SUMMARY COMPARISON OF HEALTH PLA

This is a general overview. Each plan may vary depending on location. R

(Metro New York Plan

TYPE OF PLAN	MEDICARE SUPPLEMENT	MEDICARE HMO	MEDICARE HMO	MEDICARE SUPPLEMENT	MEDICARE
NAME OF PLAN	**GHI/BC SeniorCare**	**HIP-VIP Premier Medicare Plan**	**Aetna Golden Medicare**	**GHI-HMO Medicare Senior Supplement**	**Empire Bl & Blue Medicare Relat**
MONTHLY COST PER-PERSON RATES EFFECTIVE 1/1/09 (SUBJECT TO CHANGE)	BASIC COVERAGE: $0 RETIREE OPTION: $99.75	AUTOMATIC OPTION: $109.39	NY COUNTIES: AUTOMATIC OPTION: $206.81 OUT OF AREA: CALL FOR COST	BASIC COVERAGE: $144.73 RETIREE OPTION: $202.23	BASIC COVERA RETIREE OPTIO
PHONE NUMBER	GHI: 212-501-4444 Blue Cross: 800-767-8672	800-HIP-TALK	800-307-4830	877-244-4466	800-767
WEB SITE	www.ghi.com	www.hipusa.com	www.aetna.com	www.ghihmo.com	www.empire
COVERAGE AREA	Nationwide	5 boroughs of NYC & Nassau, Suffolk and Westchester Counties	**NY:** 5 boroughs of NYC; Cayoga, Dutchess, Nassau, Onondaga, Putnam, Rockland, Suffolk, Sullivan, Ulster & Westchester Counties **NJ:** Statewide (all covered) **PA:** Eastern PA Counties	**NY:** 5 boroughs of NYC; Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Green, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington & Westchester Counties	Nation
OFFICE VISIT CO-PAYMENT	$50 GHI calendar year deductible. Reimburses 20% of amount approved by Medicare (after satisfying Medicare Part B deductible and Medicare pays 80%)	$0 co-pay $5 Specialist	$10 PCP $15 Specialist NY $15 Specialist NJ	$15 co-pay	Reimburses 20% of a approved by Medicar (after Medicare pays
OUTPATIENT LAB & X-RAY CO-PAYMENT	$50 GHI calendar year deductible. Reimburses 20% of amount approved by Medicare (after satisfying Medicare Part B deductible and Medicare pays 80%)	Covered in full. $0 co-pay	$15 co-pay NY $15 co-pay NJ	Lab: Covered in full X-ray: $15 co-pay	Reimburses 20% of a approved by Medicar (after Medicare pays
PARTICIPATING OR OUT-OF-NETWORK PROVIDER	Choice of any provider	Over 29,000 doctors in more than 50,000 locations, including private practice and neighborhood health centers.	In-network providers only	In-network providers only	Choice of any provid
HOSPITALIZATION DEDUCTIBLE OR CO-PAY (INPATIENT)	$300 deductible per admission, $750 annual maximum per person. Optional Rider increases coverage to 365 days. $50 ER co-pay (waived if admitted).	Surgeon and physician fees, semi-private room, anesthesia, x-ray, lab tests, prescribed drugs, intensive care—covered in full. $0 co-pay.	Covered in full	Covered in full	Reimburses Part A ho deductible, 365 days
PRIVATE DUTY NURSING	80% subject to $25 deductible. $2,500 maximum combined with ambulance and medical equipment	Covered in full. $0 co-pay (inpatient)	Not covered unless medically necessary and in a skilled nursing facility	Covered in full	80% after first 72 ho when authorized by $100 deductible
INPATIENT MENTAL HEALTH	Covered in full 190 days lifetime maximum	Covered in full. $0 co-pay	Covered in full 190 days lifetime maximum combined with inpatient substance abuse	Covered in full 30 days per calendar year	Covered in full 190 d lifetime maximum
OUTPATIENT MENTAL HEALTH	Not covered	$20 co-pay per visit	$25 co-pay	$15 co-pay visits 1–5 6-20 visits, $25 co-pay	Reimburses 20% of am Medicare (after Medica
OUT-OF-AREA COVERAGE	Anywhere in USA	Emergency care only	Emergency care only	Emergency care only	Anywhere in USA
RETAIL PRESCRIPTION DRUG COVERAGE 30-DAY SUPPLY	Must purchase Optional Rider. After $4,350 in member out-of-pocket costs, unlimited drugs with co-pay of 5%. $2,251-$8,562.50 member pays 60% of drug cost. $0-$2,250 member pays 25% of drug cost.	Prescription drug rider automatically included. $10 Preferred Generic. $15 Preferred Formulary Brand. 50% Non-Preferred Brand. 25% Specialty Drugs.	Prescription drug rider automatically included. $0/$20/$40 up to $2,700. 50% co-pay to $4,350 out of pocket. 5% after $4,350 in co-pays.	Must purchase Optional Rider. After $4,350 in out-of-pocket costs member pays 5% of drug cost. $2,700- $6,153.75 member pays 100% of drug cost. $295-$2,700 Member pays 25% of drug cost. Deductible $295.	Must purchase Optio Prescription drug cos $10 Generic, $25 Br $50 Non-Formulary, Coverage gap memb 5% of cost after $4,3 pocket cost.

