HMO Schedule of Benefits

Schedule of Member Payments
Embedded Out of Pocket Maximum
MVP Health Plan, Inc.
NYSHIP07HMO2525ZLAPN

Cost-Sharing	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider services are not Covered except as required for emergency care
Medical Deductible • Individual • Family	 None None	 None None	
Out-Of-Pocket Limit • Individual • Family	 $6,350 $12,700	 $6,350 $12,700	Preferred and Participating Provider Out-of-Pockets Limits are Combined

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	NA	$25 Copayment $0 Copayment to age 26	See benefit for description All Copayment and Coinsurance requirements are per visit
Specialist Office Visits (or Home Visits)	NA	$25 Copayment	See benefit for description All Copayment and Coinsurance requirements are per visit

Preventive Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Well Child Visits and Immunizations*	NA	Covered in Full	See benefit for description
Adult Annual Physical Examinations*	NA	Covered in Full	
Adult Immunizations*	NA	Covered in Full	
Routine Gynecological Services/Well Woman Exams*	NA	Covered in Full	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	NA	Covered in Full	

Sterilization Procedures for Women*	NA	Covered in Full	
Vasectomy	NA	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)	
Bone Density Testing*	NA	Covered in Full	
Screening for Prostate Cancer	Covered in Full	Covered in Full	
All other preventive services required by USPSTF and HRSA.	NA	Covered in Full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	NA	Use Cost-Sharing for appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	

Emergency Care	**Preferred Provider Member Responsibility for Cost-Sharing**	**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**	NA	$50 Copayment	See benefit for description
Non-Emergency Ambulance Services	NA	$50 Copayment	See benefit for description
Emergency Department Cost Share applies to both participating and non- participating providers Copayment waived if admitted to Hospital	NA	$75 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	NA	$25 Copayment	See benefit for description

Professional Services and Outpatient Care	**Preferred Provider Member Responsibility for**	**Participating Provider Member Responsibility for**	**Limits**

	Cost-Sharing	Cost-Sharing	
Advanced Imaging Services			See benefit for description
• Performed in a Specialist Office	NA	$25 Copayment	
• Performed in a Freestanding Radiology Facility	$0 Copayment	$25 Copayment	
• Performed as Outpatient Hospital Services	$0 Copayment	$25 Copayment	
Allergy Testing and Treatment			See benefit for description
• Performed in a PCP Office	NA	Covered in Full	
• Performed in a Specialist Office	NA	Covered in Full	
Ambulatory Surgical Center Facility Fee	$0 Copayment	$25 Copayment	See benefit for description
Anesthesia Services (all settings)	NA	Covered in Full	See benefit for description
Autologous Blood Banking	NA	Covered in Full	See benefits for description
Cardiac and Pulmonary Rehabilitation			36 visits per Calendar Year
• Performed in a Specialist Office	NA	$0 Copayment	
• Performed as Outpatient Hospital Services	NA	$0 Copayment	
• Performed as Inpatient Hospital Services	NA	Included as part of Inpatient Hospital Service Cost Sharing	
Chemotherapy and Immunotherapy			See benefit for description
• Performed in a PCP Office	NA	$25 Copayment	
• Performed in a Specialist Office	NA	$25 Copayment	
• Performed as Outpatient Hospital Services	NA	$25 Copayment	
Chiropractic Services	NA	$25 Copayment	See benefit for description
Clinical Trials	NA	Use Cost-Sharing for Appropriate Service	See benefit for description
Diagnostic Testing			See benefit for description

• Performed in a PCP Office	NA	$25 Copayment	
• Performed in a Specialist Office	NA	$25 Copayment	
• Performed as Outpatient Hospital Services	NA	$25 Copayment	
Dialysis			
• Performed in a PCP Office	NA	$25 Copayment	See benefit for description
• Performed in a Specialist Office	NA	$25 Copayment	Dialysis performed by Non-Participating Providers is limited to 10 visits per Calendar Year and requires authorization for the out of network
• Performed in a Freestanding Center	NA	$25 Copayment	
• Performed as Outpatient Hospital Services	NA	$25 Copayment	
Home Health Care	NA	$25 Copayment	See benefit for description
Infertility Services	NA	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	NA	$25 Copayment	
• Performed in Specialist Office	NA	$25 Copayment	See benefit for description
• Performed as Outpatient Hospital Services	NA	$25 Copayment	
• Home Infusion Therapy	NA	Covered in Full	
Inpatient Medical Visits	NA	Covered in Full	See benefit for description
Interruption of Pregnancy			
• Medically Necessary Abortions	Covered in Full	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	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge	One (1) procedure per Calendar Year

