PLAN SUMMARY_MVP

GENERAL INFORMATION	Medical/Rx Plan Comparison					
Plan Type	TRADITIONAL		CORE		PROGRESSIVE	
Network Indicator	MVP		MVP		MVP	
Benefit Summary	Medical/Rx PPO & POS		Medical/Rx PPO & POS		Medical/Rx PPO & POS	
BENEFIT SUMMARY	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible/Individual	$0	$1,000	$0	$2,000	$300 per person per cal yr. combined Medical & Rx	$3,000
Annual Deductible/Family	$0	$2,000	$0	$5,000		$6,000
Coinsurance	None	30%	None	30%	None	30%
Annual Out-of-Pocket Limit/Individual	$5,000	$9,500	$5,000	$9,500	$5,000	$19,000
Annual Out-of-Pocket Limit/Family	$10,000	$19,000	$10,000	$19,000	$10,000	$38,000
Deductible Included in Out-of-Pocket Limits	N/A	Yes	N/A	Yes	Yes	Yes
Medical Services/Benefits						
Office Visit/Exam	Covered in Full	30% after ded.	$10 Copayment	30% after ded	$15 Copayment after deductible	Not Covered
Specialist Visit	Covered in Full	30% after ded.	$10 Copayment	30% after ded.	$15 Copayment after deductible	Not Covered
Preventive Care/Screening	Covered in Full	30% after ded.	Covered In Full	30% after ded.	Covered In Full	Not Covered
Emergency Room Services	$300 Copayment *		$400 Copayment*		$250 Copayment after Deductible*	
Urgent Care	Covered in Full	Covered in Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Ambulance	$25 Copayment	$25 Coinsurance	$50 Copayment	$50 Copayment	$50 Copayment	$50 Copayment
Inpatient Hospital Services	Covered in Full	30% after ded.	Covered in Full	30% after ded.	$500 Copayment	Not Covered
Outpatient Surgery	Covered in Full	30% after ded.	$75 Copayment; applied to facility charge & physician in office setting	30% after ded.	$75 Copayment; applied to facility charge & physician in office setting	Not Covered
Outpatient Physical, Occupational, Speech Therapy	Covered in Full	30% after ded.	Covered In Full	30% after ded.	$15 Copayment after deductible Limited to 20 visits each	Not Covered
Home Health Care	Covered in full Limited 40 visits per calendar yr	30% after ded.	Covered in full Limited 40 visits per calendar yr	30% after ded.	$15 Copayment after deductible Limited to 40 visits per calendar yr	Not Covered
Durable Medical Equipment	50%	50% after ded.	50%	50% after ded.	50% after ded.	50% after ded.
Skilled Nursing Care	Covered in Full Limited to 45 days per calendar yr	30% after ded.	Covered in Full Limited to 45 days per calendar yr	30% after ded.	$500 Copayment for Inpatient; $15 Copayment for Outpatient Limited to 45 days per calendar yr	Not Covered
Inpatient Mental Health/Substance Abuse	Covered in Full	30% after ded.	Covered in Full	30% after ded.	$500 Copayment	Not Covered
Outpatient Mental Health/Substance Abuse	Covered in Full	30% after ded.	$10 Copayment for office visit	30% after ded.	$15 Copayment after deductible	30% after deductible
Maternity Care	Covered in Full	30% after ded.	Covered in Full	30% after ded.	$15 copayment after ded. for outpt services; $500 Copayment for inpatient	Not Covered
Laboratory Services	Covered in Full	30% after ded.	Covered in Full	30% after ded.	Covered In Full	30% after deductible
Radiology (diagnostic)	Covered in Full	30% after ded.	$15 copayment	30% after ded.	$15 copayment after ded.	30% after deductible
Chiropractic Services	Covered in Full	30% after ded.	$15 copayment	30% after ded.	$15 copayment after ded.	Not Covered
Diabetic Supplies	Covered in Full	30% after ded.	Covered in Full	30% after ded.	Subject to deductible, then subject to Rx copays	Not Covered
Telemedicine Visit	Covered in Full	30% after ded.	Covered in full	30% after ded	$15 copayment after ded.	Not covered
Medical Eye Exam	Covered in Full	30% after ded.	$10 copayment	30% after ded.	$15 copayment after ded.	Not Covered

All quotes based on data submitted. Rates subject to change pending final underwriting. If this information conflicts in any way with the contract, the contract will prevail.

