Exhibit II.C

2012 NYSHIP Benefit Plan Comparison

Program Component	THE EXCELSIOR PLAN — AN EMPIRE PLAN OPTION		THE EMPIRE PLAN	
Hospital Benefits[1]	**Network**	**Non-Network**	**Network**	**Non-Network**
Covered Inpatient Services *Preadmission Certification Required*	$250 copayment per stay for enrollee, $250 per stay for spouse/domestic partner, and $250 per stay for all dependent children combined	No coverage in a non-network hospital except network benefits apply in the event of an emergency or when there is no network hospital available within 30 miles of your residence or when no network facility within 30 miles of your residence can provide the covered service you require.	Paid-in-full	Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined.[2] When the combined coinsurance maximum is satisfied, benefits are provided at network levels.
Skilled Nursing Facility Care (No coverage if Medicare primary)	Paid-in-full in an approved facility when medically necessary		Paid-in-full in an approved facility when medically necessary	
Hospice Care	Paid-in-full when provided by an approved network program		Paid-in-full when provided by an approved network program	
Outpatient chemotherapy, radiation therapy, dialysis, preadmission testing	Paid-in-full		Paid-in-full	
Covered Outpatient Services (diagnostic radiology/laboratory)	$75 copayment per visit		$40 copayment per visit	Coinsurance of 10 percent of billed charges or $75 (whichever is greater) up to combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined.[2] When the combined coinsurance maximum is satisfied, benefits are provided at network levels.
Covered Outpatient Surgery	$100 copayment per visit		$60 copayment per visit	
Physical Therapy following related Hospitalization or Inpatient/Outpatient Surgery	$30 copayment when medically necessary		$20 copayment when medically necessary	
Emergency Room Visit	$100 copayment (waived if admitted)	Network benefit applies	$70 copayment (waived if admitted)	Network benefit applies
Medical/Surgical Benefits[1]	**Participating Providers**	**Non-Participating**	**Participating Providers**	**Non-Participating**
Physician Office Visits and covered services provided during office visit	Single $30 copayment for all covered services provided during the visit and billed by the provider. No copayment for prenatal visits, well child care and preventive care services.	Basic Medical Program: After the combined annual deductible of $750 per enrollee, $750 per spouse/domestic partner, and $750 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services.[3] After the combined coinsurance maximum of $2,500 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4]	$20 copayment for each of the following services: Office visit/office surgery; laboratory/radiology; contraceptives (maximum two copayments per visit). No copayment for prenatal visits, well child care and preventive care services.	Basic Medical Program: After the combined annual deductible of $1,000 per enrollee, $1,000 per spouse/domestic partner, and $1,000 per all dependent children combined is met, Plan pays 80 percent of reasonable and customary charges for covered services.[3] After combined coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner, and $3,000 per all dependent children combined is met, Plan pays 100 percent of reasonable and customary charges.[2]
Diagnostic Laboratory Services	Single $30 copayment for all covered services provided during the visit and billed by the provider		$20 copayment	
Diagnostic Radiology and Imaging Services (Certain radiology procedures subject to a Prospective Procedure Review)	$30 copayment per visit $75 copayment per visit for procedures subject to Prospective Procedure Review		$20 copayment	
Routine Pediatric Care	Paid-in-full	Subject to deductible and coinsurance	Paid-in-full	Subject to deductible and coinsurance
Routine Newborn Care	Paid-in-full	Not subject to deductible or coinsurance	Paid-in-full	Not subject to deductible or coinsurance
Routine Health Exams	$30 copayment per visit	Basic Medical Benefits for an active employee age 50 or older. This benefit is not subject to deductible or coinsurance. There is no Basic Medical coverage for routine health exams for spouses, retirees, vestees or dependent survivors.	$20 copayment for the office visit. An additional $20 copayment for any laboratory/radiology services provided during the visit.	Routine health exams are covered for you, the active employee if you are age 50 or over and for your spouse or domestic partner age 50 or older. This benefit is not subject to deductible or coinsurance.
Adult Immunizations	$30 copayment per visit	No coverage	$20 copayment	No coverage
Outpatient Surgical Locations	$75 copayment per visit	Basic Medical Benefits	$30 copayment	Basic Medical Benefits

[1] Certain covered preventive care services are paid in full when received from a participating provider or at a network hospital.
[2] The annual coinsurance maximum for The Empire Plan is shared among the Basic Medical Program and non-network coverage under the Hospital Program and Mental Health and Substance Abuse Program.
[3] The annual deductible for both The Empire Plan and Excelsior Plan is shared among the Basic Medical Program, non-network coverage under the Home Care Advocacy Program and the Mental Health and Substance Abuse Program.
[4] The annual coinsurance maximum for the Excelsior Plan is shared among the Basic Medical Program and non-network coverage under the Mental Health and Substance Abuse Program.

