.		Not Covered	