COUNTY OF NASSAU
COMPARISON OF HEALTH INSURANCE PLANS & PREMIUM RATES FOR EMPLOYEES AND RETIREES FOR 2009

This summary is for descriptive purposes only. Your health benefits are subject to the terms and conditions of the applicable collective bargaining agreement.

HIP, AETNA, BLUE CROSS HMO and VYTRA are HMO plans. All services must be authorized by the Primary Care Physician. Out of Network Services are subiect to Penalties and/or Deductible.

SERVICES	EMPIRE PLAN 1-877-769-7447 www.cs.state.ny.us Employees: Select "Participating Agency", "PA Core Plus Enhancements" Retirees: Select "A Participating Agency – Core Plus Enhancements"	HIP HMO 1-800-447-8255 www.hipusa.com	AETNA INC. 1-800-323-9930 www.aetna.com	BLUE CROSS HMO 1-800-453-0113 www.empireblue.com	HIP / VYTRA NETWORK 1-800-447-8255 www.hipusa.com
Hospital Inpatient Semi-Private Room	You must call for pre-admission: **1-877-769-7447** <u>Network</u> - paid in full 365 days per spell of illness for covered inpatient diagnostic and the therapeutic services or surgical care. <u>Non-Network</u> - subject to a coinsurance amount of 10 percent of billed charges up to a combined annual outpatient coinsurance maximum of $1,500. per person.	No co-pay	No co-pay	Paid in full	Fully covered, unlimited days in semi-private room, private room when medically necessary.
Skilled Nursing Facility Care (semi-private room)	You must call for pre-admission: **1-877-769-7447** <u>Network</u> - paid in full if Empire is primary coverage. <u>Non-Network</u> – contact Empire Plan for Empire BC/BS, UHC service options cost.	No co-pay : Unlimited	No co-pay	Unlimited Paid in full	Fully covered up to 45 days per year
Hospice Care	You must call for pre-admission: **1-877-769-7447** <u>Network</u> - paid in full when provided by an approved network hospice program. <u>Non-Network</u> - contact Empire Plan for Empire BC/BS, UHC service options cost.	210 days, No co-pay	No co-pay	Paid in full 210 days per lifetime	No co-pay
Home Care Services, Skilled Nursing Services & Durable Medical Equipment / Supplies	<u>Network</u> - paid in full when you use HCAP. You must call for prior authorization. <u>Non-Network</u> – First 48 hours of nursing care are <u>not</u> covered. After Basic Medical benefits deductible, plan pays up to 50 percent of the HCAP network allowance.	200 visits per calendar year - No co-pay	No co-pay	$0. co-pay 200 visits per calendar year	No co-pay
Accident & Emergency Illness	Paid in full after $60. co-pay per visit for both Network & Non-Network hospitals, inc. extension clinics, if within 72 hours of accident or if within 24 hours of the onset of a medical emergency. Co-payment is waived if admitted to hospital.	No co-pay	$15. co-pay	$35. co-pay if <u>not</u> admitted within 1 day; must notify PCP <u>or</u> Blue Choice within 1 day to be covered in network.	Fully covered after $35. co-pay (waived if admitted into hospital for emergency care).
Hospital Outpatient Care: Surgery, Diagnostic Radiology, Mammography Screening, Diagnostic Laboratory Tests	$35. co-pay per visit to a Network hospital or a Network hospital extension clinic.	No co-pay	No co-pay	Surgery requires pre-approval, otherwise no co-pay.	No co-pay
Pre-Admission/Pre-Surgical Testing, Chemotherapy, radiology, anesthesiology, dialysis and pathology	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay
Prescription Drugs **(** 2009 - $10. increase for Non - Preferred Brand Name Drugs.)**	**<u>Up to a 30 day supply from a participating retail pharmacy or through the "UHC/Medco" Prescription Mail Order Service Program</u>:** Generic Drug .... $ 5. Preferred Brand-Name Drug .... $15. **Non-Preferred Brand Name Drug .... $40. **<u>31 to 90 day supply from a participating retail pharmacy</u>:** Generic Drug .... $10. Preferred Brand-Name Drug .... $30. **Non-Preferred Brand Name Drug .... $70. **<u>31 to 90 day supply through the "UHC/Medco" Prescription Mail Order Service Program</u>:** Generic Drug .... $ 5. Preferred Brand-Name Drug .... $20. **Non-Preferred Brand Name Drug .... $65. If you choose to purchase a Brand-Name Drug which has a generic equivalent, you pay the non-preferred co-payment <u>plus</u> the difference in cost between the brand-name drug and the generic, not to exceed the full cost of the drug. You have coverage for prescriptions of up to a 90 day supply at all participating, non-participating and mail service pharmacies.	co-pays: $0. generic / $0. brand, must use HIP participating pharmacies.	<u>Retail</u>: $5. co-pay for 30 day supply <u>Mail Order</u>: $10. co-pay for 31-90 day supply through Aetna mail order delivery.	$5. co-pay for generic (or brand if generic equivalent is not available). For brand name drugs, member pays $15. co-pay plus difference in cost between generic and grand drug. Benefits at network pharmacies or mail order only.	$5. co-pay Generic $15. co-pay Brand $25. Non – Formulary <u>Retail:</u> One (1) co-pay up to a 30 day supply. <u>Mail Order:</u> Two (2) co-pays for 90 day supply.