Program Component	THE EXCELSIOR PLAN — AN EMPIRE PLAN OPTION		THE EMPIRE PLAN	
Medical/Surgical Benefits	**Participating Providers**	**Non-Participating**	**Participating Providers**	**Non-Participating**
Emergency Ambulance Service	Local commercial ambulance covered except first $35		Local commercial ambulance covered except first $35	
Prostheses and Orthotic Devices	Paid-in-full	Basic Medical benefits for Prostheses/Orthotic devices that meet the individual's functional needs when obtained from a non-participating provider.	Paid-in-full	Basic Medical benefits for Prostheses/Orthotic devices that meet the individual's functional needs when obtained from a non-participating provider.
External Mastectomy Prostheses	Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing $1,000 or more requires approval through HCAP.		Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing $1,000 or more requires approval through HCAP.	
Chiropractic Treatment and Physical Therapy	$30 copayment for all covered services provided during the visit and billed by the provider.	No coverage	$20 copayment for each office visit. An additional $20 copayment for radiology and diagnostic laboratory services provided during the visit (maximum of two copayments per visit).	$250 annual deductible per enrollee; $250 per enrolled spouse/domestic partner; $250 per all dependent children combined. The plan pays up to 50 percent of the network allowance after you meet the annual deductible. There is no coinsurance maximum.
Home Care Services, Skilled Nursing Services and Durable Medical Equipment	Paid-in-full through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After meeting Basic Medical deductible, Plan pays up to 50 percent of HCAP network allowance.	Paid-in-full through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After meeting Basic Medical deductible, Plan pays up to 50 percent of HCAP network allowance.
Mental Health and Substance Abuse Benefits	**Network Providers/Facilities**	**Non-Network**	**Network Providers/Facilities**	**Non-Network**
Inpatient Services – Approved Facilities	$250 copayment per stay for enrollee, $250 per spouse/domestic partner, and $250 per all dependent children combined.	No coverage in a non-network facility except network benefits apply in the event of an emergency or when there is no network facility available within 30 miles of your residence or when no network facility within 30 miles of your residence can provide the covered service you require.	Paid-in-full No deductibles No annual or lifetime benefit maximums	Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum of $3,000 per enrollee, $3,000 per spouse/domestic partner and $3,000 per all dependent children combined.[2] When combined coinsurance maximum is satisfied, benefits are provided at network levels.
Inpatient Practitioner Treatment or Consultation	Paid-in-full	After the combined annual deductible of $750 per enrollee, $750 per spouse/domestic partner, and $750 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services. After the combined coinsurance maximum of $2,500 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates.[4]	Paid-in-full	
Outpatient Services	Paid-in-full benefit for up to three visits per crisis; Additional visits subject to a $30 copayment.		Paid-in-full benefit for up to three visits per crisis Additional visits subject to a $20 copayment	
Covered Outpatient Substance Abuse Services	$30 copayment per visit		$20 copayment per visit	
Emergency Room Visit	$100 copayment (waived if admitted)	Network benefit applies	$70 copayment (waived if admitted)	Network benefit applies
Emergency Ambulance Service	Local commercial ambulance covered except first $35		Ambulance service covered when medically necessary	
Prescription Drug Program[5,6]				
Prescription Drug Benefits	**Mail Order Pharmacy**		**Participating Retail Pharmacy**	
Level 1	**Excelsior Plan** (most generics)	**Empire Plan** (generics)	**Excelsior Plan** (most generics)	**Empire Plan** (generics)
Up to 30 Days	$10	$5	$10	$5
31-90 Days	$20	$5	$25	$10
Level 2	**Excelsior Plan** (most Preferred Brand-Name Drugs)	**Empire Plan** (Preferred Brand-Name Drugs)	**Excelsior Plan** (most Preferred Brand-Name Drugs)	**Empire Plan** (Preferred Brand-Name Drugs)
Up to 30 Days	$30	$25	$30	$25
31-90 Days	$60	$50	$75	$50
Level 3	**Excelsior Plan** (all other covered drugs)	**Empire Plan** (all other covered drugs)	**Excelsior Plan** (all other covered drugs)	**Empire Plan** (all other covered drugs)
Up to 30 Days	$65	$45	$65	$45
31-90 Days	$130	$90	$160	$90

[4] The annual coinsurance maximum for the Excelsior Plan is shared among the Basic Medical Program and non-network coverage under the Mental Health and Substance Abuse Program.
[5] Empire Plan: If enrollee's doctor believes a brand drug is medically necessary, enrollee may appeal mandatory generic substitution. If approved, level 3 copayment applies and ancillary fee is waived. Quantity level limits exist for erectile dysfunction and migraine medications.
[6] Excelsior Plan: No generic appeal, Level 3 copayment and applicable ancillary fee is charged. Quantity level limits are included in most therapeutic categories. Plan benefit maximums are included for all smoking cessation and infertility therapies.