

**COMPARISON OF EXCLUSIVE PROVIDER ORGANIZATION (EPO), POINT-OF-SERVICE (POS) AND  
PREFERRED PROVIDER ORGANIZATION (PPO) / INDEMNITY PLAN BENEFITS  
(Services Both In- and Out-of-Network)**

	<b>Aetna Quality Point of Service</b>	<b>DC 37 Med-Team</b>	<b>Empire EPO</b>	<b>GHI-CBP /Empire BlueCross BlueShield</b>	<b>HIP Prime POS</b>
<b>Deductible</b>	\$250/Individual \$750/Family	\$1,250/Individual \$3,000/Family	None	\$200/Individual \$500/Family	\$250/Individual \$500/Family
<b>Maximum Out-of-Pocket</b>	\$2,500 Individual/ \$7,500 Family	\$3,750/Individual \$9,375/Family	None	\$1,500 per person	\$2,000/Individual \$4,000/Family
<b>Physician's Office Visits</b>	<b>In-Network</b> \$15 copay pcp/\$20 spec. <b>Out-of-Network</b> Covered 80% after deductible	<b>In-Network</b> \$10 copay <b>Out-of-Network</b> Covered 70% of allowable amount after deductible	<b>In-Network</b> \$15 copay <b>Out-of-Network</b> Not covered	<b>In-Network</b> \$15 copay- Medical providers \$20 copay- Surgical providers & Dermatologists <b>Out-of-Network</b> Per schedule of allowances after deductible	<b>In-Network</b> Covered in full <b>Out-of-Network</b> Covered 80% after deductible
<b>Outpatient Diagnostic Tests (X-rays, labs, etc.)</b>	<b>In-Network</b> \$15 copay <b>Out-of-Network</b> 80% coinsurance after deductible	<b>In-Network</b> \$10 copay <b>Out-of-Network</b> Covered 70% of allowable amount after deductible	<b>In-Network</b> Covered in full <b>Out-of-Network</b> Not covered	<b>In-Network</b> \$15 copay <b>Out-of-Network</b> Per schedule of allowances after deductible	<b>In-Network</b> Covered in full <b>Out-of-Network</b> Covered 80% after deductible when related to illness /injury. Subject to prior approval
<b>Inpatient Hospital Care (includes Maternity Care)</b>	<b>In-Network</b> Covered in full after \$100 deductible. <b>Out-of-Network</b> Covered 80% after deductible. Covered in full if admitted through emergency room.	<b>In-Network</b> \$250 copay per admission <b>Out-of-Network</b> Covered 70% of allowable amount after deductible	<b>In-Network</b> \$250 copay per admission; up to \$625 maximum per year; Precertification required. <b>Out-of-Network</b> Not covered	Covered in full after \$300 inpatient deductible (\$750 annual max. per person); subject to penalty if not precertified by NYC Healthline	<b>In-Network</b> Covered in full <b>Out-of-Network</b> Covered 80% after deductible
<b>Maternity Care - Physician Services (Mother and Newborn)</b>	<b>In-Network</b> \$15 copay <b>Out-of-Network</b> 80% coinsurance after deductible	<b>In-Network</b> Covered in full <b>Out-of-Network</b> Covered 70% of allowable amount after deductible	<b>In-Network</b> Covered in full <b>Out-of-Network</b> Not covered	<b>In-Network</b> \$15 copay <b>Out-of-Network</b> Physician: Per schedule of allowances after deductible	<b>In-Network</b> Covered in full <b>Out-of-Network</b> Covered 80% after deductible
<b>Emergency Room Care</b>	\$35 copay, waived if admitted	\$50 copay, waived if admitted	\$35 copay, waived if admitted	\$50 copay, waived if admitted	<b>In-Network</b> Covered in full <b>Out-of-Network</b> Covered in full
<b>Prescription Drug Coverage</b>	Available through optional rider	Available through DC37 Health & Security Plan	Available through optional rider	Available through optional rider	Available through optional rider