*ADDITIONAL OUT-OF-AREA PLANS ARE: AvMed Medicare Plan (Florida only) 800-782-8633; Blue Cross Blue Shield of Florida Health Options (Florida only) 800-999-6758; Cigna HealthCare for Seniors (Arizona) 800-627-7534; Humana Gold Plus (Florida only) 888-393-6765.

ANS FOR RETIREES ON MEDICARE*

etirees should contact the plan directly for options available.

*s Only)**

THESE BENEFITS & RATES ARE FOR CALENDAR YEAR 2009. SUBJECT TO CHANGE.

REVISED 7/1/09

RELATED	MEDICARE HMO	MEDICARE HMO	MEDICARE HMO	MEDICARE RELATED	MEDICARE HMO
ue Cross Shield ed Coverage	Mediblue HMO Plus (formerly Empire Blue Choice)	Elderplan (Classic)	Secure Horizons (formerly Oxford)	Healthnet MedPrime	Healthnet Ruby (Smart Choice)
AGE: $56.14 ON: $191.82	5 BOROUGHS OF NYC: AUTOMATIC OPTION: $106.00 OUT OF AREA: CALL FOR COST	NO COST	NY COUNTIES : AUTOMATIC OPTION: $88.03 OUT OF AREA: CALL FOR COST	NY COUNTIES: BASIC COVERAGE: $89.50 RETIREE OPTION: $329.63 OUT OF AREA: CALL FOR COST	CT ONLY: $77.00
-8672	800-809-7328	877-414-9015	800-203-5631	800-441-5741	800-547-8734
eblue.com	www.empireblue.com	www.elderplan.org	www.oxhp.com	www.healthnet.com	www.healthnet.com
wide	5 boroughs of NYC & Nassau, Suffolk, Rockland & Westchester Counties	NYC Boroughs of Brooklyn, Queens, Staten Island, Manhattan	**NY:** 5 boroughs of NYC; Nassau, Orange, Rockland & Westchester Counties **NJ:** Hudson, Bergen, Essex, Mercer, Middlesex, Monmouth, Ocean, Passaic & Union Counties	**NY:** Manhattan, Nassau, Suffolk, Westchester, Rockland, Dutchess, Putnam & Orange Counties. **NJ:** Statewide **CT:** Litchfield, Middlesex, New London, Tolland & Windham Counties	**CT:** Fairfield, New Haven & Hartford Counties
amount e 80%)	$0 Office visit $10 Specialist visit	$0 for PCP doctor $20 for specialist	$15 co-pay	$15 co-pay	$10 co-pay PCP/$15 specialist
amount re 80%)	Covered in full. $0 co-pay.	$0 Co-pay lab and medicare approved X-rays.	Covered in full	Covered in full	Covered in full
er	Participating providers only	Participating providers only	Participating providers only	Participating providers only	Participating providers only
ospital s	$0 co-pay	Day 1 - $200 per day Days 2-7 - $85 per day Day 8 - No co-pay	No hospitalization deductible or co-pay	Covered in full	Covered in full
urs a physician.	Not covered	Not covered	Not covered	Covered in full	Covered in full
ays	Covered in full 190 days lifetime maximum	Day 1 - $200 per day Days 2-7 - $85 per day Day 8 - No co-pay	190 days lifetime maximum. Contact plan for specifics.	Covered in full for 30 days per year	Covered in full 190 days lifetime maximum
ount approved by re pays 80%)	$25 co-pay	$20 co-pay per visit	$15 co-pay	$15 co-pay per visit	$15 co-pay per visit
	Urgent and emergency care only	$50 co-pay per visit (waived if admitted to hospital within 24 hours). Worldwide coverage	Emergency and urgent care worldwide	Emergency care only	Emergency care only
nal Rider. ts up to $2,250; and, 25% Biologicals. er pays 50% 350 out-of-	Prescription drug rider automatically included. Prescription drug costs up to $2,700; $10 Generic, $30 Preferred brand, $60 Non-preferred brand, 30% Injectables & specialty drugs 5% of cost after $4,350 out-of-pocket cost.	Covered under basic plan. $0 Generic. $25 Preferred drugs. $75 Brand drugs.	Prescription drug rider automatically included. $4 Generic. $20 Preferred. $40 Non-Preferred. 20% co-pay for Medicare Part B drugs.	Must purchase Optional Rider. $15 Generic. $15 Formulary. Non-Formulary not covered.	Prescription drug rider automatically included. $15 Generic. $35 Formulary. $60 Non-Formulary.

