

**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>	\$500/Individual \$1,500 /Family	\$1,200/Individual \$3,000/Family	None	\$200/Individual \$500/Family \$1,500/person – Catastrophic Program	\$250/Individual \$500/Family
<b>Maximum Out-of-Pocket</b>	\$3,000/Individual \$9,000/Family	\$3,750/Individual \$9,375/Family	None	None	\$2,000/Individual \$4,000/Family
<b>Physician's Office Visits</b>	<u><b>In Network</b></u> \$15 copay pcp /\$20 spec. <u><b>Out-of- Network</b></u> Covered 70% after deductible	<u><b>In Network</b></u> \$10 copay <u><b>Out-of- Network</b></u> Covered 70% of allowable amount after deductible	<u><b>In Network</b></u> \$15 copay <u><b>Out-of- Network</b></u> Not covered	<u><b>In Network</b></u> \$15 copay-Medical Providers \$20 copay-providers & dermatologists <u><b>Out-of- Network</b></u> Per schedule of allowances after deductible	<u><b>In Network</b></u> Covered in full <u><b>Out-of- Network</b></u> Covered 80% after deductible
<b>Outpatient Diagnostic Tests (X-rays, labs, etc.)</b>	<u><b>In Network</b></u> \$20 copay <u><b>Out-of- Network</b></u> 70% coinsurance after deductible	<u><b>In Network</b></u> \$10 copay <u><b>Out-of- Network</b></u> Covered 70% of allowable amount after deductible	<u><b>In Network</b></u> Covered in full <u><b>Out-of- Network</b></u> Not covered	<u><b>In Network</b></u> \$15 copay <u><b>Out-of- Network</b></u> Per schedule of allowances after deductible	<u><b>In Network</b></u> Covered in full <u><b>Out-of- Network</b></u> Covered 80% after deductible
<b>Inpatient Hospital Care</b>	<u><b>In Network</b></u> \$300 copay per admission <u><b>Out-of- Network</b></u> Covered 70% after deductible. Covered in full if admitted after emergency room visit.	<u><b>In Network</b></u> \$250 per admission <u><b>Out-of- Network</b></u> Covered 70% of allowable amount after deductible	<u><b>In Network</b></u> \$250 individual copay per admission; up to \$625 maximum per year. Precertification required. <u><b>Out-of- Network</b></u> Not covered	<u><b>In Network</b></u> Covered in full after \$300 inpatient deductible (\$750 annual max. per person); Subject to penalty if not precertified by NYC Healthline	<u><b>In Network</b></u> Covered in full <u><b>Out-of- Network</b></u> Covered 80% after deductible
<b>Maternity Care (Mother and Newborn)</b>	<u><b>In Network</b></u> \$15 copay initial visit <u><b>Out-of- Network</b></u> 70% coinsurance after deductible.	<u><b>In Network</b></u> Covered in full <u><b>Out-of- Network</b></u> Covered 70% of allowable amount after deductible	<u><b>In Network</b></u> Covered in full <u><b>Out-of- Network</b></u> Not covered	<u><b>In Network</b></u> \$15 copay <u><b>Out-of- Network</b></u> Physician: Per schedule of allowances after deductible	<u><b>In Network</b></u> Covered in full <u><b>Out-of- Network</b></u> Covered 80% after deductible
<b>Emergency Room Care</b>	\$75 copay, waived if admitted	\$50 copay, waived if admitted.	\$35 copay, waived if admitted	\$50 copay, waived if admitted	<u><b>In Network</b></u> Covered in full <u><b>Out-of- Network</b></u> Covered in full; \$50 charge if HIP is not contacted
<b>Prescription Drug Coverage</b>	Available through optional rider	Available through DC 37 Health and Security Fund	Available though optional rider.	Available though optional rider.	Available through optional rider.

