MVP EPO Schedule of Benefits

MVP Health Services Corp.

Platinum 88.32%

Hamilton College Student Health Plan

NY8STUXBAHAM25

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 **Out-Of-Pocket Limit** • Individual	None $5,000	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
Office Visits	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$25 Copayment	See benefit for description
Specialist Office Visits (or Home Visits)	$25 Copayment	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 Detection of Breast Cancer	Covered in Full	
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	$100 Copayment	See benefit for description
Non-Emergency Ambulance Services	$100 Copayment	See benefit for description
Emergency Department Cost Share applies to both participating and non-participating providers Copayment waived if Hospital admission	$100 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	$25 Copayment	See benefit for description
Professional Services and Outpatient Care	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility	 $0 Copayment $0 Copayment	See benefit for description

• Performed as Outpatient Hospital Services	$0 Copayment	
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	$25 Copayment $25 Copayment	See benefit for description
Ambulatory Surgical Center Facility Fee	10% Coinsurance	See benefit for description
Anesthesia Services (all settings)	$0 Copayment	See benefit for description
Autologous Blood Banking	$0 Copayment	See benefits for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$0 Copayment $0 Copayment Included as part of inpatient Hospital Service Cost Sharing	See benefit for description
Chemotherapy and Immunotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$25 Copayment $25 Copayment $25 Copayment	See benefit for description
Chiropractic Services	$25 Copayment	See benefit for description
Clinical Trials	Use Cost-Sharing for Appropriate Service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$0 Copayment $0 Copayment $0 Copayment	See benefit for description
Dialysis • Performed in a PCP Office	$25 Copayment	See benefit for description

• Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services	$25 Copayment $25 Copayment $25 Copayment	Dialysis Performed by Non-Participating Providers is Limited to 10 Visits Per Plan Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	 $25 Copayment $25 Copayment $25 Copayment	60 visits, per condition, per Plan Year combined therapies
Home Health Care	$25 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 • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $25 Copayment $25 Copayment $25 Copayment $25 Copayment	 See benefit for description Home Infusion counts toward Home Health Care visit limits
Inpatient Medical Visits	$0 Copayment	See benefit for description
Interruption of Pregnancy • Medically Necessary Abortions • Elective Abortions	 Covered in Full Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)	 Unlimited One (1) procedure per Plan Year
Laboratory Procedures		

• Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services	$0 Copayment $0 Copayment $0 Copayment $0 Copayment	See benefit for description
Maternity and Newborn Care		See benefit for description
• Prenatal Care - Provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA - Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in Full Use Cost-Sharing for appropriate service Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Inpatient Hospital Services and Birthing Center	10% Coinsurance	
• Physician and Midwife Services for Delivery	10% Coinsurance	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in Full	Covered for duration of breast feeding. Must use designated provider.
• Postnatal Care	Included as part of the surgeon's cost share for delivery	
Outpatient Hospital Surgery Facility Charge	10% Coinsurance	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 • Performed in Specialist Office • Performed in Outpatient Facilities	Included as part of the PCP office visit Cost-Sharing Included as part of the Specialist office visit Cost-Sharing 10% Coinsurance	See Benefit For description

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	 $25 Copayment $25 Copayment $25 Copayment	60 visits per condition, per Plan Year combined therapies
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$25 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 • Office Surgery	 10% Coinsurance 10% Coinsurance 10% Coinsurance $25 Copayment	See benefit for description **All Transplants must be performed at designated 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	$25 Copayment	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	$25 Copayment	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education	 $25 Copayment no more than $100 for a 30-day supply of insulin $25 Copayment	 See benefit for description
Durable Medical Equipment and Braces	10% Coinsurance	See benefit for description
External Hearing Aids	10% Coinsurance	Single purchase once every three (3) years
Cochlear Implants	See Surgical Services; Internal Prosthetic Devices Cost-Sharing	One (1) Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient	 10% Coinsurance 10% Coinsurance	210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies	10% Coinsurance	See benefit for description
Prosthetic Devices • External • Internal	 10% Coinsurance Included as part of Hospital Cost-Sharing	 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	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)	10% Coinsurance	See benefit for description
Observation Stay	10% Coinsurance	See benefit for description
Skilled Nursing Facility	10% Coinsurance	200 days per Plan Year

(including Cardiac and Pulmonary Rehabilitation)		
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	10% Coinsurance	60 days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	10% Coinsurance	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)	10% Coinsurance	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$25 Copayment	See benefit for description
Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital)	10% Coinsurance	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	$25 Copayment	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
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	 $10 Copayment $45 Copayment	See benefit for description

• 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.	$75 Copayment	
Mail Order Pharmacy – *Up to a 90-day supply* • Tier 1 • Tier 2 • Tier 3	 $25 Copayment $112.50 Copayment $187.50 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 items, programs, and activities in the dimensions of Social, Physical and Mind & Spirit.	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	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	
• Orthodontics Preauthorization required for Orthodontics	50% Coinsurance	
Pediatric Vision Care		

• Exams	$25 Copayment	One (1) Exam Per Plan Year
• Lenses & Frames	10% Coinsurance	One (1) Prescribed Standard Lenses & Frames in a Plan Year
• Contact Lenses	10% Coinsurance	
Vision Benefits	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Adult Vision Care		
• Exams	$25 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.