** 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.

GENERAL CONDITIONS

Lifetime Maximum Benefit (per person)	Unlimited

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Deductible	N/A	$1,000 per individual; $1,000 per spouse; $1,000 for all dependent children combined
Maximum Out-of-Pocket Expense	N/A	$3,000 per individual; $3,000 per spouse; $3,000 for all dependent children combined

HOSPITAL SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Hospital Inpatient Services (Including Maternity care and Newborn care from birth on; and mental health, and substance abuse services)	Covered in full	80% of Reasonable and Customary (R&C) after deductible
Hospital Outpatient Services (Includes Same Day Surgery and Ambulatory Surgical Centers)	$50 Co-payment	80% of Reasonable and Customary (R&C) after deductible
Emergency Room	$75 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.	
Urgent Care Facilities	$25 co-pay	80% of Reasonable and Customary (R&C) after deductible

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Pre-Admission Testing	$25 co-pay	80% of R&C after deductible
Diagnostic Tests & X-Ray (Including mammography screening) (Tests and X-Rays that are performed in an outpatient setting)	$25 co-pay	80% of R&C after deductible
Laboratory Services	Covered in Full - No co-pay if in-network lab is used	$25 co-pay All other lab providers

Please see the Empire BCBS website or call 1-844-230-4720 for in-network lab providers.
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 claim 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)	$25 co-pay	80% of R&C after deductible
Dialysis	$25 co-pay	80% of R&C after deductible
Chemotherapy	$25 co-pay	80% of R&C after deductible

PHYSICIAN SERVICES

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Physician Office Visits	$25 co-pay	80% of R&C after deductible
Telehealth Physician Visits	$25 co-pay	80% of R&C after deductible
Live Health Online Visits (livehealthonline.com only)	Covered in Full	Not Applicable
Specialist Office Visits	$25 co-pay	80% of R&C after deductible
Gynecology Office Visits	$25 co-pay	80% of R&C after deductible
Diagnostic Tests & X-Ray	$25 co-pay	80% of R&C after deductible
Laboratory Services	Covered in Full - No co-pay if in-network labs are used	$20 Co-pay All other lab providers

Please see the Empire BCBS website or call 1-844-230-4720 for in-network lab providers.
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 claim to the TPA for reimbursement.

Well Baby/Child Care (up to age 19) (Including Immunizations)	Covered in Full - No co-pay	Not subject to deductible and Coinsurance
Preventive Services (Including Immunizations, Bone Density Screening & Prostrate Screening) (Including Routine Gynecological Services, Well Women Exams, Mammography Screening and Pap Smears)	Covered in Full - No co-pay	Not subject to deductible and coinsurance

PHYSICIAN SERVICES (CONT.)

	IN-NETWORK BENEFIT PAYMENT	OUT-OF-NETWORK BENEFIT PAYMENT
Surgery (Office Setting)	$25 co-pay	80% of R&C after deductible
Anesthesiology	Covered in Full - No co-pay	80% of R&C after deductible
Maternity 18 co-pay for initial visit.	Covered in Full - No co-pay	80% of R&C after deductible
Allergy Testing	Covered in Full - No co-pay	80% of R&C after deductible
Allergy Treatment	Covered in Full - No co-pay	80% of R&C after deductible
Chiropractic Services ($25 Co-pay for related radiology)	$25 co-pay	50% of the in-network allowance after deductible
Occupational, Cardiac, Pulmonary & Speech Therapy	$25 co-pay	PT - 50% of in-network allowance after deductible OT & ST - 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
Diabetic Supplies, Equipment & Education	Covered in Full	80% of R&C after deductible
Prosthetic Devices / Orthotics	Covered in Full	80% of R&C after deductible $250 Annual Maximum
Wigs and Cranial Prosthetics (For Cancer and Alopecia Diagnosis only – Subject to an annual max of $750)	Covered in Full	80% of R&C after deductible

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	$25 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	$25 co-pay	80% of R&C after deductible

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:	$5
Preferred Brand Name Drugs	$25
Non-Preferred Brand Name Drugs	$45
Specialty Drugs	20% Co-pay

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:	$10
Preferred Brand Name Drugs	$50
Non-Preferred Brand Name Drugs	$90
Specialty Drugs	20% Co-pay

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.
If Medicare Primary, no benefits apply.

Home Health Care

Covered in full. Maximum benefit is 100 visits per year.

Ambulance

$50 Co-pay. Coverage for Emergency Services Only.
Non-emergency Servies for in-network only subject to $50 co-pay. No benefit for out-of-network services.

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:

In-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 (Cont.):

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