MVP EPO Schedule of Benefits

MVP Health Services Corp.
Metal Tier: PLATINUM 86.22%
Albany College of Pharmacy $30/$30
NY8STUXCAACP30

Cost-Sharing **Non-Participating Provider services are not covered except as required for emergency care**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Medical Deductible • Individual	$250	See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount Non-Participating Provider services are not covered except as required for emergency care and Urgent Care
Out-Of-Pocket Limit • Individual	$5,000	
Office Visits	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$30 Copayment in Office $30 Copayment by Telehealth	See benefit for description
Specialist Office Visits (or Home Visits)	$30 Copayment in Office $30 Copayment by Telehealth	See benefit for description
Preventive Care	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Well Child Visits and Immunizations*	Covered in Full	See benefit for description
Adult Annual Physical Examinations*	Covered in Full	
Adult Immunizations*	Covered in Full	
Routine Gynecological Services/Well Woman Exams*	Covered in Full	
Mammography Screenings Mammograms, Screening and Diagnostic Imaging for the	Covered in Full	

Detection of Breast Cancer		
Sterilization Procedures for Women*	Covered in Full	
Vasectomy	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)	
Bone Density Testing*	Covered in Full	
Screening for Prostate Cancer • Performed in a PCP Office • Performed in a Specialist Office	 Covered in Full Covered in Full	
All other preventive services required by USPSTF and HRSA.	Covered in Full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost-Sharing for appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
Emergency Care	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services) Cost Share applies to both participating and non-participating providers	$200 Copayment	See benefit for description
Non-Emergency Ambulance Services	$200 Copayment	See benefit for description
Emergency Department Cost Share applies to both participating and non-participating providers Copayment waived if admitted to Hospital	$200 Copayment Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See benefit for description
Urgent Care Center Cost Share applies to both participating and non-participating providers	$30 Copayment in Office $30 Copayment by Telehealth	See benefit for description
Professional Services and Outpatient Care	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services		See benefit for description

• Performed in a Specialist Office	$0 Copayment	
• Performed in a Freestanding Radiology Facility	$0 Copayment	
• Performed as Outpatient Hospital Services	$0 Copayment	
Allergy Testing and Treatment		
• Performed in a PCP Office	$30 Copayment	See benefit for description
• Performed in a Specialist Office	$30 Copayment	
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	$0 Copayment	See benefit for description
Cardiac and Pulmonary Rehabilitation		
• Performed in a Specialist Office	$0 Copayment	See benefit for description
• Performed as Outpatient Hospital Services	$0 Copayment	
• Performed as Inpatient Hospital Services	Included as part of inpatient Hospital Service Cost Sharing	
Chemotherapy and Immunotherapy		
• Performed in a PCP Office	$30 Copayment	See benefit for description
• Performed in a Specialist Office	$30 Copayment	
• Performed as Outpatient Hospital Services	$30 Copayment	
Chiropractic Services	$30 Copayment	See benefit for description
Clinical Trials	Use Cost-Sharing for Appropriate Service	See benefit for description
Diagnostic Testing		
• Performed in a PCP Office	$0 Copayment	See benefit for description
• Performed in a Specialist Office	$0 Copayment	
• Performed as Outpatient Hospital Services	$0 Copayment	
Dialysis		

• Performed in a PCP Office	$30 Copayment	
• Performed in a Specialist Office	$30 Copayment	Dialysis Performed by Non-Participating Providers is Limited to 10 Visits Per Plan Year. Cost Sharing for the visits is the same as for a Participating Provider. See benefit description for more information.
• Performed in a Freestanding Center	$30 Copayment	
• Performed as Outpatient Hospital Services	$30 Copayment	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)		60 visits, per condition, per Plan Year
• Performed in a PCP Office	$30 Copayment	
• Performed in a Specialist Office	$30 Copayment	
• Performed in an Outpatient Facility	$30 Copayment	
Home Health Care	$30 Copayment	60 visits per Plan Year
Infertility Services	Use Cost-Sharing for appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy		
• Performed in a PCP Office	$30 Copayment	See benefit for description
• Performed in Specialist Office	$30 Copayment	
• Performed as Outpatient Hospital Services	$30 Copayment	
• Home Infusion Therapy	$30 Copayment	Home Infusion counts toward Home Health Care visit limits
Inpatient Medical Visits	$0 Copayment	See benefit for description
Interruption of Pregnancy		
• Medically Necessary Abortions	Covered in Full	Unlimited
• Elective Abortions	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge	One (1) procedure per Plan Year