IMPORTANT – Continued on other side

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SERVICES	EMPIRE PLAN	HIP HMO	AETNA INC.	BLUE CROSS HMO	HIP /VYTRA NETWORK
Medical/Surgical Coverage inc.: Office Visits Surgical Procedures Radiology Services Diagnostic Laboratory Outpatient Surgical Visits Cardiac Rehab Visits Urgent Care Visits Routine Health Exams Adult Immunizations	$20. co-pay for participating provider visits. (<u>no</u> co-pay for prenatal & well-child care.) <u>Non-Participating Provider</u>: Annual deductible $363. for enrollee, $363. enrolled spouse/domestic partner; $363. all dependent children combined. The Plan pays 80% of reasonable and customary charges for covered services after annual deductible. Annual coinsurance maximum is $1,000. per employee and covered dependents combined. Routine Health Exams have limits on coverage. Adult Immunizations are not covered.	No co-pay	$2 co-pay	**$15. co-pay (new for 2009)**	Fully covered when services rendered on an in-patient basis. Doctor's office visits fully covered after $5.00 co-pay per visit except maternity which has no co-pay.
Routine Pediatrics Care (Pediatric and Newborn Child Care) up to age 19	Paid-in-full for participating provider visits. <u>Non-Participating Provider</u>: Routine Pediatric Care – same benefits as under Medical/Surgical Coverage. Routine Newborn Child Care – up to $150. with no deductible or coinsurance.	No co-pay	No co-pay as per schedule of visits	Paid in full	Fully covered as per schedule of visits: $5.00 co-pay in excess of schedule.
Private Duty Nurse	Not Covered	Covered in Full	Not covered unless pre-authorized	Not covered	Fully covered when required by physician.
Ambulance	$35. co-pay for local professional ambulance services - no deductible or coinsurance	No co-pay	No copay	No co-pay	No co-pay
Alcoholism/Substance Abuse Network Coverage	No deductibles. <u>Inpatient</u> – No co-payment. Three stays per lifetime (more may be approved case by case.) <u>Outpatient</u> - $20. co-payment per visit. Maximum number of visits is unlimited when medically necessary.	<u>Inpatient:</u> 7 days detoxification 60 days rehabilitation <u>Outpatient:</u> 120 visits – No co-pay	Detoxification inpatient No co-pay 30 days maximum Outpatient -$2 copay 60 visits max.	7 days de-tox up to 30 days rehab. requires a pre-approval	<u>Inpatient</u>: Fully covered for up to three periods of extoxification per year. (7 days in one period). <u>Outpatient</u>: $5.00 co-pay, up to 60 visits per calendar year.
Alcoholism/Substance Abuse Non-Network Coverage*	<u>Inpatient</u> - Plan pays 50% of network allowance after enrollee pays $2000. deductible per person. 1 stay per year/3 stays per lifetime. <u>Outpatient</u> - No crisis intervention. Plan pays 50% of Network allowance after $500. deductible -30 visits per year. *Maximums: annual $50,000 and lifetime $250,000.	Not covered	Not covered	Not covered	Not covered if out of Network
Mental Health Network Coverage	No deductibles. No annual or lifetime benefit maximums. <u>Inpatient</u> – Paid in full. <u>Outpatient</u> - $20 co-payment per visit with up to three visits per crisis paid in full.	<u>Inpatient</u> 30 days per calendar year – No co-pay 60 days per calendar year – No co-pay	<u>Inpatient</u>: No co-pay <u>Outpatient</u>: No co-pay for 1-2 visits, $10 co-pay for 3-10 visits, and $25 co-pay for 11-20 visits	$25. co-pay, 40 O.P. visits per year **$15 co-pay (new for 2009)**, 90 I.P. visits per year. Requires pre-approval	<u>Inpatient</u>: Fully covered for short term care up to 30 days per year. <u>Outpatient</u>: 20 visits per year for short term care. First through third visit-full covered after $5.00 copay. Fourth through 20th visit-fully covered after $25 copayment fee per visit.