Laboratory Procedures			See benefit for description
• Performed in a PCP Office	NA	Covered in Full	
• Performed in a Specialist Office	NA	Covered in Full	
• Performed in a Freestanding Laboratory Facility	$0 Copayment	Covered in Full	
• Performed as Outpatient Hospital Services	$0 Copayment	Covered in Full	
Maternity and Newborn Care			See benefit for description
• Prenatal Care		Covered in Full	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
- Provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	NA		
- Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	NA	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	NA	Covered in Full	
• Physician and Midwife Services for Delivery	NA	Covered in Full	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	NA	Covered in Full	Covered for duration of breast feeding. Must use designated provider.
• Postnatal Care	NA	Included as part of the surgeon's cost share for delivery	
Outpatient Hospital Surgery Facility Charge	$0 Copayment	$25 Copayment	See benefit for description
Preadmission Testing	NA	Covered in Full	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
• Performed in a PCP Office	NA	Included as part of the PCP office visit Cost-Sharing	

• Performed in Specialist Office • Performed in an Outpatient Facility	NA NA	Included as part of the Specialist office visit Cost-Sharing Covered in Full	
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 NA NA $0 Copayment $0 Copayment	 $25 Copayment $25 Copayment $25 Copayment $25 Copayment	See benefit for description
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 NA $0 Copayment $0 Copayment	 $25 Copayment $25 Copayment $25 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	 NA NA NA	$25 Copayment $25 Copayment $25 Copayment	30 visits per condition per Plan Year combined therapies
Second Opinions on the Diagnosis of Cancer, Surgery and Other	NA	$25 Copayment	See benefit for description Non-Participating Provider services are not covered, and You pay the full cost Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-

			Participating Specialist
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 • Office Surgery	NA NA NA NA	Covered in Full Covered in Full Covered in Full $25 Copayment	See benefit for description **All Transplants must be performed at designated Facilities and require Prior Authorization** All inpatient admissions require notification to MVP. Select procedures are reviewed prior to admission Certain procedures whether done in office, outpatient hospital, ambulatory surgery center or office require prior authorization; your participating provider has a list of these procedures
Telemedicine Program	NA	Covered in Full	See benefit for description

Additional Services, Equipment and Devices	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	NA	$25 Copayment	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	NA	$25 Copayment	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education	NA NA	$25 Copayment $25 Copayment	See benefit for description
Durable Medical Equipment and Braces	NA	50% Coinsurance	See benefit for description
Cochlear Implants	NA	See Surgical Services; internal Prosthetic Devices Cost-Sharing	One (1) Per Ear Per Time Covered
Hospice Care • Inpatient	NA	Covered in Full	210 days per Calendar Year; Five (5) visits for family

• Outpatient	NA	Covered in Full	bereavement counseling
Medical Supplies	NA	50% Coinsurance	See benefit for description
Out of Service Area	NA	Use Cost-Sharing for Appropriate Service	Up to $2500 in out of service area covered benefits per member, per Calendar Year. See benefit for description Use of this benefit does not eliminate the need for prior authorization or medical necessity on services that would otherwise require Prior Approval
Prosthetic Devices • External • Internal	 NA NA	 50% Coinsurance Covered in Full	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements; See benefit for description Unlimited; See benefit for description

Inpatient Services and Facilities	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	NA	Covered in Full	See benefit for description
Observation Stay	NA	Covered in Full	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	NA	Covered in Full	45 days per Calendar Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	NA	Covered in Full	30 days per Calendar Year

Mental Health and Substance Use Disorder Services	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous	NA	Covered in Full	See benefit for description

confinement when in a Hospital including Residential Treatment			
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	NA	$25 Copayment	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital including Residential Treatment	NA	Covered in Full	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	NA	$25 Copayment	Unlimited; Up to 20 visits per Calendar Year may be used for family counseling
Wellness Benefits	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Wellness Program	NA	Up to $200 earnable for completing activities through MVP's Website and up to $200 reimbursement for participation in WellBeing program and activities and up to $200 for tracking steps via MVP's Connected! program	See benefit for description **Up to $600 per Calendar Year**
Pediatric Dental Care and Vision Care	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care			
• Preventive Dental Care	NA	$25 Copayment	See benefit for description
Vision Care			
• Exams	Na	$25 Copayment	One (1) Exam Per Two (2) Calendar Years
• Lenses & Frames	NA	Not a Covered Benefit	
• Contact Lenses	NA	Not a Covered Benefit	

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.