NAME OF PLAN	GHI-CBP	HIP PRIME	HIP PRIME POS	EMPIRE EPO	
PREVENTIVE CARE (Including Well-Child Care & Immunization)	Immunizing agents relative to adult vaccinations for influenza and pneumonia covered in full with $15 co-pay for office visit. Covered only when rendered by CBP participating provider. For non-Medicare eligible employees and their eligible dependents age 45 and older, GHI-CBP will provide for annual physical through CBP participating providers only with $15 co-pay. No co-pay for lab and diagnostic radiological services when completed in office of exam. Outside lab or radiological subject to provisions of $15 co-pay currently in effect for lab and diagnostic X-rays. Well-child care & immunization: GHI will provide necessary immunizations as recommended by the American Academy of Pediatrics for hepatitus A, varicella and pneumococcal conjugate vaccine (Prevnar).	Covered in full, including routine physicals.	In network: Covered in full. Out-of-network: Adult preventive care not covered. Preventive care for children covered 80% after deductible.	Covered in full. $0 copay.	Covered $0 co-pa
OFFICE VISIT	Payment in full for participating providers. $15 co-pay for office visits to Medical Providers/ Practitioners. $20 for Surgeons, all Surgical Subspecialties and Dermotologists (a full list appears on www.ghi.com). Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full. $0 co-pay.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network with $15 copay.	Covered with $15
SPECIALIST CONSULTATION — OUT-OF-HOSPITAL	Payment in full for participating providers except for $15 co-pay for office visits to Medical Providers/ Practitioners. $20 for Surgeons, all Surgical Subspecialties and Dermotologists (a full list appears on www.ghi.com). Reimbursement for non-participating is covered under NYC Schedule of Allowances. Limited to one per specialty per year for each condition. Covered only upon referral of your provider.	Covered in full. $0 co-pay.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network with $15 copay.	Covered with $15
X-RAYS AND LABORATORY TESTS	Payment in full for participating providers except for $15 co-pay. A maximum of one co-pay for these services will apply per date of service, per provider. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full. $0 co-pay.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	Covered in full in-network with $0 copay.	Covered with $0
PRIVATE DUTY NURSING	In network: No out-of-pocket expenses for covered services. Pre-certification by GHI's Managed Care Department is required. Out-of-network: 80% of participating provider schedule of allowances after $250 deductible per person per calendar year. $100,000 maximum per person per year without optional rider; $200,000 with optional rider.	Supplemental Welfare Fund benefit for employees: No coverage first 72 hours. reimbursed at 80% for up to 504 subsequent hours in hospital.	Not covered out-of-network. Supplemental Welfare Fund benefit for employees, as described under HIP Prime.*	Not covered.	Not cove
AMBULANCE SERVICE	Coverage at 80% of GHI's schedule of allowances.	Covered in full. $0 co-pay.	In network: $0 co-pay. Out-of-network: Covered 80% after deductible.	$0 co-pay up to allowed amount. You pay difference between allowed amount and total charge.	$0 co-pa You pay amount
EMERGENCY SERVICE	After $50 co-pay, emergency room covered by Blue Cross for sudden or serious illness or accidental injury. Co-pay waived if admitted to hospital. Empire also covers the emergency room physicians and non invasive pathology, radiology and cardiology services rendered in the emergency room.	$50 co-pay. Waived if admitted.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	$35 co-pay waived if admitted within 24hours.	$35 co-p admitted
OUT-OF-AREA CARE AND/OR TRAVEL COVERAGE	Benefits are paid without regard to any geographical limitations.	Out-of-area care applies to emergency service only. Call 1-800-HIP-TALK.	Out-of-area care applies to emergency service only. Call 1-800-HIP-TALK.	Access to over 668,000 providers and 8,500 hospitals nationwide participating in the Blue Card® PPO Program. BlueCard® Worldwide provides health care coverage for members traveling in Europe, Caribbean, Latin America, Asia, South Pacific, Africa and the Middle East.	Urgent an members Card® pr work. Gue members days throu Shield pla
