

EASY CHOICE HEALTH PLAN OF NEW YORK

Summary of Benefits

HNY Individual High Deductible Health Plan

FINANCIALS

| | <u>What You Pay</u> |
|--|----------------------------|
| Office visit Co-pay | \$20 co-payment |
| Deductible Single/Family | \$1,200/\$2,400 |
| Maximum Out of Pocket (after deductible) Single/Family | \$5,250/\$10,500 |

DOCTOR'S SERVICES

| | <u>What You Pay</u> |
|--|-------------------------------|
| Office Visits (PCP or Specialist) | \$20 co-payment |
| Anesthesia | \$20 co-payment |
| Diagnostic Services and Treatments | \$20 co-payment |
| Mammography Screening | \$20 co-payment |
| Obstetrical/Gynecological Services | \$20 co-payment |
| Pap Smears | \$20 co-payment |
| Prostate Cancer Screening | \$20 co-payment |
| Second Surgical Opinions | \$20 co-payment |
| Periodic Adult Physical Examinations | \$20 co-payment |
| Well-Child Care Visits (including immunizations) | No co-payment |
| Pre- and Post-Natal Care | \$10 co-payment |
| Delivery of Child | \$200 or 20%whichever is less |
| Surgical Services | \$200 or 20%whichever is less |

AMBULATORY SERVICES

| | |
|------------------------------------|-----------------|
| Radiation Therapy and Chemotherapy | \$20 co-payment |
| Hemodialysis | \$20 co-payment |
| Pre-admission Testing | \$20 co-payment |
| X-Ray and Laboratory Services | \$20 co-payment |

HOSPITAL SERVICES

| | |
|--|------------------|
| Inpatient Admission (per continuous confinement) | \$500 co-payment |
| Outpatient Surgery Facility Charges | \$75 co-payment |
| Blood and Blood Products | \$20 co-payment |
| Emergency Room Care (no admission to hospital) | \$50 co-payment |

HOSPITAL ALTERNATIVES

| | |
|--|-----------------|
| Home Health Care - 40 visits per calendar year (only following surgery or hospital stay) | \$20 co-payment |
|--|-----------------|

REHABILITATIVE SERVICES

| | |
|--|-----------------|
| Physical Therapy | |
| Outpatient: limited to 30 visits per calendar year (only following surgery or hospital stay) | \$20 co-payment |

DIABETIC EQUIPMENT & SUPPLIES

| | |
|---------------------------------|--------------------------------|
| Diabetic Equipment and Supplies | \$20 per item or 34-day supply |
|---------------------------------|--------------------------------|

Note 1: Benefit limitations and maximums are per Member per calendar year.

Note 2: The benefits outlined in this summary may have been modified as a result of healthcare reform. If applicable, please see PPACA Rider under separate cover.

EXCLUSIONS: This SUMMARY OF BENEFITS highlights the standard benefits of the HNY contract.

Benefits shown may be subject to Restrictions, Exclusions and Limitations found in the Subscriber Contract.

