Onondaga County - **Jan. 1, 2027**		**Onpoint 25**		**MVP HMO**	
Plan Benefit Summary Comparison		**In-Network Benefits**	**Out-Of-Network Benefits**	**In-Network Benefits**	**NO Out-Of-Network Benefits**
Physician Services	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	
Women's Care / OB-GYN					
	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	
Maternity	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	
Pediatric Care					
	Well Baby / Child Visits (to age 19)	Paid in full	25% Coinsurance After Deductible *	Paid in Full	
Surgery					
	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	
Hospital		$75 Co-pay	25% Coinsurance After Deductible *	Paid in Full	
	Hospitalization (365 Days)				
	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	
Emergency Room	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	
Transportation	Ambulance	$75 Co-pay	$75 Co-pay	Paid in Full	
Durable Medical Equipment		25% Coinsurance	50% Coinsurance After Deductible *	50% Copay	
Skilled Nursing Facility		$75 Co-pay (per admit)	25% Coinsurance After Deductible *	Paid in Full. Limited to 45 days per year.	
Home Health Care		$75 Co-pay (per calendar year)	25% Coinsurance After Deductible *	$15 Co-pay per visit	
Physical Therapy		$20 Co-pay	* see plan document	$15 Co-pay (30 visit max) requires PCP prescript.	

Onondaga County - **Jan. 1, 2027**		**Onpoint 25**		**MVP HMO**	
Plan Benefit Summary Comparison		**In-Network Benefits**	**Out-Of-Network Benefits**	**In-Network Benefits**	**NO Out-Of-Network Benefits**
Hospice Care		$75 Co-pay (per episode) (210 Day Combined Max per lifetime)	25% Coinsurance After Deductible *	Paid in Full (210 day Combined Max)	MVP
Mental Health	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	
Substance Abuse					
	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	
Rx Drug: Retail (Up to a 30 Day Supply)		Generic-$10 Co-pay Preferred Brand Name - $25 Non-Preferred Brand - $45		$5 Formulary Generic $20 Formulary Brand Name $40 Non-Formulary	
Rx Drug: Mail Order (Up to a 90 Day Supply)		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.	
Chiropractic Care		$20 Co-pay (30 Visit Max)	50% Coinsurance After Deductible * (30 Visit Combined Max) *	$15 Co-pay Requires PCP Prescription	
Vision Care		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.	
Dependent Coverage		Dependents to Age 26		Dependents to Age 26	
Deductible		N/A	$500 Individual / $1,500 Family	N/A	
Lifetime Maximum Benefit		N/A			
Out of Pocket Maximum - Medical		$1,500 Individual $4,500 Family	$2,000 Individual $6,000 Family	N/A	
Out of Pocket Maximum - Prescription Drug/Rx		$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				