SKILLED NURSING FACILITY	Covered by Blue Cross subject to NYC Healthline pre-authorization. A maximum of 90 days coverage for skilled nursing facility care which may include 30 inpatient days in a rehabilitation hospital primarily for physical therapy, physical rehabilitation or physical medicine.	Covered in full unlimited days. $0 co-pay.	In network: Covered in full. Out-of-network: Not covered.	Covered in full up to 60 days per calendar year. Precertification by Empire's Medical Management Program is required.	Covered calendar by PCP fr Managem
ROUTINE PODIATRIC CARE	Not covered except as prescribed for metabolic diseases, such as diabetes, then payment in full for participating providers except for $20 co-pay for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Not covered.	Not covered.	Not covered.	Not cove
ALLERGY TESTING AND ALLERGY TREATMENTS	Payment in full for participating providers except for $15 co-pay for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. More than 30 visits subject to medical review by GHI.	Covered in full. $0 co-pay.	In network: $0 co-pay. Out-of-network: Covered 80% after deductible.	Covered in full in-network with $15 co-pay (waived for treatments).	Covered co-pay (w
CHIROPRACTIC CARE	Payment in full for participating providers except for $15 co-pay for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Coverage is unlimited, subject to medical review.	Covered in full when services provided through HIP chiropractors.	In network: $0 co-pay. Out-of-network: Covered 80% after deductible.	Covered in full in-network with $15 co-pay (when medically necessary).	Covered co-pay (w PCP refe
RADIATION THERAPY	Payment in full to participating providers. Reimbursement for non-participating covered under NYC Schedule of Allowances.	Covered in full. $0 co-pay.	In network: $0 co-pay. Out-of-network: Covered 80% after deductible.	Covered in full in-network. $0 co-pay.	Covered i
VISITING NURSE SERVICE	Payment in full to participating providers. Precertification by GHI's Managed Care Department is required. Up to 200 visits per year. Non-participating providers are covered subject to $50 deductible per episode; 80% of Schedule of Allowances. Maximum of 40 visits per calendar year.	Covered in full. $0 co-pay.	In network: Covered in full. Out-of-network: Not covered.	Covered in full in-network up to 200 visits per calendar year under home health care. Precertification by Empire's Medical Management Program is required.	Covered visits per health ca through Program
PHYSICAL THERAPY	Payment in full for participating providers except for $15 co-pay for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. More than 16 visits subject to medical review by GHI.	Outpatient: $0 co-pay. 90 visits per calendar year.	In network: Covered in full. Out-of-network: Covered 80% after deductible.	Inpatient covered in network in full up to 30 days per calendar year. Outpatient covered in-network combined 30 visits in home, office, outpatient facility per calendar year. Precertification by Empire's Medical Management is required.	Inpatient days per c network c outpatien fication by Managem
APPLIANCES	Subject to separate annual deductible of $100 per person* when using GHI preferred provider panel. If non-panel, 50% reimbursement of allowed charge after deductible. Equipment in excess of $2,000 must be preauthorized by GHI.	Retiree: Durable Medical Equipment which includes crutches, canes, wheelchairs, commodes and walkers through rider. In-Service: Additional Welfare Fund benefit reimbursed at 80% of reasonable charge, subject to $25 deductible, $1,500 annual maximum and $3,000 lifetime	In network: $0 annual deductible. Not covered out-of-network. In-Service: Supplemental Welfare Fund benefit for employees, as described under HIP Prime.	Durable medical equipment, medical supplies, prosthetics, orthotics covered in full. Precertification by Empire's Medical Management is required. In-network provider only.	Durable supplies, full. Prec Empire's required
