

COBRA and Health Net Individual Pay copayment/coinsurance comparison

Available to NYSNA Benefits Fund participants

January 1 – December 31, 2008

Covered Service	COBRA (Can be continued for up to 18 months)		Health Net Individual Pay (Can be continued indefinitely)		
	In-network	Out-of-network (Coinsurance)	HMO Plan	POS Plan	
				In-network	Out-of-network (Coinsurance)
Monthly premium	\$540 - \$561 per person (subject to change)		\$914 - \$1,058 per person**	\$1,095 - \$1,268 per person**	
Deductible	None	\$50 - \$100 per person \$150 - \$200 per family	None	None	\$1,000 per person \$2,000 per family
Routine office visits	\$0 - \$10 copayment	20% of UCR*	\$0 - \$15 copayment	\$0 - \$10 copayment	You pay full cost
Nonroutine office visits	\$10 copayment	20% of UCR*	\$15 copayment	\$10 copayment	20% of UCR*
Radiology	No cost	20% of UCR*	\$15 copayment	\$10 copayment	20% of UCR*
Lab tests	No cost	20% of UCR*	\$15 copayment	\$10 copayment	20% of UCR*
Outpatient physical therapy	\$10 copayment	20% of UCR*	\$15 copayment	\$10 copayment	20% of UCR*
Inpatient hospital room and board	No cost	Generally paid so there are no out-of-pocket facility charges	\$500 copayment	No cost	20% of hospital charges*
Inpatient medical visits	No cost	Up to 20% of UCR*	\$15 copayment	\$10 copayment	20% of UCR*
Outpatient surgery	No cost	Up to 17% of UCR*	\$75 copayment	\$10 copayment	20% of hospital charges*
Emergency room	\$25 copayment (waived if admitted)		\$50 copayment	\$35 copayment	20% of UCR*
Outpatient mental health	\$10 copayment	20% of UCR*	10% of UCR*	10% of UCR*	10% of UCR*
Prescription drugs Maintenance medications must be filled by mail-order	\$0 - \$5 copayment	Reimbursed at average wholesale price minus in-network copayment (less than 34-day supply only)	\$5 - \$20 copayment after meeting \$100 deductible per person or \$300 deductible per family		You pay full cost
Dental care services Diagnostic and preventive	No cost	20% of usual and prevailing fee*	Option not available		
Dental care services Basic restorative, endodontics, periodontics, maintenance of prosthodontics, and oral surgery	20% of fee schedule coinsurance	20% of usual and prevailing fee*	Option not available		
Dental care services Major restorative, installation of prosthodontics, and orthodontics	50% of fee schedule coinsurance	50% of usual and prevailing fee*	Option not available		
Routine vision care services Eye exam every 2 years (yearly for children up to age 18)	\$10 copayment	Paid at up to \$75 for exam and glasses or contact lenses every two years	\$15 copayment (vision screening)	\$10 copayment (vision screening)	Option not available
Routine vision care services Eyeglasses or contact lenses every 2 years	\$30 copayment for lenses and/or Designer selection frames <i>or</i> \$150 credit toward other frames <i>or</i> \$25 - \$45 copayment for contact lenses		Option not available		

** Subject to change. Contact GHBA at (800) 762-3511 for current rates.

*Subject to deductible and/or any charges above UCR.