<p><b>Mental Health (Inpatient Care)</b></p>	<p><b><u>In-Network</u></b> Covered in full 35 days per 365-day period. <b><u>Out-of-Network</u></b> Covered at 80% after deductible for 35 days per 365-day period.</p>	<p><b><u>In-Network</u></b> Covered in full up to 30 days per calendar year; subject to \$250 copay per admission. <b><u>Out-of-Network</u></b> Not covered</p>	<p><b><u>In-Network</u></b> Up to 30 days per calendar year; precertification required; \$250 copay per admission. <b><u>Out-of-Network</u></b> Not covered</p>	<p><b><u>In-Network</u></b> Covered in full 30 days per year <b><u>Out-of-Network</u></b> 50% of Network allowance; 30 days per year</p>	<p><b><u>In-Network</u></b> Covered in full up to 30 days per year <b><u>Out-of-Network</u></b> Covered 80% up to 30 days after deductible (combined with in-network visits)</p>
<p><b>Mental Health (Outpatient Care)</b></p>	<p><b><u>In-Network</u></b> \$25 copay per visit for 20 visits per 365-day period. <b><u>Out-of-Network</u></b> Covered at 50% after deductible for 20 visits per 365-day period.</p>	<p><b><u>In-Network</u></b> \$25 copay per visit for 20 visits per calendar year. <b><u>Out-of-Network</u></b> Not covered</p>	<p><b><u>In-Network</u></b> \$25 copay per visit; up to 20 visits per calendar year; precertification required. <b><u>Out-of-Network</u></b> Not covered</p>	<p><b><u>In-Network</u></b> \$15 copay for 30 visits per year; 5 assessment visits covered in full See Optional Rider for additional benefit <b><u>Out-of-Network</u></b> Available through optional rider only</p>	<p><b><u>In-Network</u></b> \$5 copay per visit – 20 visits per calendar year <b><u>Out-of-Network</u></b> Covered 50% up to 20 visits (combined with in-network visits after deductible)</p>
<p><b>Substance Abuse/ Chemical Dependency (Inpatient Care)</b></p>	<p><b><u>In-Network</u></b> Detox covered in full for acute phase of treatment; Rehab covered in full 30 days per year combined annual maximum for drug and/or alcohol treatment <b><u>Out-of-Network</u></b> Detox covered at 80% after deductible 30 days per year; Rehab covered at 80% after deductible 30 days per year</p>	<p><b><u>In-Network</u></b> Covered in full up to 7 days per calendar year for detox only – subject to \$250 copay per admission. Rehab not covered. <b><u>Out-of-Network</u></b> Not covered</p>	<p><b><u>In-Network</u></b> Rehab covered for 30 days annually; precertification required; \$250 copay per admission. Detox covered for 7 days annually; precertification required; \$250 copay per admission. <b><u>Out-of-Network</u></b> Not covered</p>	<p><b><u>In-Network</u></b> Detox, Rehab covered in full up to 30 days per year, 60 days per lifetime See Optional Rider for additional benefits <b><u>Out-of-Network</u></b> Detox covered at average network allowance; Rehab not covered. See Optional Rider for additional benefits</p>	<p><b><u>In-Network</u></b> Detox covered in full limited to 30 days per calendar year Rehab not covered <b><u>Out-of-Network</u></b> Detox covered 80% after deductible; limited to 30 days per calendar year. 50% penalty applies for failure to notify plan. Rehab not covered</p>
<p><b>Substance Abuse/ Chemical Dependency (Outpatient Care)</b></p>	<p><b><u>In-Network</u></b> \$15 copay per visit; 60 visits combined annual maximum; drug and/or alcohol treatment <b><u>Out-of-Network</u></b> Covered at 80% after deductible for 60 visits; combined annual maximum for alcohol and/or drug treatment.</p>	<p><b><u>In-Network</u></b> Covered in full 60 visits, which may include 20 visits for family counseling. <b><u>Out-of-Network</u></b> Covered 70% of allowable amount after deductible; up to 60 visits which may include 20 visits for family counseling.</p>	<p><b><u>In-Network</u></b> Covered in full for up to 60 visits per calendar year; including up to 20 visits for family counseling. <b><u>Out-of-Network</u></b> Not covered</p>	<p><b><u>In-Network</u></b> Covered in full 60 visits (combined with non-network visits); 5 assessment visits covered in full <b><u>Out-of-Network</u></b> 75% of Network allowance; 60 visits annually</p>	<p><b><u>In-Network</u></b> Covered in full 60 visits combined annual maximum for drug/alcohol treatment <b><u>Out-of-Network</u></b> Covered 80% up to 60 visits (combined with In-network visits) after deductible</p>

**NOTE:** In-network coverage applies only if care is provided or authorized by a participating physician. Some plans require referral, authorization or notification before the use of non-participating providers is covered.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