ALCOHOLISM AND DRUG ABUSE (Chemical Dependency)	Outpatient: In network covered in full; 60 visits/year combined with non-network visits. Evaluations/assessments covered (limit five visits per year combined with mental health). Out-of-network treatment covered at 75% of network allowance; 60 visits/year combined with network visits. Inpatient: In-network detoxification covered in full; 30 days/year, 60 days lifetime combined with rehabilitation treatment. Optional Rider increases network benefit with additional 30 days per year for detoxification and/or rehabilitation covered at 100%. Out-of-network detoxification covered at 100% of network allowance, no rehabilitation benefits. Optional Rider increases benefit with 30 days/lifetime for detoxification and/or rehabilitation, covered at 75% of network allowance. $1,000 co-insurance maximum per admission, covered at 100% thereafter. Non-network inpatient benefits subject to $500 penalty if not precertified.	$0 co-pay. Provides inpatient hospital benefits for alcohol and chemical abuse. Maximum 30 days per calendar year. Provides up to 60 visits for outpatient drug and/or alcohol treatment.	In network: $0 co-pay. Out-of-network: Inpatient detoxification and outpatient rehabilitation covered 80% after deductible.	In-network outpatient: covered up to 60 visits which may include 20 family counseling visits per calendar year. Behavioral health care management must pre-approve all care. In-network inpatient up to 7 days detox per calendar year, 30 days rehab, subject to co-pay of $250 individual/$625 maximum per contract per calendar year. Behavioral Health Care Management must pre-approve all care.	In-network which may per calend agement r inpatient u 30 days re ual/$625 year. Beha pre-approv
OUT-PATIENT PSYCHIATRIC CARE	Out-patient Psychiatric Care: In/Out network benefit For **biologically based conditions** - Outpatient mental health visits rendered by GHI Behavioral Management Program (GHI/BMP) participating providers are unlimited per person, per calendar year. Each visit is subject to medical necessity. Pre-certification under GHI/BMP and $15 office co-pay. GHI Out-of-network Outpatient Mental Health visits rendered by non participating providers are unlimited per person, per calendar year and are subject to the $200/$500 medical deductible, 100% co-insurance based on GHI/BMP participating network schedule of allowances. Outpatient Psychiatric Care: In/Out network benefit, For **Non-Biologically based conditions** - Outpatient mental health visits rendered by GHI Behavioral Management Program (GHI/BMP) participating providers are unlimited per person, per calendar year. Each visit is subject to medical necessity, pre-certification under GHI/BMP and $15 office co-pay. GHI Optional Rider Benefit; GHI Out-of-network Outpatient Menial Health visits rendered by non participating providers are limited to 30 visits annually and are subject to $200 ind/$500 family deductible, 100% co-insurance based on participting schedule of allowances; $2 million lifetime max. This benefit is not subject to pre-certification.	Inpatient: $0 copay - 30 days inpatient mental health with unlimited biological and childhood coverage Outpatient: $0 copay – 60 visits per calendar year with unlimited coverage for biological and childhood conditions.	Inpatient: $0 copay - 30 days inpatient mental health with unlimited biological and childhood coverage Outpatient: $0 copay – 60 visits per calendar year with unlimited coverage for biological and childhood conditions. Out of network subject to deductible and coinsurance.	Inpatient: $300/$750 co-pay max per year with no limit on number of days for biologically based conditions, 30 day limit for non-biologically based conditions. Outpatient: treatment for biologically based conditions $15 co-pay, unlimited visits. For non-biologically based conditions $15 copay, 20 visits max. All mental health substance abuse treatments/ hospitalizations are subject to Empire Behavioral Health pre-authorization and approval.	Inpatient: no limit on based con biologicall treatment co-pay, un based con mental he hospitaliza Health pre
FULL-TIME STUDENTS	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered

