St. Lawrence County Chamber of Commerce	MVP PREFERRED EPO A-AS EC0048S CHAMBERS - $40 Copay	MVP PREFERRED EPO B-BS EC0052S CHAMBERS - $30/$50 Copay	MVP PREFERRED EPO C-CS EC0022S Chambers - $40 Hybrid Copay	MVP PREFERRED EPO D-DS EC0034S $30/$50 Hybrid Split Copay
PHYSICIAN SERVICES - Office				
PCP OFFICE VISIT (Well Baby and Child Care covered with no copay according to Mandate)	$40/Visit	$30/Visit	$40/Visit	$30/Visit
Adult Preventive Care: Periodic Physicals, Gynecological Exams, Mammographies, Prostate Cancer Screenings	Covered in full	Covered in full	Covered in full	Covered in full
Specialist Office Visit	$40/Visit	$50/Visit	$40/Visit	$50/Visit
Surgery	Subject to Office Copay	Subject to Office Copay	Subject to Office Copay	Subject to Office Copay
Vision/Eyewear - Exams for the purpose of vision correction - once every two years. Eyeglass & Lenswear - once every two years. Calendar Year Benefit.	Exam = $40 copay per visit Eyewear = $100 maximum	Exam = $50 copay per visit Eyewear = $100 maximum	Exam = $40 copay per visit Eyewear = $100 maximum	Exam = $50 copay per visit Eyewear = $100 maximum
Laboratory Services	Covered in full	Covered in full	Covered in full	Covered in full
Second Surgical Opinions - Not required/Optional	Subject to Office Copay	Subject to Office Copay	Subject to Office Copay	Subject to Office Copay
X-Ray Services	Subject to Office Copay	Subject to Office Copay	Subject to Office Copay	Subject to Office Copay
High Tech Imaging Services (e.g. CT's, MRAs, MRIs, PET Scans, MRCP's and CTA's require PRIOR-AUTH)	Subject to Office Copay	Subject to Office Copay	Subject to Office Copay	Subject to Office Copay
PHYSICIAN SERVICES - Hospital				
Surgery	Covered in full	Covered in full	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Anesthesiology	Covered in full	Covered in full	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Radiology	Covered in full	Covered in full	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Visits/Consultations	Covered in full	Covered in full	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
HOSPITAL				
Hospital Inpatient	$500 First Admission Only; Limited to 3 copays maximum per family per contract year.	$500/Visit Per Continuous Confinement	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Hospital Outpatient - Surgery	$150 Facility Visit	$150 Facility Visit	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Hospital Outpatient - Lab & X-Ray	Lab - Covered in full Xray - $40/Visit	Lab - Covered in full Xray - $50/Visit	Lab - Covered in full Xray - Subject to Deductible and Coinsurance	Lab - Covered in full Xray - Subject to Deductible and Coinsurance
Hospital Outpatient - High Tech Imaging Services (e.g. CT's, MRAs, MRIs, PET Scans, MRCP's and CTA's require PRIOR-AUTH)	Subject to Office Copay	Subject to Office Copay	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Hospital Outpatient Therapeutic Services - Radiation Therapy, Chemotherapy, Infusion Therapy and Inhalation Therapy	$40/Visit	$30/Visit	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
MATERNITY				

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Physician Services	Initial diagnostic visit copay only	Initial diagnostic visit copay only	Initial diagnostic visit copay only	Initial diagnostic visit copay only
Hospital Services	May be subject to Inpatient Hospital Copay	Subject to Inpatient Hospital Copay	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Nursery Care	Covered in full	Covered in full	Covered in full	Covered in full
EMERGENCY HOSPITAL CARE				
In-Area	$100/Visit	$100/Visit	$200/Visit	$200/Visit
Out-of-Area	$100/Visit	$100/Visit	$200/Visit	$200/Visit
MENTAL HEALTH				
