** **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 (per person)	Unlimited
Calendar Year Maximum Benefit (per person)	$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; and mental hyealth and substance abuse services)

Hospital Outpatient Services $35 Co-payment.
(Includes Same Day Surgery and Ambulatory Surgical Centers)

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.

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Pre-Admission Testing	$18 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)	$18 co-pay	80% of R&C after deductible

SECTION II - HOSPITAL SERVICES (CONT.)

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Laboratory Services	Covered in Full - No co-pay if in-network lab is used	$18 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 claims 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)	$18 co-pay	80% of R&C after deductible
Hemodialysis	$18 co-pay	80% of R&C after deductible
Chemotherapy	$18 co-pay	80% of R&C after deductible

SECTION III - PHYSICIAN SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Physician Office Visits	$18 co-pay	80% of R&C after deductible
Specialist Office Visits	$18 co-pay	80% of R&C after deductible
Gynecology Office Visits (Including PAP Smear and related lab tests subject to lab benefit)	$18 co-pay	80% of R&C after deductible
Diagnostic Tests & X-Ray (Including mammography screening)	$18 co-pay	80% of R&C after deductible
Laboratory Services	Covered in Full - No co-pay if in-network labs are used	$18 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 claims 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
Routine Adult Physical Exams One exam per year (Including Immunizations)	$18 co-pay.	80% of R&C after deductible
Surgery	$18 co-pay	80% of R&C after deductible
Anesthesiology	$18 co-pay	80% of R&C after deductible
Maternity	$18 co-pay for initial visit. Covered in Full thereafter.	80% of R&C after deductible

SECTION III - PHYSICIAN SERVICES (CONT.)

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Allergy Testing	$18 co-pay	80% of R&C after deductible
Allergy Treatment	Paid in Full	80% of R&C after deductible
Chiropractic Services	$18 co-pay	80% of R&C after deductible
Physical, Occupational & Speech Therapy	$18 co-pay	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

SECTION IV - 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	$18 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	$18 co-pay	80% of R&C after deductible

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, please see Part V "Prescription Drug Coverage" of this Plan Document for additional details):

Generic Drugs:	$2
Preferred Brand Name Drugs	$20
Non-Preferred Brand Name Drugs	$40

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:	$2
Preferred Brand Name Drugs	$25
Non-Preferred Brand Name Drugs	$50

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 visits per year.

Home Health Care

Covered in full. Maximum benefit is 100 visits 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 $1,500 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.

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. You will receive a check reimbursing you up to the allowable expense

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