NY44 Health Benefits Plan Trust

PLAN SUMMARY_MVP

GENERAL INFORMATION	Medical/Rx Plan Comparison					
Plan Type	TRADITIONAL		CORE		PROGRESSIVE	
Network Indicator	MVP		MVP		MVP	
Benefit Summary	Medical/Rx PPO & POS		Medical/Rx PPO & POS		Medical/Rx PPO & POS	
BENEFIT SUMMARY	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Benefits						
Prescription Drug Deductible						
Retail - 30 day supply						
Generic / Tier 1	$0 Copayment	Not Covered	$5 Copayment	Not Covered	$5 Copayment	Not Covered
Brand (Formulary/Preferred) / Tier 2	$15 Copayment	Not Covered	$25 Copayment	Not Covered	$40 Copayment	Not Covered
Brand (Non-Formulary/Non-preferred) / Tier 3	$30 Copayment	Not Covered	$60 Copayment	Not Covered	$75 Copayment	Not Covered
Specialty / Tier 4	Paid according to applicable Tier; Participants are required to utilize the Payer Matrix program	Not Applicable	Paid according to applicable Tier; Participants are required to utilize the Payer Matrix program	Not Applicable	7% Coinsurance after deductible to a maximum of $120 for 30 day supply; Participants are required to utilize the Payer Matrix program	Not Applicable
Mail Order - 90 day supply	Mandatory Mail after 2nd fill at Retail		Mandatory Mail after 2nd fill at Retail		Mandatory Mail after 2nd fill at Retail	
Generic / Tier 1	$0 Copayment	Not Covered	$12.50 Copayment	Not Covered	$12.50 Copayment	Not Covered
Brand (Formulary/Preferred) / Tier 2	$37.50 Copayment	Not Covered	$62.50 Copayment	Not Covered	$100 Copayment	Not Covered
Brand (Non-Formulary/Non-preferred) / Tier 3	$75 Copayment	Not Covered	$150 Copayment	Not Covered	$187.50 Copayment	Not Covered
Vision Benefits	Must use Davis Vision Provider		Must use Davis Vision Provider		Must use Davis Vision Provider	
Routine Eye Exam	Covered in Full; One exam every 12 months	Not Covered	$10 Copayment; One exam every 12 months	Not Covered	Subject to deductible, then $15 copayment	Not Covered
Frames	$40 Copayment, then 10% discount on balance of frames over $70; One set every 12 months	Not Covered	$40 Copayment, then 10% discount on balance of frames over $70; One set every 12 months	Not Covered	Not Covered	Not Covered
Lenses	Single $35 copay Bifocal $55 copay Trifocal $65 copay Progressive $125 copay Once every 12 months	Not Covered	Single $35 copay Bifocal $55 copay Trifocal $65 copay Progressive $125 copay Once every 12 months	Not Covered	Not Covered	Not Covered
Contact Lenses	20% discount off provider U&C schedule of allowance for conventional contact lenses (applies to materials only)	Not Covered	20% discount off provider U&C schedule of allowance for conventional contact lenses (applies to materials only)	Not Covered	Not Covered	Not Covered
Laser Vision Correction	25% discount off U&C schedule of allowance or 5% off promotional pricing; Must use U.S. Laser Network for LASIK or PRK	Not Covered	25% discount off U&C schedule of allowance or 5% off promotional pricing; Must use U.S. Laser Network for LASIK or PRK	Not Covered	Not Covered	Not Covered
Children's Eye Care	Eye exam - Covered in full Glasses subject to $40 copayment, 10% discount on balance of frames over $70	Not Covered	$10 Copayment for exam; Glasses subject to $40 copayment, 10% discount on balance of frames over $70	Not Covered	$15 Copayment for Eye exam; Eye glasses not covered	Not Covered

* Copayments are waived if admitted or for certain long-term observation holds; capped at two times copayment in the event a common accident or injury occurs for a family unit at the same time.

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