*Additional Welfare benefits. See Red Apple.

** Unmarried dependent students covered until the end of the calendar year of the student's 23rd birthday <u>or</u> graduation, whichever occurs first.

See City Summary Program Description for complete details.This chart is a general outline of benefits provided and is not the contract. Refer to appropriate booklets for contactual provisions

SIDE

EMPIRE HMO	AETNA INC (POS)	AETNA INC (HMO)	CIGNA HEALTHCARE	VYTRA	HEALTH NET	GHI/HMO
in full. y.	In-network routine physicals, routine GYN exams, mammograms, well-child care covered in full. Out-of-network or without referral, routine physicals & routine GYN exams not covered. Mammograms, well-child care subject to deductible & co-insurance.	In-network routine physicals, routine GYN exams, mammograms, well-child care covered in full.	Dependent preventive care (birth to age 19), well child care physical exams, routine immunizations and injections; NY providers: no charge for office visit. $15 or $20 co-pay per office visit for non-NY provider.	$5 co-pay. Co-pay is waived for well child visits if it meets standard set by the American Academy of Pediatricians.	Children through 18-no cost in accordance with HN's schedule of covered well exams. 19 and over-$15 co-pay, in accordance with HN's schedule of covered well exam.	Covered in full. **Nutritional counseling:** $15 co-pay, two visits. **Acupuncture:** $15 co-pay, up to six visits.
in full in-network co-pay for PCP.	In-network $15 co-pay to PCP. $20 specialists when seen with referral from PCP. Out-of-network or without referral subject to deductible and co-insurance.	$15 co-pay to PCP. $20 specialists when seen with referral from PCP.	$15 per visit.	Covered in full with $5 co-pay.	Covered in full with $15 PCP, $20 specialist co-pay.	Covered in full with $15 co-pay.
in full in-network co-pay and PCP referral.	In-network covered in full with $20 co-pay and referral from PCP. Out-of-network or without referral subject to deductible and co-insurance.	Covered in full with $20 co-pay and referral from PCP.	$25 per visit when referred by primary care physician. Women have direct access to a participating OB/GYN for well-woman gynecological care and acute gynecological conditions.	Covered in full with $5 co-pay with referral from PCP.	Covered in full.	Covered in full – $15 co-pay with a referral from PCP.
in full in-network co-pay.	In-network covered in full with referral from PCP. $20 co-pay may apply. Out-of-network or without referral subject to deductible and co-insurance.	Covered in full with referral from PCP. $20 co-pay may apply.	Covered in full at in-network facility.	X-rays covered in full as part of office visit. Lab tests covered in full. Members must use assigned radiologist.	Covered in full.	Lab tests covered in full. X-rays $15 co-pay.
red.	Referral care covered in full when medically necessary and approved and coordinated through Aetna. Non-referred care subject to deductible & co-insurance. Precertification required or benefits will be substantially reduced.	Referral care covered in full when medically necessary and approved and coordinated through Aetna.	Covered in full when medically necessary and approved by Cigna.	Covered in full on inpatient basis only when medically necessary.	Not covered.	Covered in full when approved in advance by medical director.
y up to allowed amount. difference between allowed and total charge.	Covered in full when medically necessary.	Covered in full when medically necessary.	Emergency care per ride, no charge.	Covered in full when medically necessary.	Covered in full when medically necessary.	Covered in full when medically necessary.
ay waived if within 24 hours.	Covered anytime, anywhere in the world, 24 hours a day, 7 days a week. $75 co-pay for emergency room visit (waived if admitted). $100 hospitalization co-pay.	Covered anytime, anywhere in the world, 24 hours a day, 7 days a week. $75 co-pay for emergency room visit (waived if admitted). $100 hospitalization co-pay.	$50 co-pay for outpatient emergency room visit. No charge if hospitalized. Physician's office, $15 co-pay.	$5 co-pay for emergency care in doctor's office or participating urgent center. $25 co-pay for emergency care at hospital. Waived if admitted.	$15 PCP, $20 specialist co-pay for emergency care in doctor's office. $25 co-pay for urgent care at urgent care center. $50 co-pay at hospital emercency room. Waived if admitted.	$35 co-pay. Waived if admitted. Must notify GHI/HMO within 48 hours.
d emergency care is available to nationwide through Empire's Blue- ogram's traditional provider net- est membership is available to HMO living in another city for at least 90 ugh local Blue Cross and/or Blue ns.	Worldwide emergency care coverage as described above.	Worldwide emergency care coverage as described above.	Emergency room care as previously described. Emergency hospitalization is covered. $150 co-pay.	Emergency room care as previously described. Emergency hospitalization is covered.	Covered in full for medially necessary emergency room care, less $50 co-pay.	Emergency room care as previously described. Emergency hospitalization is covered.
