COUNTY OF NASSAU
COMPARISON OF HEALTH INSURANCE PLANS
FOR EMPLOYEES AND RETIREES FOR 2014

This summary is for descriptive purposes only. Your health benefits are subject to the terms and conditions of the applicable collective bargaining agreement. These are the benefits known to us at the time of this printing. Due to New Federal Regulations there may be changes throughout the year. You will be notified by the carrier you are enrolled in of any changes.

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 not covered.

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.** In-Network-paid in full 365 days per spell of illness for covered inpatient diagnostic and the therapeutic services or surgical care. Non-Network-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 copay	No copay	Paid in Full	Fully covered,
Skilled Nursing Facility Care (semi-private room	You must call for pre-admission **1-877-769-7447.**	No copay-Unlimited	No copay	Coverage is limited to 365 days per calendar year. Failure to obtain pre authorization may result in non coverage or reduced benefits for in network services	Fully covered up to 45 days per year Prior approval required.
Hospice Care	In Network-paid in full when medically necessary in lieu of hospitalization if patient is not medicare eligible. Non-Network- 10% Co-insurance or $75 (whichever is greater)-Precertification is required.$200 penalty applied if not pre certified.	210 days-No copay	No copay	Paid in full 210 days per lifetime	No copay; coverage limited to 210 days.
Home Health Care and In-Home Services	In Network-paid in full. You must call and pre-certify. Non-Network – First 48 hours of nursing care are not covered. After $388.00 deductible. Plan pays up to 50 percent of the in-network allowance.	200 visits per calendar year-No copay	No copay	$0 co-pay 200 visits per calendar year	$5 copay; coverage limited to 40 visits per year. Prior approval required.
Accident & Emergency Illness **Hospital Outpatient Care** Surgery Diagnostic X-ray & Laboratory Tests Preadmission Testing Physical Therapy	Paid in full after $70.00 co-payment [if within 72 hours of accident or if within 24 hours of the onset of a medical emergency]. Paid in full after $60.00 co-pay per visit. Paid in full after $40.00 co-pay per visit. Paid in full after $35.00 co-pay per visit. Paid in full after $20.00 co-pay per visit.	No copay No copay No copay No copay **Therapies No copay** **Inpatient Therapies: 90 days** **Outpatient Therapies: 90 visits**	$15 Copay No copay No copay No copay	$35 Copay if not admitted within 24 hours; must notify PCP or Blue Choice within 1 day for services to be covered in network; subject to sudden or serious criteria. Requires pre-approval. No copay No copay No copay Rehabilitation services: Coverage is limited up to 30 visits per calendar year for Physical, Speech and occupational therapy. Prior approval required.	Fully covered after $25 co-payment No copay Rehabilitation services: Inpatient: No charge; Outpatient: $5 copay/visit Inpatient coverage limited to 30 days/year. Outpatient coverage limited to 120 visits/year.
Prescription Drugs	**Up to a 30 day supply from a participating retail pharmacy or through the "NYSHIP" Prescription Mail Order Service Program:** Most Generic Drug (Level 1)..... **$ 5** Preferred Brand-Name Drug (Level 2) ..... **$25** Non-Preferred Brand Name Drug (Level 3)..... **$45** **31 to 90 day supply from a participating retail pharmacy:** Most Generic Drug (Level 1)..... **$10** Preferred Brand-Name Drug (level 2)..... **$50** Non-Preferred Brand Name Drug(Level 3)..... **$90** **31 to 90 day supply through the "NYSHIP" Prescription Mail Order Service Program:** Most Generic Drug (level 1)..... **$ 5** Preferred Brand-Name Drug (Level 2)..... **$50** Non-Preferred Brand Name Drug (Level 3)..... **$90** If you choose to purchase a Brand-Name Drug which has a generic equivalent, you pay the non-	$0 Generic/$0 Brand; copay Unlimited Must use HIP Participating pharmacies.	Retail: $5 Copay for 30 day supply Net Work pharmacy only Mail Order: $10 Copay for 31-90 day supply through Aetna mail order delivery.	Copay $5.00 for generic fore retail/mail order.$15 copay for preferred brand retail/mail order retail/mail. $25 copay for non preferred brand drugs retail/mail. All have one copay for 30day retail (Net work only pharmacies only). and 2 copay for 31-90 day mail order.	Generic ; Preferred brand Retail: $5 copay 30 day supply Mail Order – $7.50 Copays for 90 day supply. Non preferred-$5 copay 30 day supply Limitation: Must be dispensed at participating pharmacy only.

SERVICES	EMPIRE PLAN	HIP HMO	AETNA INC.	BLUE CROSS HMO	HIP /VYTRA NETWORK
Prescription Cont'd	preferred co-payment plus 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 prescription of up to a 90 day supply at all participating, nonparticipating and mail service pharmacies.				
Medical/Surgical Coverage In-Home Medical Care Surgery Assistant Surgery Anesthesia Maternity X-ray & Lab Test Doctor's Office	$20 copay for participating provider office visits. **Non-Participating Provider**: **Annual deductibles**: Individual - $1,000; Family - EE $1,000, SP/ DP $1,000 ea., child/children $1,000 combined. After $1,000 – 80% of usual and customary charges; After $3,000 each covered enrollee / dependent – 100% will be paid for usual and customary charges. X-ray and lab. Co-pays $20	No copay	$2 copay	No copay No copay No copay No copay $15.00 copay	Fully covered when services rendered on an in-patient basis. Doctor's office visits fully covered after $5.00 copay per visit except maternity. No copay for maternity
Routine Pediatrics care (Exams)	Paid in full through participating providers	No copay	No copay as for 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	Not covered	Check with the carrier for the cost.
Ambulance	$35 Co-Pay for local professional ambulance services.	No copay	No copay	No copay	No copay
Mental Illness/Alcoholism **Substance Abuse needs** Network Coverage	$20 co-payment per visit out patient. No charge -In patient	Inpatient /Out patient- No charge Prior approval may be needed	No copay $2 copy for substance abuse OP No Charge for Inpatient	$15 copay outpatient; no charges for inpatient Limitation: Prior authorization must	Out Patient: $5 copay In patient: No copay Prior approval required.
Alcoholism/Substance Abuse Non-Network Coverage	20% Coinsurance out patient 10% Coinsurance Inpatient No coverage for non network Residential Treatment facilities, halfway or group homes.	Not covered	Not covered	Not covered	Not covered if out of Network
Crutches, Wheelchairs, Prosthetic, Appliances, etc	Benefits are determined after authorization is obtained for using participating provider. Call: **1-877-769-7447.**	No copay	No copay	20% coinsurance; must obtain prior authorization.	No copay Pre-authorization required
Dental	None	Not covered	Not covered	None	None
Physical Therapy	In-Network: $20 copay per visit Non-network: 50% co-insurance for office visits under Managed Physical Medicine Program; 10% co-insurance or $75 (whichever is greater) for outpatient hospital	Rehabilitation Service: Inpatient: No charge Outpatient: No charge Inpatient coverage limited to 90 days/year. Outpatient coverage limited to 90 visits/year.	No copay; 60 consecutive days per condition	$15 copay 30 visits per calendar year.Prior authorization must	$5.00 copay in home or office up to 30 visits per calendar year combined in home, office or out-patient facility.
Hearing Aids	Covered with limitations – please check your policy	Not covered	Hearing Exams Covered – No copay Appliances not covered	Not covered	Not covered