| Your Out-of-Pocket Responsibility | BSNENY EPO 5004 | BSNENY EPO 5010 | CDPHP 2009 CoPay In-Network | CDPHP 2009 CoPay Out-of-Network | CDPHP 2009 Coinsurance Plan - In-Network | CDPHP 2009 Coinsurance Plan - Out-of-Network |
|---|---|---|---|---|---|---|
| **Annual Deductible** | NONE | NONE | NONE | $1,000 single, $3,000 family | $500 single, $1,250 family | $1,000 single, $2,500 family |
| **COPAYMENT-office visits** | $25 | $25 | $25 | N/A | N/A | N/A |
| COPAYMENT-routine eye exam- 1every 2 years | $25 | $25 | N/A | N/A | N/A | N/A |
| COPAYMENT-specialists office visits | $25 | $40 | $25 | N/A | N/A | N/A |
| **Coinsurance** | N/A | N/A | N/A | 30% Coinsurance | 20% Coinsurance | 30% Coinsurance |
| **Coinsurance Maximum** | N/A | N/A | N/A | $5,000 single, $10,000 | $1,500 single, $3,750 family | $3,000 single, $7,500 family |
| **Annual Benefit Maximum** | Unlimited | Unlimited | Unlimited | | Unlimited | |
| **Physician Services** | | | | | | |
| Office visits for illness, injury, or second opinion | $25 | $25 | $25 | Deductible then 30% Coinsurance | 20% Coinsurance | Deductible then 30% Coinsurance |
| Physician services during inpatient stay | Covered in Full | Covered in Full | Covered in Full | Deductible then 30% | Covered in Full | Deductible then 30% |
| Well baby and child care, including immunizations / inoculations | Covered in Full | Covered in Full | Covered in Full | Deductible then 30% | Covered in Full | Deductible then 30% |
| Annual Adult exam | $25 | $25 | Covered in Full | Deductible then 30% | Covered in Full | Deductible then 30% |
| Annual Gynecological exam | $25 | $25 | Covered in Full | Deductible then 30% | Covered in Full | Deductible then 30% |
| **Hospital Services** | | | | | | |
| Inpatient hospital (semi-private room, anesthesia, X-ray, lab tests, etc.) | $250 | $500 | $240 | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| Outpatient surgery | $25 | $100 | $100 | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| **Diagnostic Testing** | | | | | | |
| Laboratory services ***(deductible and coinsurance waived when designated laboratory provider is used)*** | $25 | $25 | $25 | Deductible then 30% | Deductible then 20% coinsurance. Coinsurance waived when designated laboratory provider is used. | Deductible then 30% |
| Radiology and imaging (X-rays, ultrasounds, CT scans, etc.) ***(coinsurance waived when preferred provider is used)*** | $25 | $25 | $25 | Deductible then 30% | Deductible then 20% coinsurance. Coinsurance waived when designated laboratory provider is used. | Deductible then 30% |
| Mammogram | $25 | Covered in Full | Covered in Full | Deductible then 30% | Covered in full | Deductible then 30% |
| Cytology screening | Covered in Full | Covered in Full | Covered in Full | Deductible then 30% | Covered in full | Deductible then 30% |
| Prostate cancer screening | $25 | $40 | Covered in Full | Deductible then 30% | Covered in full | Deductible then 30% |
| **Maternity** | | | | | | |
| Physician services | Covered in Full after first $25 copay at first visit | Covered in Full after first $25 copay at first visit | Covered in Full | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| Inpatient hospital services | $250 | $500 | $240 | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| Newborn nursery | Covered in Full | Covered in Full | Covered in Full | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| **Emergency Care** | | | | | | |
| Emergency room care | $50 | $75 | $50 | | 20% Coinsurance | |
| Ambulance | $50 | $75 | $50 | All emergency care is considered in-network. | 20% Coinsurance | All emergency care is considered in-network. |
| **Urgent Care** – non participating Urgent Care facility services within CDPHP's UBI service area not covered | Not covered | Not covered | Office visit plus $10 | Office visit plus $10 | 20% Coinsurance | Office visit plus $10 |