in full up to 60 days per year. Precertification rom Empire's Medical ment Program is required.	Covered in full when medically necessary in lieu of hospitalization after $300 co-pay. In-network covered in full when approved and coordinated through Aetna. Out-of-network subject to deductible and co-insurance. Covered at 240 days and 35 physician visits per calendar year. Precertification required or benefits will be substantially reduced.	Covered in full when medically necessary in lieu of hospitalization and when coordinated through Aetna after $300 co-pay.	Inpatient healthcare facilities such as skilled nursing and rehabilitation, up to 60 days per contract year: $0 co-pay.	Covered in full when medically necessary; 45 days per calendar year. Must be admitted within three days of inpatient hospital stay.	Inpatient skilled services such as physical, occupational therapy and skilled nursing care covered in full to a combined maximum of 90 consecuive days per calendar year when medically necessary and approved in advance by PHS medical director.	Covered in full 120 days per year.
red.	In-network covered in full with $20 co-pay and referral from PCP, for diabetics only. Out-of-network or without referral, subject to deductible and co-insurance, for diabetics only.	Covered in full with $20 co-pay and referral from PCP, for diabetics only.	Routine care of the feet not covered.	Routine foot care not covered except when patient is diabetic.	Routine care of the feet not covered.	Routine care of the feet not covered.
in full in-network with $15 waived for treatments).	In-network covered in full with $20 co-pay and referral from PCP. Out-of-network or without referral subject to deductible and co-insurance.	Covered in full with $20 co-pay and referral from PCP.	$15 per visit.	Allergy testing and treatment covered in full with $5 co-pay.	Covered in full after $15 PCP office, $20 specialist office co-pay.	$15 co-pay with PCP referral.
in full in-network with $15 when medically necessary). rral required	In-network covered in full with $20 co-pay and referral from PCP. Out-of-network or without referral subject to deductible and co-insurance. Precertification required or benefits will be substantially reduced. Also, access to Natural Alternatives™ Program which provides negotiated discounted fees for chiropractic manipulation.	Covered in full with $20 co-pay and referral from PCP. Also, access to Natural Alternatives™ Program which provides negotiated discounted fees for chiropractic manipulation.	$15 per visit. (See Physical Therapy short-term rehab if NJ residents) $15 co-pay per visit in NY.	Covered in full when medically necessary with $5 co-pay.	$20 co-pay per visit. Unlimited visits when medically necessary. Prior authorization necessary for second and subsequent visits	$15 co-pay with PCP referral when medically necessary.
n full in-network. $0 copay.	In-network covered in full with $20 co-pay and referral from PCP. Out-of-network or without referral subject to deductible and co-insurance.	Covered in full with $20 co-pay and referral from PCP.	Outpatient, no charge.	No co-pay (inpatient). $5 co-pay for initial visit only (outpatient).	Covered in full.	Covered in full.
in full in-network up to 200 calendar year under home are. Precertification by your PCP Empire's Medical Management is required.	Covered when medically necessary. In-network covered in full when coordinated by PCP through Aetna's Patient Management Dept. Out-of-network subject to deductible and co-insurance. Precertification required or benefits will be substantially reduced.	Covered when medically necessary. Covered in full when coordinated by PCP through Aetna's Patient Management Dept.	Home health care per use, no charge. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment. **HOSPICE CARE:** $0 co-pay.	Covered in full. Not subject to co-pay under Home Health Care. 40 visits per calendar year.	Covered in full under Home Health Care Program when approved in advance by Health Net.	Covered in full for 40 visits only, when medically necessary.
covered in network in full up to 30 calendar year. Outpatient covered in- ombined 30 visits in home, office, t facility per calendar year. Precerti- y your PCP through Empire's Medical ent is required.	IN-NETWORK: Inpatient covered in full under hospitalization or skilled nursing facility benefit. Outpatient covered in full minus $20 co-pay and referral from PCP. Treatment covered over 60-day consecutive period per incident of illness or injury beginning with first day of treatment. OUT-OF-NETWORK OR WITHOUT REFERRAL: Inpatient subject to deductible and co-insurance. Precertification required or benefits will be substantially reduced. Outpatient subject to deductible and co-insurance. Treatment covered over 60-day consecutive period per incident of illness or injury beginning with first day of treatment.	In-network inpatient covered in full under hospitalization or skilled nursing facility benefit. In-network outpatient covered in full minus $20 co-pay and referral from PCP. Treatment covered over 60-day consecutive period per incident of illness or injury beginning with first day of treatment.	Short-term rehabilitation and physical therapy combined 60 visits maximum per contract year, $15 co-pay. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment.	Covered in full with $5 co-pay. Short-term rehabilitation only (two consecutive months per diagnosis).	Outpatient physical and occupational therapy for up to 30 visits per year with $20 co-pay per visit when medically necessary.	$15 co-pay, 30 visits per 60-day period.
