

Onondaga County		January 1, 2008						
Plan Benefit Summary Comparison		OnPoint		Onpoint - Specific Unions			MVP	
		In-Network Benefits	Out-Of-Network Benefits	In-Network Benefits - OCSPA. CORRECTION OFF.	In-Network Benefits - DSBA	Out-Of-Network Benefits	In-Network Benefits	Out-Of-Network Benefits
Physician Services								
	Office Visit - Primary Care Physicians	\$17 Co-pay Pediatric \$12 Co-pay	20% Coinsurance After Deductible *	\$10 Co-pay	\$17 Co-pay	20% Coinsurance After Deductible *	\$15 Co-pay	MVP
	Office Visit - Specialist	\$17 Co-pay Pediatric \$12 Co-pay	20% Coinsurance After Deductible *	\$10 Co-pay	\$17 Co-pay	20% Coinsurance After Deductible *	\$15 Co-pay	Has In-Network
	Office Visit Co-Payment	\$17 Co-pay Pediatric \$12 Co-pay	20% Coinsurance After Deductible *	\$10 Co-pay	\$17 Co-pay	20% Coinsurance After Deductible *	\$15 Co-pay	Benefits Only
	Routine Physical Exams	\$17 Co-pay (Benefit Available Every Year)	In Network Benefit Only	\$10 Co-pay (Benefit available every yr.)	\$17 Co-pay (\$250 max. every two yrs.)	20% Coinsurance After Deductible *	\$15 Co-pay	
Women's Care / OB-GYN								
	Routine Gynecology Visits	\$17 Co-pay	20% Coinsurance After Deductible *	\$10 Co-pay	\$17 Co-pay	20% Coinsurance After Deductible *	\$15 Co-pay	
	Pap Tests	Included with Office Visit Co-pay	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	\$15 Co-pay	
	Mammograms	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	\$15 Co-Pay	
Maternity								
	Prenatal and Postnatal Visits	Initial \$17 Co-pay, Then Paid in Full	20% Coinsurance After Deductible *	Initial \$10 Co-pay, Then Paid in Full	Initial \$17 Co-pay, Then Paid in Full	20% Coinsurance After Deductible *	Initial visit \$15 co-pay, then Paid in Full	
	Hospital Services (Hospital Stay)	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	
	Pediatrician Charges	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	
	Nursery Charges	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	
Pediatric Care								
	Well Baby / Child Visits (to age 19)	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	
Surgery								
	Inpatient	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	
	Outpatient	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	\$15 Co-pay	
	Anesthesiology	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	
Hospital								
	Hospitalization (365 Days)	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	Paid in Full	20% Coinsurance After Deductible *	Paid in Full	
	Outpatient Lab / X-Ray / Other Diag. Svcs.	Lab - Paid in Full X-Ray/Diag - \$17 Co-pay	20% Coinsurance After Deductible *	Lab - Paid in Full X-Ray/Diag - \$10 Co-pay	Lab - Paid in Full X-Ray/Diag - \$17 Co-pay	20% Coinsurance After Deductible *	Paid in Full	
Emergency Room								
	Emergency Room Services	\$35 Co-pay (Waived If Admitted) - \$17 Co-pay at Urgent Care Facility	20% Coinsurance After Deductible *	\$35 Co-pay (Waived If Admitted) - \$15 Co-pay at Urgent Care Facility	\$35 Co-pay - \$17 Co-pay at Urgent Care Fac. (Waived If Admitted)		\$50 Co-pay (Waived If Admitted)	
	Ambulance	\$17 Co-pay	20% Coinsurance After Deductible *	\$10 Co-pay	\$17 Co-pay	20% Coinsurance After Deductible *	Paid in Full	
Durable Medical Equipment		20% Coinsurance (No Deductible)	50% Coinsurance After Deductible *	20% Coinsurance (No Deductible)	20% Coinsurance (No Deductible)	50% Coinsurance After Deductible *	50% Copay	
Skilled Nursing Facility		Paid in Full (100 Day Max)	20% Coinsurance After Deductible (100 Day Combined Max) *	Paid in Full (100 Day Max)	Paid in Full (100 Day Max)	20% Coinsurance After Deductible (100 Day Combined Max) *	Paid in Full. Limited to 45 days per year.	
Home Health Care		Paid in Full (40 Visit Max)	20% Coinsurance After Deductible (40 Visit Combined Max) *	Paid in Full (40 Day Max)	Paid in Full (40 Visit Max)	20% Coinsurance After Deductible (40 Visit Combined Max) *	\$15 Co-pay per visit	
Physical Therapy		\$17 Co-pay	50% Coinsurance After Deductible *	\$10 Co-pay	\$17 Co-pay	50% Coinsurance After Deductible *	\$15 Co-pay (30 visit max) requires PCP prescript.	MVP