**COMPARISON OF HEALTH MAINTENANCE ORGANIZATION BENEFITS  
(Services from Participating Providers Only)**

	<b>Aetna HMO</b>	<b>CIGNA HealthCare</b>	<b>Empire HMO</b>	<b>Health Net</b>
<b>Outpatient Care/Office Visits</b>	\$15 copay	\$10 copay	\$15 copay	\$15 copay
<b>Specialist Care</b>	\$20 copay	\$10 copay	\$15 copay	\$20 copay
<b>Outpatient Diagnostic Tests (x-rays, labs, etc.)</b>	\$15 copay	Covered in full	Covered in full	Covered in full
<b>Inpatient Hospital Care</b>	Covered in full	\$150 copay per admission	\$250 copay/individual coverage; \$625 copay/family coverage	Covered in full
<b>Maternity Care (Mother and Newborn)</b>	\$15 copay initial visit	\$10 copay initial visit	Covered in full	Covered in full
<b>Emergency Room Care</b>	\$35 copay, waived if admitted.	\$50 copay, waived if admitted.	\$35 copay, waived if admitted.	\$50 copay, waived if admitted.
<b>Mental Health (Inpatient Care)</b>	Covered in full for 35 days per 365 day period.	\$150 copay per admission; covered up to 30 days per contract year.	Covered in full 30 days; Subject to copay (\$250 individual/\$625 family).	Covered in full 30 days per calendar year when approved in advance.
<b>Mental Health (Outpatient Care)</b>	\$25 copay per visit for 20 visits per 365 day period.	\$20 copay per session for 20 sessions per contract year.	\$25 copay per visit – 20 visits	\$20 copay per visit – 20 visits per calendar year. (After 6 <sup>th</sup> visit must be approved in advance).
<b>Substance Abuse/Chemical Dependency (Inpatient Care)</b>	Detox covered in full for acute phase of treatment; Rehab not covered.	Detox \$150 copay per admission; covered up to 30 days (combined annual max. for drug and/or alcohol treatment). Rehab not covered.	Detox covered 7 days annually and subject to copay (\$250 indiv./\$625 family); Rehab covered in full. 30 days annually.	Detox covered in full up to 30 days per calendar year when approved in advance.
<b>Substance Abuse/Chemical Dependency (Outpatient Care)</b>	\$15 copay per visit. 60 visit combined annual maximum for drug and/or alcohol treatment.	\$10 copay per session for up to 60 sessions.	Covered in full. 60 visits (includes 20 visits family counseling).	\$10 copay per visit. 60 visits per calendar year when approved in advance.
<b>Prescription Drug Coverage</b>	Available through optional rider	Available through optional rider	Available through optional rider	Available through optional rider

**NOTE:** Coverage levels indicated apply only if care is provided or authorized by a participating physician.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

**COMPARISON OF HEALTH MAINTENANCE ORGANIZATION BENEFITS  
(Services from Participating Providers Only)**

	<b>GHI HMO</b>	<b>HIP Prime HMO</b>	<b>MetroPlus Health Plan</b>	<b>Vytra Health Plans</b>
<b>Outpatient Care/Office Visits</b>	\$15 copay	Covered in full	Covered in full	\$5 copay
<b>Specialist Care</b>	\$15 copay	Covered in full	Covered in full	\$5 copay
<b>Outpatient Diagnostic Tests (x-rays, labs, etc.)</b>	Lab covered in full; x-rays – \$15 copay.	Covered in full	Covered in full	Covered in full
<b>Inpatient Hospital Care</b>	Covered in full	Covered in full	Covered in full	Covered in full
<b>Maternity Care (Mother and Newborn)</b>	\$15 copay for OB/GYN visits; Hospital covered in full.	Covered in full	Covered in full	Covered in full
<b>Emergency Room Care</b>	\$35 copay, waived if admitted.	Covered in full	Covered in full	\$25 copay, waived if admitted
<b>Mental Health (Inpatient Care)</b>	Covered in full 30 days per calendar year.	Covered in full 30 days per calendar year.	Covered in full 60 days (combined drug, alcohol and/or mental health).	Covered in full 30 days per calendar year.
<b>Mental Health (Outpatient Care)</b>	20 visits per calendar year; \$15 copay for visits 1-5; \$25 copay for visits 6-20.	\$10 copay per visit, 60 visits per calendar year	Covered in full - 20 visits per calendar year.	Covered for 20 visits per calendar year; \$5 copay for visits 1-3; \$25 copay for visits 4-20.
<b>Substance Abuse/Chemical Dependency (Inpatient Care)</b>	Detox covered in full; 7 days combined per calendar year for drug and/or alcohol treatment. Rehab covered in full up to 30 days combined for drug and/or alcohol treatment.	Detox covered in full; 30 days per calendar year. Rehab covered in full - 30 days per calendar year.	Detox covered in full; Rehab covered in full - 60 days (combined drug, alcohol and/or mental health).	Detox covered in full for 3 periods per calendar year for drugs and/or alcohol. Rehab not covered.
<b>Substance Abuse/Chemical Dependency (Outpatient Care)</b>	\$15 copay per visit, 60 visits combined per calendar year for drug and/or alcohol treatment.	Covered in full, 60 visits per calendar year.	Covered in full, 60 visits per calendar year (combined annual maximum for drug, alcohol and/or mental health).	\$5 copay per visit, 60 visits combined annual maximum for drug and/or alcohol.
<b>Prescription Drug Coverage</b>	Available through optional rider	Available through optional rider	Available through optional rider	Available through optional rider

**NOTE:** Coverage levels indicated apply only if care is provided or authorized by a participating physician.

The health plan descriptions and comparison charts in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.