Mental Health Non-Network Coverage	<u>Inpatient</u> - Plan pays 90% of billed charges; 100% after the $1,000. coinsurance maximum per person. <u>Outpatient</u> - same coverage as under Medical/Surgical "Non-Participating Provider."	Not covered	Not covered	Not covered	
Prostheses and Orthotic Devices	<u>Network</u> - Paid in full benefits that meet the patient's functional needs. <u>Out-of Network</u> – same coverage as under Medical/Surgical "Non-Participating Provider."	No co-pay	No co-pay	No co-pay	No co-pay - Pre-authorization required
Dental	None	<u>General Dental Care</u> covered at reduced member fee schedule.	Not covered	None	None
Chiropractic Care & Physical Therapy	<u>Network (when you use MPN)</u> - $20. co-pay per visit. <u>Out-of-Network (when you don't use MPN)</u> - $250 separate deductible per person then paid up to 50% of the network allowance. Annual maximum benefit is $1500.	No co-pay <u>Inpatient</u> therapies: max. 90 days, <u>Outpatient</u> therapies: max 90 visits	No co-pay; 60 consecutive days per condition	<u>Inpatient</u> therapies : No co-pay, max 30 visits, <u>Outpatient</u> therapies: must be pre-approved, $5.00 co-pay after 15th visit in calendar year. 30 visits max.	<u>Inpatient</u>: No-copay, <u>Outpatient</u>: $5.00 co-pay in home or office up to 30 visits per calendar year combined in home, office or out-patient facility.
Hearing Aids	Hearing aid evaluation, fitting and purchase of hearing aids covered up to a maximum reimbursement of $1500. per hearing aid, per ear, once every four years. This benefit is not subject to deductible or co-insurance.	Not covered Cochlear implants covered	Hearing Exams Covered – No copay Appliances not covered	Not covered	Fully covered hearing tests to determine hearing disorder for children up to age 17 (appliances not covered).
Other Features	Centers of Excellence for Cancer Program – call to register for paid-in-full benefits for services at a designated Center: **1-866-936-6002.** Pre-hospital Admission Review Program; Outpatient Psychiatric Case Management; Concurrent Inpatient Psychiatric Review Program; Voluntary Catastrophic Case Management Program; Second Surgical Opinion Program, $200 deductible if preadmission and/or 2nd surgical opinion not obtained. MRI, MRA, CT, PET and/or Nuclear Medicine – you must call for authorization: **1-877-769-7447.** New for 2009 – Half Prescription Tablet Program. **(Please refer to 1/09 Empire Plan "At A Glance" guide that briefly describes plan benefits. This guide was mailed to all plan enrollees.)**	13,000 Doctors in private practice, Laser vision correction discounts, Acupuncture, massage therapy & yoga discounts, gym & tennis club discounts, Optical & general dental benefits.	Routine eye exams covered. (Ophthalmologist or Optometrist), $2. co-pay, Vision reimbursement-$200, every 2 years, discounts up to 70% lenses, frames, contacts at participating locations. Reduced fees for massage therapy, acupuncture, nutritional counseling. Maternity, healthy eating, healthy breathing programs.	Covers a broad range of services including vision delivered by medical groups or physicians in their private offices.	Vision Care Service available at participating Vision Centers – 1 routine eye exam per year.