Hospice Care		Paid in Full (210 Day Combined Max)	20% Coinsurance After Deductible *	Paid in Full (210 Day Lifetime Max)	Paid in Full (210 Day Lifetime Max)	20% Coinsurance After Deductible *	Paid in Full (210 day Combined Max)	Has In-Network
Mental Health								Benefits Only
	Outpatient	\$17 Co-pay (30 Visits per Calendar Year)	50% Coinsurance After Deductible (30 Visits per Calendar Year) *	\$10 Co-pay (30 Visits per Calendar Year)	\$17 Co-pay (30 Visits per Calendar Year)	50% Coinsurance After Deductible (30 Visits per Calendar Year) *	\$15 Co-pay (20 Visits Max.)	
	Inpatient	Paid in Full (60 Day Combined Max)	50% Coinsurance After Deductible *	Paid in Full (60 Day Combined Max)	Paid in Full (60 Day Combined Max)	50% Coinsurance After Deductible *	Subject to Hospital/Facility Inpatient copay. Max. 30 days	
Substance Abuse								
	Inpatient / Detoxification	Paid in Full (56 Day Combined Max)	50% Coinsurance After Deductible *	Paid in Full (56 Day Combined Max)	Paid in Full (28 Days, two confinements per cal. Yr.)	50% Coinsurance After Deductible *	Paid in full for 7 days detox/30 days inpatient rehabilitation	
	Outpatient Rehabilitative Services	\$17 Co-pay (60 Visit Combined Max.)	50% Coinsurance After Deductible *	\$10 Co-pay (60 Visit Combined Max.)	\$17 Co-pay (60 Visit Combined Max.)	50% Coinsurance After Deductible *	\$15 Co-pay (60 Visit Max.)	
Rx Drug: Retail (Up to a 30 Day Supply)		Generic-\$7 Co-pay/ Preferred Brand Name - 25% Co-pay(\$20 Min.-\$100 max)/Non-Preferred Brand Name-35% co-pay(\$35 Min-\$125 max) Birth Control Medications & Devices Included.		Generic-\$7 Co-pay/ Preferred Brand Name - 25% Co-pay(\$20 Min.-\$100 max)/Non-Preferred Brand Name-35% co-pay(\$35 Min-\$125 max) Birth Control Medications & Devices Included.	Generic-\$5 Co-pay/ Brand Name - The greater of \$10 or 20% cost. Birth Control Medications & Devices Excluded.		\$5 Formulary Generic \$20 Formulary Brand Name \$40 Non-Formulary	
Rx Drug: Mail Order (Up to a 90 Day Supply)		Generic - \$7 Co-pay / Preferred Brand Name - \$20 Co-Pay / Non-Preferred Brand Name - \$40 Co-Pay. Birth Control Medications & Devices Included.		Generic - \$7 Co-pay / Preferred Brand Name - \$20 Co-Pay / Non-Preferred Brand Name - \$40 Co-Pay. Birth Control Medications & Devices Included.	Generic - \$5 Co-pay / Brand Name - \$10 copayment. Birth Control Medications & Devices Excluded.		Receive 90-day supply for the cost of two copayments, or 3-for-2 savings. Medco by mail.	
Chiropractic Care		\$17 Co-pay (30 Visit Max)	50% Coinsurance After Deductible (30 Visit Combined Max) *	\$10 Co-pay (30 Visit Max)	\$17 Co-pay (20 Visit Max)	50% Coinsurance After Deductible (30 Visit Combined Max) *	\$15 Co-pay Requires PCP Prescription	
Vision Care		Eye Exam - \$17 Co-pay (Paid in Full when provided at Empire/Davis Vision Centers) Hardware - (Empire/Davis Vision Centers Only): Eye Glasses w/regular lenses - \$17 Co-pay / Contact Lenses - \$17 Co-pay. Benefit is Available Every Twelve Months.		Eye Exam - \$10 Co-pay (Paid in Full when provided at Empire/Davis Vision Centers) Hardware - (Empire/Davis Vision Centers Only): Eye Glasses w/regular lenses - \$10 Co-pay / Contact Lenses - \$10 Co-pay. Benefit is Available Every Twelve Months.	Eye Exam - \$17 Co-pay (Paid in Full when provided at Empire/Davis Vision Centers) Hardware - (Empire/Davis Vision Centers Only): Eye Glasses w/regular lenses - \$17 Co-pay / Contact Lenses - \$17 Co-pay. Benefit is Available Every 24 Months.		Eye Exam - \$15 Co-Pay - Benefit Available once every two years.	
Dependent Coverage		Dependents to Age 19 - Dependent Students to Age 26		Dependents to Age 19 - Dependent Students to 26			Dependents to Age 19 - Dependent Student to 25	
Deductible		N/A	\$250 Individual / \$750 Family	N/A		\$250 Individual / \$750 Family	N/A	
Lifetime Maximum Benefit		\$1,000,000 Annual Max / \$2,000,000 Lifetime Max		\$1,000,000 Annual Max / \$2,000,000 Lifetime Max			N/A	
Out of Pocket Maximum		N/A	\$1,500 Individual / \$4,500 Family	N/A		\$1,500 Individual / \$4,500 Family	N/A	

* Based on the allowable amount This benefit Summary is intended to provide a synopsis of the coverage provided by the County plan.

For a complete description of the benefits, please refer to the plan document as it will govern benefit decisions.