NY44 HEALTH BENEFITS PLAN TRUST

BENEFIT SUMMARY

EFFECTIVE 7/1/2013
MVP Option A

Benefits	In-Network	Out-of-Network
Outpatient Services		
Office Visit	$0	Subject to deductible and co-payment
Adult Immunizations	$0	Not covered
Well-Child Visits	$0	Subject to deductible and co-payment
Allergy Testing/Treatment	$0	Subject to deductible and co-payment
Chemotherapy	$0	Subject to deductible and co-payment
EKG's and Other Diagnostic Procedures	$0	Subject to deductible and co-payment
Diagnostic X-rays	$0	Subject to deductible and co-payment
Mammogram	$0	Subject to deductible and co-payment
Laboratory Testing, Including Pap Smears	$0	Subject to deductible and co-payment
Rehabilitation Therapies (physical, occupational, and speech**)**	Covered in full up to 30 visits per therapy, per calendar year; additional medically necessary visits may be covered only if preauthorized	Subject to deductible and co-payment
Outpatient Surgery (performed in a physician's office)	$0	Subject to deductible and co-payment
Outpatient Surgery (performed in a hospital or surgery center)	$0	Subject to deductible and co-payment
Medical Eye Exam	$0	Not Covered
Chiropractic Services	If medically necessary, $0 Preauthorization is required for visits in excess of three in a course of treatment	Subject to deductible and co-payment

Maternity Coverage		
Physician Services (Prenatal/ delivery/ postpartum covered in full)	$0	Subject to deductible and co-payment
Hospital Services	$0	Subject to deductible and co-payment

Hospital Services		
Inpatient Hospital	$0	Subject to deductible and co-payment

Benefits	In-Network	Out-of-Network
Hospice	$0	Subject to deductible and co-payment

Emergency Services		
Medically Necessary and Ambulance Transportation	$25 co-payment	$25 co-insurance
Emergency Room Services	$50 co-payment	$50 co-insurance

Mental Health Services		
Outpatient services for mental health issues.	$0	Subject to deductible and co-payment

Substance Abuse Treatment		
Detoxification	$0	Subject to deductible and co-payment
Inpatient Treatment	$0	Subject to deductible and co-payment
Outpatient Treatment – limited to 60 visits/calendar year	$0	Subject to deductible and co-payment

Additional Services		
Durable Medical Equipment	Covered at 50%	Covered at 50% after deductible
Prosthetics & Appliances	Covered at 50%	Covered at 50% after deductible
Home Health Care Services	$0	Subject to deductible and co-payment
Skilled Nursing Facility	$0	Subject to deductible and co-payment

Diabetic Supplies & Services		
Durable Medical Equipment (for diabetic supplies)	$0	Subject to deductible and co-payment
Insulin and Oral Agents (Pharmacy benefit applies)	$0	$0
Up to a 30-day supply of outpatient diabetic supplies (test strips, syringes, etc.)	$0	Subject to deductible and co-payment

Vision Plan		
Refractive (Routine) Eye Exam	$0 co-payment	Not Covered.
Vision Coverage	Not covered.	Not Covered.

Dental Plan		
Dental Coverage	Not covered.	Not Covered.

Benefits	In-Network	Out-of-Network
Prescription Plan		
Prescription Co-pay (Through Pharmacy Benefit Dimensions)	$0 / $15 / $30 $0 copay for insulin and other oral agents Tiers I and II	When outside of NY State, prescriptions should be filled using Pharmacy Benefit Dimensions' nationwide pharmacy network. In-network benefits apply.
Contraceptive drugs and devices	Includes contraceptive drugs and devices	When outside of NY State, prescriptions should be filled using Pharmacy Benefit Dimensions' nationwide pharmacy network. In-network benefits apply.

Limitations		
Deductible Out-of-Network	N/A	$1,000 / $2,000
Co-payment	N/A	70% / 30%
Out-of-Pocket Maximum	N/A	$5,000 / $10,000
Annual Maximum Benefit	N/A	Unlimited

Dependent Eligibility
Dependents include the spouse, domestic partner, and children up to age 26, including stepchildren, adopted children, and children over whom you have legal guardianship.

Exclusions
✯ Items such as television set rental and phone charges while an inpatient in a Hospital
✯ Hearing aid appliances
✯ Cosmetic surgery, unless medically necessary
✯ Custodial care or rest cures
✯ Experimental medical procedures
✯ Long-term physical therapy
✯ Military-related disabilities
✯ In-vitro fertilization, gamete or zygote intrafallopian tube transfers
✯ Physical examinations requested for employment, licensing, insurance, camp
✯ Outpatient medical supplies (except diabetic supplies)
✯ Dental surgery, treatment or care
✯ All benefits of the plan are subject to coordination of benefits.

This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is NOT a contract and may be subject to change. For more detailed information, consult your Summary Plan Description. Certain medical procedures require your physician to get prior approval from MVP Health Plan.