THE FEDCAP GROUP
The Power of Possible

easterseals

In our continuous effort to harmonize benefit plans, several changes have been made which will result in more diversified benefit options for Easterseals NY Downstate employees.

- Easterseals NY Downstate medical and vision benefit plans will be replaced by Fedcap staff plans effective January 1, 2019. This change is due to:
  - Premium increases to the previous Easterseals NY Downstate plan which negate previous cost advantages.
  - The Fedcap staff plan premium decrease for 2019.
  - The addition of an HRA (Health Reimbursement Account) plan option which provides health coverage at a lower cost.

- Highlighted below are the differences between the new Fedcap Staff and the previous Easterseals NY Downstate plan:
  - 4 medical plan options compared to 1 plan option.
  - 4 plan tiers compared to 3 tiers.
  - Potentially lower annual deductible, depending on the selected plan.
  - Lower deductible on prescription drugs.
  - Lower Outpatient Lab & X-Ray.
  - Higher Out-of-Pocket Maximums for medical.
  - Lower vision copays.

Vision Benefit Comparison

Plan Features	Empire Blue View Vision Benefits (Current Plan)		Empire Vision Benefits (New Plan)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
		Reimbursed up to...		Reimbursed up to...
Eye Exam Once every 12 months	$10 copay	$40	$5 copay	$30
Lenses Once every 24 months	$10 copay	Single: $25 Bifocal: $40 Trifocal: $55	$10 copay	Single: $25 Bifocal: $35 Trifocal: $45 Lenticular: $80
Frames Once every 24 months	Covered up to $130 (retail allowance) 20% discount off remaining balance	$45	Covered up to $120 (retail allowance) 20% discount off balance over $120	$120
Contact Lenses (in lieu of eyeglasses) Once every 24 months	Conventional: Covered up to $130 (retail allowance); 15% discount off remaining balance Disposable: $130 (retail allowance); no additional discount Non-Elective: Covered in full	Conventional/ Disposable: Up to $105 Non-Elective: Up to $210	Covered up to $120 (retail allowance); 15% discount (conventional) Medically Necessary: Covered 100% Evaluation & Fitting: Covered 100%	Up to $120 Up to $200

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Medical Benefit Comparison

	Current Plan	New Plans				
Plan Features	EPO	Plan 1: EPO1	Plan 2: EPO2 (Blue Priority)	Plan 3: PPO		Plan 4: HRA3000
	In-Network Only	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network Only
Annual Deductible (individual/family)	$1,000/$2,500	$1,000/$2,500	None	$750/$1,875	$2,000/$5,000	$3,000/$6,000
Coinsurance (plan/member)	90%/10%	80%/20%	100%/0%	90%/10%	70%/30%	90%/10%
Out-of-Pocket Maximum (individual/family)	$2,000/$5,000 (all in-network cost shares)	$5,000/$12,500 (all in-network cost shares)	$5,080/$12,700 (all in-network cost shares)	$3,250/$8,125 (includes deductible; all in-network cost shares)	$4,000/$10,000 (includes deductible)	$7,150/$14,300 (includes deductible; all in-network cost shares)
Annual Preventive Physical	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered in-network only	Covered 100%
Office Visits (PCP/Specialist)	$25/$40 copay	$35/$50 copay	$25/$40 copay	$20/$35 copay	Deductible/ Coinsurance	Deductible/ Coinsurance
Live Health Online	$0 copay	$0 copay	$0 copay	$0 copay	N/A	Deductible/ Coinsurance (If deductible is not met cost is $49. If deductible is met cost is $4.90)
Outpatient Lab & X-Ray*	$25/$40 copay**	Covered 100%	Covered 100%	$20/$35 copay**	Deductible/ Coinsurance	Deductible/ Coinsurance
MRI/MRA, CAT, PET Scans	$25/$40 copay**	Deductible/ Coinsurance	$50 copay	$20/$35 copay**	Deductible/ Coinsurance	Deductible/ Coinsurance
Urgent Care	$40 copay	$50 copay	$40 copay	$35 copay	$35 copay	Deductible/ Coinsurance
Emergency Room (waived if admitted)	$100 copay	$250 copay	$250 copay	$250 copay	$250 copay	Deductible/ Coinsurance
Routine Maternity Care	Deductible/ Coinsurance	Deductible/ Coinsurance	Covered 100%	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Inpatient Hospital	Deductible/ Coinsurance	Deductible/ Coinsurance	$100 per admission; $250 limit/ cal year	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance
Durable Medical Equipment	Deductible/ Coinsurance	Deductible/ Coinsurance	20% coinsurance	Deductible/ Coinsurance	Covered in-network only	Deductible/ Coinsurance

*covered in full when part of office visit on same day of service **exam/evaluation only; other services subject to deductible/coinsurance

Prescription Drug Coverage	EPO	Plan 1: EPO1	Plan 2: EPO2 (Blue Priority)	Plan 3: PPO (in network only)	Plan 4: HRA3000
Retail (30-day supply)	$500 deductible	$100 deductible*	$50 deductible*	No deductible	Deductible then;
▸ Tier 1	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay
▸ Tier 2	$25 copay	$35 copay	$35 copay	$25 copay	$35 copay
▸ Tier 3	$50 copay	20%** $80 min/$300 max	20%** $80 min/$300 max	20%** $80 min/$300 max	20%** $80 min/$300 max
Mail Order (90-day supply)	No deductible	No deductible	No deductible	No deductible	Deductible then;
▸ Tier 1	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay
▸ Tier 2	$50 copay	$70 copay	$70 copay	$50 copay	$70 copay
▸ Tier 3	$100 copay	$140 copay	$140 copay	$100 copay	$140 copay

*per person; does not apply to generic **20% of prescription drug cost