New York
Plan Name: HMO
Plan Form: NY1HMO019XL
Plan Status: Active

HMO	COVERAGE INFORMATION
Plan Cost-Sharing Highlights	
Annual Deductible	$0 Person/$0 Family
Coinsurance	As Noted Below
Annual Out-of-Pocket Maximum	$6,600 Person/$13,200 Family
Primary Care Physician Office Visits	$25 copay
Specialist Office Visits	$40 copay
Preventive & Well Care Services	
Well Child Care & Immunizations	Covered in Full For a full list of covered preventive care services, visit www.mvphealthcare.com
Adult Annual Physical	
Mammography	
Annual Pap Test & Ob/Gyn Exam	
Immunizations for Adults	
Colonoscopy/Sigmoidoscopy Screening	
Bone Density Tests	
Physician Office Services	
Diagnostic Laboratory Services	Covered in Full
Diagnostic X-ray	PCP: $25 copay/Spec: $40 copay
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $40 copay/Free-Stnd: $40 copay
Rehabilitative Services (PT/OT/ST)	$40 copay
Allergy Services	$40 copay
Chemotherapy	$25 copay
Inpatient Services - Hospital	
Medical/Surgical Admissions	$500 copay
Surgical Services	$100 copay
Inpatient Physical Rehabilitation	$500 copay
Outpatient Hospital Services	
Hospital Rehab Services (PT/OT/ST)	$40 copay
Diagnostic Laboratory Services	Covered in Full
Diagnostic X-ray	$40 copay
Advanced Imaging Services (CT/PET scans, MRIs)	$40 copay
Ambulatory/Outpatient Surgery	$75 copay
Emergency Care	
Emergency Room (ER) Visit	$100 copay
Urgent Care Centers	$25 copay
Ambulance (Emergency Medical Transportation)	$100 copay
Behavioral Health Services	
Mental Health Inpatient Hospital	$500 copay
Mental Health Outpatient	$25 copay
Substance Abuse Inpatient Hospital	$500 copay
Substance Abuse Outpatient	$25 copay
Residential Treatment	Covered in Full
Psychiatry Office Visits	$25 copay

*** Denotes that a deductible applies to this benefit**

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HMO	COVERAGE INFORMATION
Maternity Services	
Prenatal Office Visit	Covered in Full
Physician Delivery	$200 copay
Inpatient Hospital Services	$500 copay
Other Services	
Skilled Nursing Facility	Covered in Full
Home Health Care	$25 copay
Hospice	Covered in Full
Durable Medical Equipment	50% coinsurance
Diabetic Supplies & Equipment	$25 copay
Chiropractic Benefit	$40 copay
Prescription Coverage	
Tier 1	Pharm: $10 copay/Mail: $25 copay
Tier 2	Pharm: $30 copay/Mail: $75 copay
Tier 3	Pharm: $50 copay/Mail: $125 copay
Prescription Drug Deductible	None
Vision Care	
Adult Vision Care	$40 copay
Pediatric Vision Care	$40 copay
Other Plan Features	
Wellness Benefits	Not covered
Plan Highlights	Telemedicine, $2,500 out of area for dependent students, 20% discount at CVS on health related items

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