| Your Out-of-Pocket Responsibility | BSNENY EPO 5004 | BSNENY EPO 5010 | CDPHP 2009 CoPay | | CDPHP 2009 Coinsurance Plan - | |
|---|---|---|---|---|---|---|
| | | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Physical Therapy** Limited to 30 visits per benefit period in- and out-of-network combined | $25 (60 visits aggregate) | $40 (60 visits aggregate) | $25 | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| **Speech Therapy** Limited to 20 visits per benefit period | $25 (60 visits aggregate) | $40 (60 visits aggregate) | $25 | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| **Occupational Therapy** Limited to 30 visits per benefit period in- and out-of-network combined | $25 (60 visits aggregate) | $40 (60 visits aggregate) | $25 | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| **Chiropractic Benefits** | $25 | $40 (60 visits aggregate) | $25 | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| **Home Health Care** | $25 (200 visits aggregate) | $40 (200 visits aggregate) | Covered in full | Deductible then 30% '(deductible not to exceed $50) | 20% Coinsurance (deductible not to exceed $50) | Deductible then 30% '(deductible not to exceed $50) |
| **Hospice** | $25 (210 days) | $40 (210 days) | | | | |
| **Skilled Nursing Facility** – per benefit period | $ 250-non-custodial (120 days) | $ 500-non-custodial (120 days) | 240 (Up to 45 days) | Deductible then 30% | 20% Coinsurance | Deductible then 30% |
| **Prosthetic Devices and Durable Medical Equipment (DME)** -Not subject to deductible) | **20% copay - no lifetime max** | 20% copay - no lifetime max | **50% coinsurance - no lifetime max** | Covered in network only | **50% coinsurance** | Covered in network only |
| **Mental Health Services** - ***(not subject to deductible)*** | | | | | | |
| Outpatient mental health, up to per benefit period | $25 (60 visits) | $40 (60 visits) | 25 (20 visits) | Deductible then 30% | **20% coinsurance** | 30% coinsurance |
| Inpatient mental health, per benefit period | $ 250-non-custodial (30 days) | $ 500-(30 days) | 240 (up to 30 days) | Deductible then 30% | **20% coinsurance** | 30% coinsurance |
| ***Biologically based mental illness and coverage for children with serious emotional disturbance is available beyond those limits for outpatient and inpatient services*** | | | | | | |
| **Diabetic Services – Not subject to Deductible** | | | | | | |
| Insulin and oral medications – Up to 30 day supply | $25 copayment | $25 copayment | $15 copayment | 30% coinsurance | $15 copayment | 30% coinsurance |
| Diabetic Supplies (needles, syringes, etc.) - up to 30 day supply | $25 copayment | $25 copayment | $15 copayment | 30% coinsurance | $15 copayment | 30% coinsurance |
| Glucometers | $25 copayment | $25 copayment | $15 copayment | 30% coinsurance | $20 copayment | 30% coinsurance |
| Diabetic DME | $25 copayment | $25 copayment | $15 copayment | 30% coinsurance | **20% coinsurance** | 30% coinsurance |
| **Chemical Abuse and Dependency Services** - Not subject to Deductible | | | | | | |
| Outpatient Services - Up to 60 visits per calendar year | $25 | $40 (60 visits) | $25 | 30% coinsurance | 20% coinsurance | 30% coinsurance |
| Inpatient detoxification –unlimited days per benefit period | $ 250-(7 days) | $ 500-(7 days) | $240 | Covered in network only | 20% coinsurance | Not covered |
| Inpatient rehabilitation - Up to 30 visits per benefit period | N/A | N/A | $240 | Covered in network only | 20% coinsurance | Not covered |
| **Dependent Coverage-To age 19, students covered to 25** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Coast to Coast coverage through the same network** | Yes | Yes | N/A | N/A | N/A | N/A |
| **No primary physician and no referrals required** | Yes | Yes | Yes | Yes | Yes | Yes |