**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.

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**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>Mental Health Inpatient Care</b>	<p><b><u>In Network</u></b> \$300 copay per admission</p> <p>Biologically Based: No Inpatient or Outpatient limits Non-Biologically Based: 35 days Inpatient and 20 visits Outpatient</p> <p><b><u>Out-of- Network</u></b> Covered at 70% after deductible</p>	<p><b><u>In Network</u></b> Covered in full up to 30 days per calendar year; subject to \$250 copay per admission</p> <p><b><u>Out-of- Network</u></b> Not covered</p>	<p><b><u>In Network</u></b> \$250/\$625 max per contract per year; Unlimited medically necessary days per calendar year for biologically and non-biologically based conditions.</p> <p><b><u>Out-of- Network</u></b> Not covered</p>	<p><b><u>In Network &amp; Out of Network</u></b> Biologically Based: Covered up to 365 days subject to admission deductible of \$300, max of \$750 per person per calendar year. Non-Biologically Based: In Network: 30 days per person per calendar year subject to admission deduct. Out of Network: 30 days (combined with in-network) subject to admission deduct. and 50% coinsurance</p>	<p><b><u>In Network</u></b> Covered in full up to 30 days per year</p> <p><b><u>Out-of- Network</u></b> 30 days per year at 50% of Network allowance</p>
<b>Mental Health Outpatient Care</b>	<p><b><u>In Network</u></b> \$20 copay per visit Biologically Based: No Inpatient or Outpatient limits Non-Biologically Based: 35 days Inpatient and 20 visits Outpatient</p> <p><b><u>Out-of- Network</u></b> Covered at 70% after deductible</p>	<p><b><u>In Network</u></b> \$25 copay per visit for 20 visits per calendar year.</p> <p><b><u>Out-of- Network</u></b> Not covered</p>	<p><b><u>In Network</u></b> \$15 copay per visit; unlimited visits for biologically and non-biologically based conditions</p> <p><b><u>Out-of- Network</u></b> Not covered</p>	<p><b><u>In Network &amp; Out of Network</u></b> Biologically Based: Unlimited visits subject to \$15 copay per visit</p> <p>Non-Biologically Based: <b><u>In Network</u></b>: unlimited visits subject to \$200 ind/\$500 family deductible. <b><u>Out of Network</u></b>: 30 visits subject to a \$100 deductible and 50% coinsurance</p>	<p><b><u>In Network</u></b> \$5 copay per visit – 20 visits per calendar year</p> <p><b><u>Out-of- Network</u></b> Covered 50% up to 20 visits (combined with In-Network visits).</p>
<b>Substance Abuse/ Chemical Dependency Inpatient Care</b>	<p><b><u>In Network</u></b> Detox- \$300 copay per admission for acute phase of treatment; Rehab not covered.</p> <p><b><u>Out-of- Network</u></b> Detox covered at 70% after deductible; Rehab not covered</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.</p> <p><b><u>Out-of- Network</u></b> Not covered.</p>	<p><b><u>In Network</u></b> Subject to \$250/\$625 max per calendar year; up to 7 days detox per calendar year; subject to precertification</p> <p><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 7 days per calendar year Rehab not covered</p> <p><b><u>Out-of- Network</u></b> Detox covered 80% after deductible; limited to 7 days per calendar year. 50% penalty applies for failure to notify plan.</p>
<b>Substance Abuse/ Chemical Dependency Outpatient Care</b>	<p><b><u>In Network</u></b> \$15 copay per visit. 60 visit combined annual max for drug and/or alcohol treatment</p> <p><b><u>Out-of- Network</u></b> Covered at 70% after deductible for 60 visits; combined annual max 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</p> <p><b><u>Out-of- Network</u></b> Covered at 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> \$15 copay per visit; up top 60 visits (includes 20 visits family counseling)</p> <p><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</p> <p><b><u>Out-of- Network</u></b> Covered 80% up to 60 visits (combined with In-Network visits)</p>

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

	<b>Aetna HMO</b>	<b>CIGNA HealthCare</b>	<b>Empire HMO</b>	<b>GHI HMO</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	\$15 copay
<b>Outpatient Diagnostic Tests (X-rays, labs, etc.)</b>	\$15 copay may apply	Covered in full	Covered in full	Lab covered in full X-rays – \$15 copay
<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	\$15 copay for OB/GYN visits Hospital covered in full
<b>Emergency Room Care</b>	\$35 copay, waived if admitted	\$50 copay, waived if admitted	\$35 copay, waived if admitted	\$35 copay, waived if admitted
<b>Mental Health Inpatient Care</b>	\$300 copay per admission Biologically Based: No Inpatient limits Non-Biologically based: 35 days inpatient	\$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
<b>Mental Health Outpatient Care</b>	\$20 copay per visit Biologically based: No Outpatient limits Non-Biologically based: 20 visits outpatient.	\$20 copay per session for 20 sessions per contract year	\$25 copay per visit – 20 visits	20 visits per calendar year \$15 copay visits 1-5 \$25 copay visits 6-20
<b>Substance Abuse/ Chemical Dependency Inpatient Care</b>	<b>In Network</b> Detox - \$300 copay per admission 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 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.
<b>Substance Abuse/ Chemical Dependency Outpatient Care</b>	<b>In Network</b> \$15 copay per visit. 60 visits 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)	\$15 copay per visit - 60 visits combined per calendar year for drug and/or alcohol treatment.
<b>Prescription Drug Coverage</b>	Available through rider	Available through rider	Available through rider	Available through rider

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	<b>HealthNet</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>	\$20 Copay	Covered in full	Covered in full	\$5 copay
<b>Outpatient Diagnostic Tests (X-rays, labs, etc.)</b>	Covered in Full	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>	Covered in Full	Covered in full	Covered in full	Covered in full
<b>Emergency Room Care</b>	\$50 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 when approved in advance	Covered in full 30 days per calendar year	Covered in full 30 days (combined annual maximum for drug, alcohol and/or mental health)	Covered in full 30 days per calendar year
<b>Mental Health Outpatient Care</b>	\$20 copay per visit – 20 visits per calendar year. (after 6 <sup>th</sup> visit must be approved in advance)	\$5 copay per visit - 20 visits per calendar year	\$25 copay per visit – 20 visits	Covered for 20 visits per calendar year: \$5 copay visits 1-3, \$25 copay visits 4-20
<b>Substance Abuse/ Chemical Dependency Inpatient Care</b>	Detox covered in full; Rehab covered in full up to 30 days per calendar year when approved in advance	Detox covered in full – 30 days. Rehab not covered	Detox covered in full; Rehab covered in full 30 days (combined annual maximum for 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>	\$20 copay per visit. 60 visits per calendar year when approved in advance	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 visit combined annual maximum for drug and/or alcohol
<b>Prescription Drug Coverage</b>	Available through rider	Available through rider	Available through rider	Available through rider

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