

Onondaga County - Jan. 1, 2025		Onpoint 25		MVP HMO	
Plan Benefit Summary Comparison		In-Network Benefits	Out-Of-Network Benefits	In-Network Benefits	NO Out-Of-Network Benefits
<b>Physician Services</b>	Office Visit - Primary Care Physicians	\$25 Co-pay Pediatric \$20 Co-pay	25% Coinsurance After Deductible *	\$15 Co-pay	MVP HAS IN-NETWORK BENEFITS ONLY
	Office Visit - Specialist	\$25 Co-pay Pediatric \$20 Co-pay	25% Coinsurance After Deductible *	\$15 Co-pay	
	Office Visit Co-Payment (not otherwise specified)	\$25 Co-pay Pediatric \$20 Co-pay	25% Coinsurance After Deductible *	\$15 Co-pay	
	Routine Physical Exams	Paid in full	In Network Benefit Only	Paid in full	
<b>Women's Care / OB-GYN</b>					
	Routine Gynecology Visits	Paid in full	25% Coinsurance After Deductible *	Paid in full	
	Pap Tests	Paid in full	25% Coinsurance After Deductible *	Paid in Full	
	Mammograms	Paid in full	25% Coinsurance After Deductible *	Paid in Full	
<b>Maternity</b>	Prenatal and Postnatal Visits	Initial \$25 Co-pay, Then Paid in Full	25% Coinsurance After Deductible *	Paid in Full	
	Hospital Services (Hospital Stay)	\$75 Co-pay	25% Coinsurance After Deductible *	Paid in Full	
	Pediatrician Charges	Paid in full	25% Coinsurance After Deductible *	Paid in Full	
	Nursery Charges	Paid in full	25% Coinsurance After Deductible *	Paid in Full	
<b>Pediatric Care</b>					
	Well Baby / Child Visits (to age 19)	Paid in full	25% Coinsurance After Deductible *	Paid in Full	
<b>Surgery</b>					
	Inpatient	\$75 Co-pay	25% Coinsurance After Deductible *	Paid in Full	
	Outpatient	\$75 Co-pay	25% Coinsurance After Deductible *	\$15 Co-pay	
	Anesthesiology	Paid in full	25% Coinsurance After Deductible *	Paid in Full	
<b>Hospital</b>					
	Hospitalization (365 Days)	\$75 Co-pay	25% Coinsurance After Deductible *	Paid in Full	
	Outpatient Lab / X-Ray / Other Diag. Svcs.	Labs - Paid in Full X-Ray/Other Diagnostic (Imaging, CT/PET scan, MRI) \$25 Co-pay	25% Coinsurance After Deductible *	Labs - Paid in Full X-Ray/Other Diagnostic (Imaging, CT/PET scan, MRI) \$15 Co-pay	
<b>Emergency Room</b>	Emergency Room Services (co-pay waived if admitted)	\$75 Co-pay	\$75 Co-pay	\$50 Co-pay (Waived If Admitted)	
	Urgent Care (co-pay waived if admitted)	\$25 Co-pay	\$25 Co-pay	\$15 Co-pay	
<b>Transportation</b>	Ambulance	\$75 Co-pay	\$75 Co-pay	Paid in Full	
<b>Durable Medical Equipment</b>		25% Coinsurance	50% Coinsurance After Deductible *	50% Copay	
<b>Skilled Nursing Facility</b>		\$75 Co-pay (per admit)	25% Coinsurance After Deductible *	Paid in Full. Limited to 45 days per year.	
<b>Home Health Care</b>		\$75 Co-pay (per calendar year)	25% Coinsurance After Deductible *	\$15 Co-pay per visit	
<b>Physical Therapy</b>		\$20 Co-pay	* see plan document	\$15 Co-pay (30 visit max) requires PCP prescript.	

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<b>Hospice Care</b>		\$75 Co-pay (per episode) (210 Day Combined Max per lifetime)	25% Coinsurance After Deductible *	Paid in Full (210 day Combined Max)	MVP
<b>Mental Health</b>	Outpatient	\$20 Co-pay (unlimited visits)	25% Coinsurance After Deductible (unlimited visits) *	\$15 Co-pay	Has In-Network Benefits Only
	Inpatient	\$75 Co-pay	25% Coinsurance After Deductible (365 Days) *	Paid in full	
<b>Substance Abuse</b>					
	Inpatient / Detoxification	\$75 Co-pay (365 days)	25% Coinsurance After Deductible (365 Days) *	Paid in full	
	Outpatient Rehabilitative Services	\$20 Co-pay (365 days)	25% Coinsurance After Deductible (unlimited visits) *	\$15 Co-pay	
<b>Rx Drug: Retail (Up to a 30 Day Supply)</b>		Generic-\$10 Co-pay Preferred Brand Name - \$25 Non-Preferred Brand - \$45		\$5 Formulary Generic \$20 Formulary Brand Name \$40 Non-Formulary	
<b>Rx Drug: Mail Order (Up to a 90 Day Supply)</b>		Generic - \$20 Co-pay Preferred Brand Name - \$50 Non-Preferred Brand -\$90		Receive 90-day supply for the cost of 2.5 copayments. Medco by mail.	
<b>Chiropractic Care</b>		\$20 Co-pay (30 Visit Max)	50% Coinsurance After Deductible * (30 Visit Combined Max) *	\$15 Co-pay Requires PCP Prescription	
<b>Vision Care</b>		Eye Exam - \$25 Co-pay (Paid in Full when provided at Empire/Davis Vision Centers) Hardware - (Empire/Davis Vision Centers Only): Eye Glasses w/regular lenses - \$10 Co-pay / Contact Lenses - \$10 Co-pay. Benefit is Available Every 12 Months.		Eye Exam - \$15 Co-Pay - Benefit Available once every two years.	
<b>Dependent Coverage</b>		Dependents to Age 26		Dependents to Age 26	
<b>Deductible</b>		N/A	\$500 Individual / \$1,500 Family	N/A	
<b>Lifetime Maximum Benefit</b>		N/A			
<b>Out of Pocket Maximum - Medical</b>		\$1,500 Individual \$4,500 Family	\$2,000 Individual \$6,000 Family	N/A	
<b>Out of Pocket Maximum - Prescription Drug/Rx</b>		\$5,350 Individual \$9,200 Family	N/A	N/A	
This benefit Summary is intended to provide a synopsis of the coverage provided by the County plan. For a complete description of the benefits, please refer to the plan document as it will govern benefit decisions.					
	* Based on the allowable amount				