Healthy New York Summary of Benefits

Services	Healthy New York Plan
Hospital Inpatient Services	
Hospital Services	Unlimited days of semi-private room accommodations and all medically necessary services for acute care covered with a $500 inpatient co-payment per admission. Private room covered when medically necessary and authorized by MVP Health Care Medical Director.
Skilled Nursing Facility	Not covered.
Surgery	20% coinsurance, maximum $200. In addition to $500 co-payment
Anesthesia	Covered in Full.
Hospital Outpatient Services	
Diagnostic X-ray	$20 co-payment per visit.
Diagnostic Laboratory and Pathology	$20 co-payment per visit.
Chemotherapy	$20 co-payment per visit.
Radiation Therapy	$20 co-payment per visit
Surgical Care	$75 co-payment per visit
Pre-Admission Testing	$20 co-payment per visit
Emergency Service	
Life Threatening and Urgent Medical Emergencies	In Physician's Office, $20 co-payment per visit In Emergency Room, $50 co-payment per visit or waived when admitted within 24 hours. Primary Care Physician referral not required. Worldwide coverage for emergency care.
Ambulance	Not covered.
Physician Services	
Office Visits	
Diagnostic Office Visit	In Primary Care Physician's office, $20 co-payment per visit
Routine Adult Physical Exam	Routine physicals covered once every three years (age 19 and older with a 20$ co-payment per visit Semi-Annual GYN visits covered with a $20 co-payment per visit
Allergy Tests and Injections	In Primary Care Physician's office, $20 co-payment per visit. In Specialist's office, $20 co-payment per visit.

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Services	Healthy New York Plan
Physician's Office	
Immunizations (Periodic & Routine)	In Primary Care Physician's office, $20 co-payment per visit (unless part of well-child visit.)
Diagnostic Prostate Cancer Screening	$20 co-payment per visit
Eye Exam	Routine eye exams not covered
Eye Wear	Not covered
Hearing Aids	Not covered
Chemotherapy	$20 co-payment per visit
Radiation Therapy	$20 co-payment per visit
Diagnostic Laboratory and Pathology	$20 co-payment per visit
Diagnostic X-ray	$20 co-payment per visit
Maternity	
Hospital Charges for Mother (including Delivery Room)	Semi-private accommodations and all medically necessary services are covered with a 20% coinsurance (maximum $200). Inpatient hospitalization co-payment of $500 also applies.
Physician Services	
Pre and Post-Natal Care and Delivery	$10 co-payment per visit
Well-Baby & Well-Child Care	$0 co-payment per visit (through age 18).
Psychiatric & Substance Abuse	
Mental Health	Not covered
Substance Abuse	Not covered
Other Services	
Insulin & Diabetic Supplies	A 34 day supply of insulin, oral agents and supplies is covered at a $20 co-payment
Home Care	$20 co-payment per visit. Limited to 40 post-hospital or post surgical visits per calendar year.
Private Duty Nursing (in Hospital)	Not covered
Physical Therapy	$20 co-payment per visit. Limited to 30 post-hospital or post-surgical visits per calendar year.
Speech/Occupational Therapy	Not covered
Durable Medical Equipment	Not covered
Prosthetics and Orthopedic Braces and Support	No coverage for prosthetics with the exception of breast prostheses after mastectomy

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Services	Healthy New York Plans
Other Services (Continued)	
Chiropractic Services	Not covered
Dental	Covered when related to an accidental injury to sound, natural teeth. Services must be rendered within 12 months of accident $20 Specialist co-payment per visit. Preauthorization from your Primary Care Physician is required.
Out-of-Area Coverage	Coverage provided worldwide for emergency services. Primary Care Physician referral required for non-emergency out-of-area services. Physician's office, $20 co-payment per visit. Emergency Room, $50 co-payment per visit or waived when admitted within 24 hours. Coverage out-of-area follow-up care in addition to urgent and emergency care for dependent college students who attend colleges located outside of our service area. Follow up care must be preauthorized by Primary Care Physician.
Dependent Coverage	Coverage for dependent children to age 19. Full time students to age 23.
Prescription Coverage (Optional)	
Prescriptions	Retail: Up to a 34 day supply. There is a co-payment for each 34 day supply of $10 generic, $20 brand name co-payment. Mail Order maintenance: Up to a 90 day supply of approved maintenance drugs is covered with $20 generic, $40 brand name co-payment. Under the Generic MAC Program, if there is an A-rated generic drug, you have the option of choosing the brand name drug but will be responsible for the difference in cost between the generic and the brand name drug plus your co-payment. Oral contraceptives covered under retail or mail order program. Not covered: Non-standard/unevaluated medications and cosmetic drugs. $100 deductible per individual. Maximum $3000 benefit per calendar year.
Depo Provera	In Primary Care Physician's office, $20 co-payment per visit. Only available in conjunction with rider prescription drug

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	coverage
Services	**Healthy New York Plans**
High Deductible Health Plan - OPTIONAL	
Individual Deductible	$1,200 with an annual out-of-pocket maximum of $5,250 which includes the deductible and co-payments. Once the annual out-of-pocket maximum is met, all covered services will be covered in full. The deductible must be met in full before you begin paying the established co-payments. Once the deductible is met, then services are paid according to the applicable co-payments until the annual out-of-pocket maximum is met.
Family Deductible	$2,400 with an annual out-of-pocket maximum of $10,500 which includes the deductible and co-payments. Once the annual out-of-pocket maximum is met, all covered services will be covered in full. The deductible must be met in full before you begin paying the established co-payments. Once the deductible is met, then services are paid according to the applicable co-payments until the annual out-of-pocket maximum is met.
	The deductible will **NOT** be applied to adult preventive services (cervical cytology, periodic physicals (1 every 3 years), adult immunizations, prostate cancer screenings, routine prenatal care, well child visits or child immunizations. However, all applicable co-payments will apply. In addition, there will not be a separate deductible for prescription drug coverage. The applicable co-payments will apply. **CERTIFICATION OF INTENT TO ESTABLISH A HEALTH SAVINGS ACCOUNT IS REQUIRED FOR INITIAL ENROLLMENT AND MUST BE RECERTIFIED ANNUALLY.**

NON-GRANDFATHERED BENEFITS EFFECTIVE 10/1/10 UPON RENEWAL (NGF = EFFECTIVE DATE ON/AFTER 3/23/10)	
HNY HMO and HDHP	**Vermont Non-Group Individual Plan VIIP**
DEP TO AGE 26	DEP TO AGE 26
REMOVE LIFETIME DOLLAR MAXIMUMS	REMOVE LIFETIME DOLLAR MAXIMUMS
REMOVAL OF PRE-EX FOR KIDS UNDER 19	REMOVAL OF PRE-EX FOR KIDS UNDER 19
REMOVE ANNUAL MAXIMUM FOR ESSENTIAL BENEFITS	Implement the following $ maximums: 2010 - 2011 $750,000 2011-2012 $1.25 2012-2013 $2 2014 eliminated
NO COPAY FOR CERTAIN PREVENTIVE SVCS	NO COPAY FOR CERTAIN PREVENTIVE SVCS
ER OUT OF NETWORK EQUAL TO IN-NETWORK	ER OUT OF NETWORK EQUAL TO IN-NETWORK