Inpatient - Hospital **30 day maximum per contract year**	May be subject to Inpatient Hospital Copay	Subject to Inpatient Hospital Copay	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Inpatient - Physician	Covered in full	Covered in full	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Outpatient **20 visits per contract year**	Subject to Office Copay	$50/Visit	Office Setting = Subject to Office Visit Copay Facility Setting = Subject to Deductible and Coinsurance	Office Setting = Subject to Office Visit Copay Facility Setting = Subject to Deductible and Coinsurance
EXTENDED MENTAL HEALTH BENEFITS (MANDATED FOR LARGE GROUPS - OPTIONAL RIDER FOR SMALL GROUPS)				
Inpatient - Hospital	May be subject to Inpatient Hospital Copay	Subject to Inpatient Hospital Copay	Subject to Deductible and Coinsurance	Subject to Inpatient Hospital Copay
Inpatient - Physician	Covered in full	Covered in full	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Outpatient	Subject to Office Copay	$50/Visit	Office Setting = Subject to Office Visit Copay Facility Setting = Subject to Deductible and Coinsurance	Office Setting = Subject to Office Visit Copay Facility Setting = Subject to Deductible and Coinsurance
SUBSTANCE ABUSE DIAGNOSIS & TREATMENT				
Detoxification - 7 day maximum	May be subject to Inpatient Hospital Copay	Subject to Inpatient Hospital Copay	Subject to Deductible and Coinsurance	Subject to Inpatient Hospital Copay
Rehabilitation Outpatient - 60 visits per contract year	Subject to Office Copay	$30/Visit	Office Setting = Subject to Office Visit Copay Facility Setting = Subject to Deductible and Coinsurance	Office Setting = Subject to PCP Office Visit Copay Facility Setting = Subject to Deductible and Coinsurance
OTHER SERVICES				
Ambulance	$150/Trip	$150/Trip	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Chiropractic Benefit	Subject to Office Copay	$50/Visit	Subject to Office Copay	$50/Visit
Durable Medical Equipment/External Prosthetic Devices/Ostomy Supplies **$25,000 Lifetime Maximum**	50% of Cost	50% of Cost	50% of Cost	50% of Cost
Physical/Occupational/Speech Therapy **30 Visits Per Contract Year**	Subject to Office Copay	$50/Visit	Office Setting: Subject to Office Copay Facility Setting: Subject to Deductible and Coinsurance	Office Setting = Subject to Office Visit Copay Facility Setting = Subject to Deductible and Coinsurance

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Cardiac Rehabilitation - 36 visits for short-term acute diagnosis.	Subject to Office Copay	$50/Visit	Office Setting: Subject to Office Copay Facility Setting: Subject to Deductible and Coinsurance	Office Setting = Subject to Office Visit Copay Facility Setting = Subject to Deductible and Coinsurance
Home Health Care - 60 visits per contract year	Subject to Office Copay	$30/Visit	Subject to Coinsurance Only	Subject to Coinsurance Only
Skilled Nursing Facility - 60 days per contract year	Covered in full	Covered in full	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
STUDENT/DEPENDENT COVERAGE				
Benefits	**Small Groups**: Unmarried Dependent to Age 23 covered in core contract.	**Small Groups**: Unmarried Dependent to Age 23 covered in core contract.	**Small Groups**: Unmarried Dependent to Age 23 covered in core contract.	**Small Groups**: Unmarried Dependent to Age 23 covered in core contract.
PRESCRIPTION COVERAGE DEDUCTIBLES/MAXIMUMS				
Annual Deductible	None	None	$1000/$2500	$1000/$2500
Co-insurance	None	None	20%	20%
Benefit Year	Contract Year	Contract Year	Contract Year	Contract Year
Lifetime Maximum Coverage	None	None	None	None
Annual Out-of-Pocket Expense	None	None	$3000/$7500	$3000/$7500
Rx Coverage	**10/25/40-$2500 annual max**	**10/30/50 No cap**	**No Copay- $1000 annual max**	**10/25/40 $2500 annual max**