New York
Plan Name: Preferred PPO
Plan Form: Elmira City Schools
Plan Status: Active

Preferred PPO	COVERAGE INFORMATION	
Plan Cost-Sharing Highlights	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	$0 Person/$0 Family	$1,000 Person/$2,000 Family - Aggregate
Coinsurance	As Noted Below	30% Person/30% Family
Annual Out-of-Pocket Maximum	$4,600 Person/$9,200 Family - Embedded	$9,500 Person/$19,000 Family - Aggregate
Primary Care Physician Office Visits	Covered in Full	30% coinsurance*
Specialist Office Visits	Covered in Full	30% coinsurance*
Preventive & Well Care Services	**IN-NETWORK**	**OUT-OF-NETWORK**
Well Child Care & Immunizations	Covered in Full For a full list of covered preventive care services, visit www.mvphealthcare.com	Well Child Care & Immunizations Covered in Full; Subject to out of network cost share for all other services.
Adult Annual Physical		
Mammography		
Annual Pap Test & Ob/Gyn Exam		
Immunizations for Adults		
Colonoscopy/Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Services	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Laboratory Services	Covered in Full	PCP: 30% coinsurance*/Spec: 30% coinsurance*
Diagnostic X-ray	Covered in Full	PCP: 30% coinsurance*/Spec: 30% coinsurance*
Advanced Imaging Services (CT/PET scans, MRIs)	Covered in Full	Spec: 30% coinsurance*/Free-Stnd: 30% coinsurance*
Rehabilitative Services (PT/OT/ST)	Covered in Full	30% coinsurance*
Allergy Services	Covered in Full	30% coinsurance*
Chemotherapy	Covered in Full	30% coinsurance*
Inpatient Services - Hospital	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical/Surgical Admissions	Covered in Full	30% coinsurance*
Surgical Services	Covered in Full	30% coinsurance*
Inpatient Physical Rehabilitation	Covered in Full	30% coinsurance*
Outpatient Hospital Services	**IN-NETWORK**	**OUT-OF-NETWORK**
Hospital Rehab Services (PT/OT/ST)	Covered in Full	30% coinsurance*
Diagnostic Laboratory Services	Covered in Full	30% coinsurance*
Diagnostic X-ray	Covered in Full	30% coinsurance*
Advanced Imaging Services (CT/PET scans, MRIs)	Covered in Full	30% coinsurance*
Ambulatory/Outpatient Surgery	Covered in Full	30% coinsurance*
Emergency Care	**IN-NETWORK**	**OUT-OF-NETWORK**
Emergency Room (ER) Visit	$50 copay	$50 copay
Urgent Care Centers	Covered in Full	30% coinsurance*
Ambulance (Emergency Medical Transportation)	Covered in Full	Covered in Full

*** Denotes that a deductible applies to this benefit**

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Behavioral Health Services	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health Inpatient Hospital	Covered in Full	30% coinsurance*
Mental Health Outpatient	Covered in Full	30% coinsurance*
Substance Abuse Inpatient Hospital	Covered in Full	30% coinsurance*
Substance Abuse Outpatient	Covered in Full	30% coinsurance*
Residential Treatment	Covered in Full	30% coinsurance*
Psychiatry Office Visits	Covered in Full	30% coinsurance*
Maternity Services	**IN-NETWORK**	**OUT-OF-NETWORK**
Prenatal Office Visit	Covered in Full	30% coinsurance*
Physician Delivery	Covered in Full	30% coinsurance*
Inpatient Hospital Services	Covered in Full	30% coinsurance*
Other Services	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered in Full	30% coinsurance*
Home Health Care	Covered in Full	30% coinsurance*
Hospice	Covered in Full	Inpt: 30% coinsurance*/Outpt: 30% coinsurance*
Durable Medical Equipment	20% coinsurance	30% coinsurance*
Diabetic Supplies & Equipment	Covered in Full	30% coinsurance*
Chiropractic Benefit	Covered in Full	30% coinsurance*
Prescription Coverage	**IN-NETWORK**	**OUT-OF-NETWORK**
Tier 1	Pharm: $0 copay/Mail: $0 copay	Not covered
Tier 2	Pharm: $15 copay/Mail: $37.50 copay	Not covered
Tier 3	Pharm: $30 copay/Mail: $75 copay	Not covered
Prescription Drug Deductible	None	None
Vision Care	**IN-NETWORK**	**OUT-OF-NETWORK**
Adult Vision Care	Annual Eye Exam - Covered in Full	Not covered
Pediatric Vision Care	Annual Eye Exam - Covered in Full	Not covered
Other Plan Features	**IN-NETWORK**	**OUT-OF-NETWORK**
Wellness Benefits	$300 allowance	Included in In-Network benefit
Plan Highlights	myVisitNow (Telemedicine), National network, 24/7 Nurse Advice line, exclusive member discounts	

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This plan overview is intended to provide a general outline of coverage. In the event of any conflict between this document and your Certificate of Coverage, Schedule and any applicable Rider(s), your Certificate of Coverage, Schedule and Rider(s) will be controlling. For plan details, call **1-800-TALK-MVP (825-5687)** or visit **DiscoverMVP.com**.

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