Laboratory Procedures • Performed in a PCP Office	$0 Copayment	See benefit for description
• Performed in a Specialist Office	$0 Copayment	
• Performed in a Freestanding Laboratory Facility	$0 Copayment	
• Performed as Outpatient Hospital Services	$0 Copayment	
Maternity and Newborn Care		See benefit for description
• Prenatal Care	Covered in Full	
- Provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA		One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
- Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing	
• Inpatient Hospital Services and Birthing Center	20% Coinsurance after Deductible	
• Physician and Midwife Services for Delivery	20% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in Full	Covered for duration of breast feeding. Must use designated provider.
• Postnatal Care	Included in Physician and Midwife Services for Delivery Cost Sharing	
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	See benefit for description
Preadmission Testing	$0 Copayment	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities • Performed in a PCP Office	Included as part of the PCP office visit Cost-Sharing	See Benefit for Description
• Performed in Specialist Office	Included as part of the Specialist office visit Cost-Sharing	

• Performed in Outpatient Facilities	20% Coinsurance after Deductible	
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 $0 Copayment $0 Copayment $0 Copayment $0 Copayment	See benefit for description
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 $0 Copayment $0 Copayment $0 Copayment	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	 $30 Copayment $30 Copayment $30 Copayment	60 visits per condition, per Plan Year
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$30 Copayment	See benefit for description Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description **All Transplants must be performed at designated**

• Office Surgery	$30 Copayment	**Facilities**
Telemedicine Program	Covered in Full	See benefit for description
Additional Services, Equipment and Devices	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$30 Copayment in Office $30 Copayment by Telehealth	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	$30 Copayment	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education		
• Diabetic Equipment, Supplies and Insulin (30-day supply)	$30 Copayment but not more than $100 for a 30-day supply of insulin	See benefit for description
• Diabetic Education	$30 Copayment	
Durable Medical Equipment and Braces	20% Coinsurance after Deductible	See benefit for description
External Hearing Aids	20% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants	See Internal Prosthetic Devices Cost-Sharing	One (1) Per Ear Per Time Covered
Hospice Care		210 days per Plan Year Five (5) visits for family bereavement counseling
• Inpatient	20% Coinsurance after Deductible	
• Outpatient	20% Coinsurance after Deductible	
Medical Supplies	20% Coinsurance after Deductible	See benefit for description
Prosthetic Devices		
• External	20% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements; See benefit for description
• Internal	Included as part of Hospital Cost-Sharing	Unlimited; See Benefit For description
Inpatient Services and Facilities	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Autologous Blood Banking	$0 Copayment	See benefits for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for	20% Coinsurance after Deductible	See benefit for description

Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)		
Observation Stay	20% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	20% Coinsurance after Deductible	200 days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	20% Coinsurance after Deductible	60 days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	20% Coinsurance after Deductible	60 days per Plan Year combined therapies
Mental Health and Substance Use Disorder Services	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care including Residential Treatment for a continuous confinement when in a Hospital (including Residential Treatment)	20% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services	 $30 Copayment in Office $30 Copayment by Telehealth $30 Copayment in Office $30 Copayment by Telehealth	See benefit for description
Inpatient Substance Use Services including Residential Treatment for a continuous confinement when in a Hospital (including Residential Treatment)	20% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization,		Unlimited; Up to 20 visits per Plan Year may be used for family counseling

Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits • All Other Outpatient Services	 $30 Copayment in Office $30 Copayment by Telehealth $30 Copayment in Office $30 Copayment by Telehealth	
Prescription Drugs *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy – *30-day supply* • Tier 1 • Tier 2 • Tier 3 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal	 $10 Copayment $50 Copayment $100 Copayment	See benefit for description
Mail Order Pharmacy – *Up to a 90-day supply* • Tier 1 • Tier 2 • Tier 3	 $25 Copayment $125 Copayment $250 Copayment	See benefit for description
Enteral Formulas	Subject to the applicable pharmacy Copayments and days' supply per dispensing	See benefit for description
Wellness Benefits	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

Wellness Program	Up to $125 reimbursement per contract for gym and fitness club membership, youth sports and fitness fees, healthy weight support, tobacco cessation or massage therapy.	See Benefit for Description
Pediatric Dental and Vision Care	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care		
• Preventive Dental Care	$25 Copayment	One (1) dental exam and cleaning per six (6) month period
• Routine Dental Care	20% Coinsurance after Deductible	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) Preauthorization Required for Prosthodontics	50% Coinsurance after Deductible	
• Orthodontics Preauthorization required for Orthodontics	50% Coinsurance after Deductible	
Pediatric Vision Care		
• Exams	$30 Copayment	One (1) Exam Per Plan Year
• Lenses & Frames	20% Coinsurance after Deductible	One (1) Prescribed Standard Lenses & Frames in a 12 month period
• Contact Lenses	20% Coinsurance after Deductible	
Vision Benefits	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Adult Vision Care		
• Exams	$30 Copayment	One (1) exam per Plan Year

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the Full cost of the services.