HOWARD S. WEITZMAN, COUNTY COMPTROLLER, Health Insurance Division, 240 Old Country Road, Mineola, N.Y. 11501

COUNTY OF NASSAU
COMPARISON OF HEALTH INSURANCE PLANS & PREMIUM RATES
FOR SURVIVORS, VESTEES, RETIREES & COBRA ELIGIBLES FOR 2009
(Note: Active Employee Rates on separate schedules)

Health Insurance Plan:	Plan Type	PREMIUM: SURVIVOR or VESTEE	PREMIUM: RETIREE I	PREMIUM: RETIREE II	PREMIUM: RETIREE III & RET. POLICE	PREMIUM: RETIREE ORDINANCE	PREMIUM: COBRA ELIGIBLE
Empire Plan	Ind	$598.58	$299.29	$149.64	$0.00	$29.93	$610.55
Empire Plan	Fam	1,282.17	743.62	491.43	0.00	128.22	1,307.81
One Over 65	Ind	359.22	179.61	89.80	0.00	17.96	366.40
One Over 65	Fam	1,042.81	623.94	431.59	0.00	104.28	1,063.67
Two Over 65	Fam	803.45	468.36	311.91	0.00	80.35	819.52
HIP HMO	Ind	558.54	259.25	109.60	0.00	27.93	569.71
HIP HMO	Fam	1,368.43	829.88	577.69	86.26	223.10	1,395.80
HIP VIP Nassau	Ind	327.52	147.91	58.10	0.00	16.38	334.07
HIP VIP Nassau	2-VIP	655.04	319.95	163.50	0.00	65.50	-
HIP VIP Suffolk	Ind	426.52	246.91	157.10	67.30	88.63	435.05
HIP VIP Suffolk	2-VIP	853.04	517.95	361.50	49.59	134.89	-
HIP VIP NY	Ind	311.52	131.91	42.10	0.00	15.58	-
HIP VIP NY	2 VIP	623.04	287.95	131.50	0.00	62.30	-
HIP1VIP/more than 1 HMO Suffolk	1-VIP 1 HMO	1,368.43	949.56	757.21	325.62	223.10	1,395.80
HIP HMO/VIP SUFFOLK	1-VIP 1 HMO	985.06	566.19	373.84	0.00	98.51	1,004.76
HIP HMO/VIP NASSAU	1-VIP 1 HMO	886.06	467.19	274.84	0.00	88.61	-
HIP Choice Plus	Ind	643.56	344.27	194.62	44.98	77.16	656.43
HIP Choice Plus	Fam	1,576.74	1,038.19	786.00	294.57	452.24	1,608.27
AETNA Standard Plan HMO	Ind	707.84	408.55	258.90	109.26	144.65	722.00
AETNA Standard Plan HMO	Fam	1,918.95	1,380.40	1,128.21	636.78	828.68	1,957.33
Blue Cross HMO	Ind	712.97	413.68	264.03	114.39	150.04	727.23
Blue Cross HMO	Fam	1,866.29	1,327.74	1,075.55	584.12	770.75	1,903.62
Over 65	Ind	635.38	455.77	365.96	276.16	307.93	648.09
One Over 65 w/Other Dep.	Fam	1,787.96	1,369.09	1,176.74	745.15	923.95	-
Two Over 65	Fam	1,787.96	1,452.87	1,296.42	984.51	1,163.31	-
HIP/VYTRA Network:	Ind	578.56	279.27	129.62	0.00	28.93	590.13
HIP/VYTRA Network:	Fam	1,417.46	878.91	626.72	135.29	277.04	1,445.81
Over 65	Ind	578.56	398.95	309.14	219.34	248.27	-
One Over 65 w/Other Dependent	Fam	1,417.46	998.59	806.24	374.65	516.40	-
Two Over 65	Fam	1,417.46	1,082.37	925.92	614.01	755.76	-

Legend for Column Headers:

SURVIVOR - Spouse or dependents of deceased retirees
VESTEE - Pension Vestee Employees who terminated employment before age 55
RETIREE I - Retirees who retired prior to May 19, 1975
RETIREE II - Retirees who retired between May 19, 1975 and December 31, 1975
RETIREE III - Retirees who retired on or after January 1, 1976
RETIREE ORDINANCE - Ordinance policy retirees who were employed January 1, 2002 and after