

<b>Irvington BOE HMO Plans</b>	<b>HMO 10</b>	<b>HMO 1525</b>
<b>BENEFIT</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>
<b>Benefit Period</b>	Calendar Year	Calendar Year
<b>Deductible</b>		
Individual	None	None
Family	None	None
	Deductible is Calendar Year	Deductible is Calendar Year
<b>Coinsurance</b>	100%	100%
<b>Maximum Out-of-Pocket</b>		
Individual	\$5,720	\$5,720
Family	\$11,440	\$11,440
<b>Benefit Period Maximum</b>	Unlimited	Unlimited
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Primary Care Physician Selection</b>	<b>Required</b>	<b>Required</b>
<b>Doctor's Office Visits</b>		
Primary Care Office Visit	100% after \$10 copay	100% after \$15 copay
Specialist Office Visit	100% after \$10 copay A referral is required to visit a specialist.	100% after \$25 copay A referral is required to visit a specialist.
Maternity Visits	100%	100%
Allergy Testing and Treatment	100%	100%
<b>Preventive Care</b>		
Routine Adult Physicals, GYN Exams, PAP, Mammograms, Prostrate Cancer Screening, Colorectal Screening, Immunizations	100%	100%
Well Child Exams	100%	100%
Well Child Immunizations and Lead Screening	100%	100%
<b>Diagnostics Procedures</b>		
Laboratory*	100% in office or Quest Diagnostics 100% in Outpatient facility	100% in office or Quest Diagnostics 100% in Outpatient facility
Outpatient X-Ray/Radiology Services	100% in office	100% in office

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Outpatient X-Ray/Radiology Services	100% in Outpatient facility	100% in Outpatient facility
<b>Hospital Care</b>		
Inpatient Admission	100%	100%
Surgery in Hospital	100%	100%
Inpatient Physician Services	100%	100%
Outpatient Department Services	100%	100%
<b>Emergency Care</b>		
Emergency Room	100% after \$35 facility copay	100% after \$75 facility copay
Ambulance	100%	100%
<b>Non Urgent Care</b>		
Walk in Clinic	100% after \$10 copay	100% after \$15 copay
<b>Outpatient Surgery</b>		
Hospital Outpatient Surgery	100%	100%
Surgery in an Ambulatory SurgiCenter	100%	100%
<b>Mental Health Services</b>		
Inpatient	100%	100%
Outpatient	100% after \$10 copay	100% after \$25 copay
Office Setting	100% after \$10 copay	100% after \$25 copay
<b>Substance Abuse Services</b>		
Inpatient	100%	100%
Outpatient	100%	100%
Office Setting	100%	100%
<b>Alcohol Abuse Services</b>		
Inpatient	100%	100%
Outpatient	100%	100%
Office Setting	100%	100%
<b>Other Services</b>		
Diabetic Education	100% after office copay	100% after office copay
Diabetic Supplies	\$10 per item	\$15 per item
Durable Medical Equipment	100%	100%

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Home Health Care	100% -Unlimited	100%-Unlimited
Hospice Care	100%	100%
Infertility (including in-vitro fertilization)	100% after office copay Limited 4 egg retrievals per lifetime	100% after office copay Limited 4 egg retrievals per lifetime
Orthotics and Prosthetics	100% after office copay	100% after office copay
Short-term Therapies: Physical, Occupational, Speech, Respiratory	100% after \$10 copay	100% after \$20 copay
Skilled Nursing Facility/ Extended Care Center	100% Limited to 120 days per benefit period	100% Limited to 120 days per benefit period
Therapeutic Manipulation (Chiropractic Care)	100% after \$10 copay 30 visit maximum per benefit period	100% after \$25 copay 30 visit maximum per benefit period
Vision - Routine Eye Exam	100%	100%
	Limited to one exam every 12 months	Limited to one exam every 12 months
Vision Hardware	Not Covered	Not Covered
<b>Prescription Drugs :</b>		