medical equipment, medical prosthetics, orthotics covered in certification by your PCP through Medical Management is . In-network provider only.	In-network covered in full when coordinated by PCP. Coverage for durable medical equipment must be deemed medically necessary and is subject to the approval of and coordination through Aetna's Patient Management Dept. Out-of-network subject to deductible and co-insurance. Must pre-certify through Aetna if DME costs exceed $1,500.	Covered in full when coordinated by PCP. Coverage for durable medical equipment must be deemed medically necessary and is subject to the approval of and coordination through Aetna's Patient Management Dept.	Short term rental/purchase of certain durable medical equipment: no charge when approved by Cigna physician. Initial purchase/fitting of certain external prosthetic devices when approved by Cigna physician: covered up to $1,000 per contract year after $200 deductible. Durable medical equipment covered in full.	Covered in full when medically necessary and obtained through a VYTRA designated vendor. Prior authorization required.	Health Net pays 50% of cost of durable medical equipment (certain devices require prior authorization) to a maximum benefit payment of $1,500 per member per calendar year. Internal prosthetics covered in full. External prosthetics covered to $5,000 maximum.	80% covered to an annual maximum of $1,500.
outpatient: covered up to 60 visits include 20 family counseling visits ar year. Behavioral health care man- must pre-approve all care. In-network up to 7 days detox per calendar year, ehab, subject to copay of $250 individ- maximum per contract per calendar avioral Health Care Management must ve all care.	Detoxification covered in full for acute phase of treatment for in-network inpatient after $300 co-pay. In-network outpatient covered in full with $15 co-pay. 60-visit combined annual maximum for drug and/or alcohol treatment. Out-of-network or without referral inpatient subject to deductible and co-insurance. Precertification required or benefits will be substantially reduced. Covered for 30 days per year for alcohol and/or drug addiction. Out-of-network or without referral outpatient subject to deductible and co-insurance. 60-visit combined annual maximum for drug and/or alcohol treatment.	Detoxification covered in full for acute phase of treatment for in-network inpatient after $300 co-pay. In-network outpatient covered in full with $15 co-pay. 60-visit combined annual maximum for drug and/or alcohol treatment.	Substance abuse detoxification services available as inpatient or outpatient, depending on necessity. Services provided by national network of Psychological Managed Care Consultants who evaluate patient needs, provide treatment and coordinate counseling and therapy. Inpatient: $150 co-pay per admission, up to 30 days per contract year. Outpatient Individual: 60 visits per contract year, Outpatient Group: 60 visits per contract year, $25 co-pay per session.	Outpatient drug and alcohol treatment covered in full except for $5 co-pay. 60-visit combined annual maximum for drug and/or alcohol treatment. Detoxification covered in full for three periods of detox in a calendar year for drug and/or alcohol. Inpatient rehabilitation not covered.	Inpatient diagnosis and medical treatment for drug and alcohol detoxification covered in full when approved by Health Net. Outpatient rehab for drug/alcohol addiction covered up to 60 visits per calendar year with $10 co-pay when approved by Health Net.	Inpatient: Detox covered in full, seven-day combined annual maximum for drug and/or alcohol treatment. Rehabilitation covered in full, 30-day combined annual maximum for drug and/or alcohol treatment. Outpatient: $15 co-pay per visit, 60-visit combined annual maximum for drug/alcohol treatment.
$300/$750 co-pay max per year with n number of days for biologically ditions, 30 day limit for non- y based conditions. Outpatient: for biologically based conditions $15 limited visits. For non-biologically ditions $15 copay, 20 visits max. All alth substance abuse treatments/ ations are subject to Empire Behavioral e-authorization and approval.	20 visits per year. In-network requires precertification. $20 co-pay per visit. Out-of-network subject to deductible and 50% coinsurance.	20 visits per year. Precertification required. $20 co-pay per visit.	Services provided by CIGNA Behavioral Health. Inpatient: $150 co-pay per admission up to 30 days per contract year. Outpatient individual: $25 co-pay/session up to 20 per contract year. Outpatient Group Therapy: 40 visits maximum per contract year. Structured group programs as authorized by Cigna: $25 co-pay per session.	Impatient: No co-pay; 30 days per calendar year. Unlimited biologically based mental illness and serious childhood emotional disorders. Outpatient: $5 co-pay; 20 visits per calendar year. Unlimited biologically based mental illness and serious childhood emotional disorders.	Covered after $20 co-pay per visit up to 20 visits per year. Medically necessary visits beyond the sixth must be approved in advance by Health Net.	Inpatient: Covered in full, 30-day annual maximum. Outpatient: 20 visits per year, $15 co-pay.
to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**	Covered to age 23.**

*Benefits in California and Arizona may differ. See City Summary Program Description.

s. Prepared August 2009.

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PLEASE POST