

**New York**  
**Plan Name:** MVP EPO Platinum 1  
**Plan Form:** NY-EPO-SP-001 (2023)  
**Plan Status:** Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
<b>Annual Deductible per Contract Year</b>	\$0 Person/\$0 Family - Embedded	None
<b>Co-insurance</b>	As Noted Below	None
<b>Annual Out-of-Pocket Maximum</b>	\$2,450 Person/\$4,900 Family - Embedded	None
<b>Primary Care Physician Office Visits</b>	\$5 copay	First 3 Combined PCP/MH/SA Visits Covered in
<b>Specialist Office Visits</b>	\$45 copay	None
<b>Preventive &amp; Well Care Services</b>		
Well Child Care & Immunizations Adult Annual Physical (One per Contract Year) Mammography Annual Pap Test & Ob/Gyn Exam Immunizations for Adults Colonoscopy /Sigmoidoscopy Screening Bone Density Tests	Covered in Full. For a full list of covered preventive care services, visit <a href="http://mvphealthcare.com">mvphealthcare.com</a> .	None
<b>Physician Office Visits</b>		
<b>Diagnostic Laboratory Services</b>	PCP: \$5 copay/Spec: \$45 copay	None
<b>Diagnostic X-ray</b>	PCP: \$5 copay/Spec: \$45 copay	None
<b>Advanced Imaging Services (CT/PET scans, MRIs)</b>	Spec: \$100 copay/Free-Stnd: \$100 copay	None
<b>Rehabilitative Services (PT/OT/ST)</b>	\$45 copay	54 visits per condition, per Plan Year combined therapies
<b>Allergy Services</b>	\$45 copay	Cost share dependent on location of services
<b>Chemotherapy Visit</b>	\$45 copay	None
<b>Inpatient Services - Hospital</b>		
<b>Medical/Surgical Admissions</b>	\$300 copay	Per continuous confinement
<b>Surgical Services</b>	\$100 copay	None
<b>Inpatient Physical Rehabilitation</b>	\$300 copay	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
<b>Hospital Rehab Services (PT/OT/ST)</b>	\$45 copay	54 visits per condition/year combined therapies
<b>Diagnostic Laboratory Services **</b>	\$45 copay	None
<b>Diagnostic X-ray **</b>	\$45 copay	None
<b>Advanced Imaging Services (CT/PET, scans, MRIs) **</b>	\$100 copay	None
<b>Ambulatory/Outpatient Surgery **</b>	\$100 copay	None
<b>Emergency Care</b>		
<b>Emergency Room (ER) Visit</b>	\$100 copay	None
<b>Urgent Care Centers</b>	\$45 copay	None
<b>Ambulance (Emergency Medical Transportation)</b>	\$100 copay	None
<b>Maternity Services</b>		
<b>Maternity – Prenatal Care</b>	Covered in Full	None
<b>Maternity – Physician Delivery</b>	\$100 copay	None
<b>Maternity – Inpatient Hospital Services</b>	\$300 copay	None

\*Deductible applies to this benefit



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	\$300 copay	Including residential treatment
<b>Mental Health Outpatient</b>	\$5 copay	First 3 Combined PCP/MH/SA Visits Covered in Full
<b>Substance Use Disorder Inpatient Hospital</b>		
<b>Substance Use Disorder Outpatient</b>	\$300 copay	Including residential treatment
<b>Residential Treatment</b>	\$5 copay	First 3 Combined PCP/MH/SA Visits Covered in Full; 20 visits per plan year may be used for family counseling
	\$300 copay	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	20% coinsurance	None
<b>Skilled Nursing Facility</b>	\$300 copay	200 days per plan year
<b>Home Health Care</b>	\$45 copay	60 visits per plan year
<b>Hospice</b>	Inpt: \$300 copay / Outpt: \$45 copay	210 days per plan year, 5 visits for family bereavement counseling
<b>Durable Medical Equipment</b>	50% coinsurance	Standard equipment covered
<b>Diabetic Supplies &amp; Equipment</b>	\$5 copay	Not more than \$100 for a 30-day supply of insulin
<b>Chiropractic Benefit</b>	\$45 copay	None
<b>Acupuncture</b>	50% coinsurance	12 visits per plan year
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	Pharm: \$5 copay/Mail: \$12.50 copay	30 day retail/90 day mail order
<b>Tier 2</b>	Pharm: \$30 copay/Mail: \$75 copay	\$100 max out of pocket on 30 day supply of Insulin
<b>Tier 3</b>	Pharm: \$50 copay/Mail: \$125 copay	30 day retail/90 day mail order
<b>Prescription Drug Deductible</b>	None	None
<b>Vision Care</b>		
<b>Adult Vision Care</b>	Not covered	None
<b>Pediatric Vision Care</b>	\$45 copay	One exam per 12-month period
<b>Other Plan Features</b>		
<b>Gia® Virtual Care</b>	Covered in Full	None
<b>Wellness Benefits</b>	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement
<b>Plan Highlights</b>	Visit <a href="http://mvphealthcare.com">mvphealthcare.com</a> for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.	
<b>Pediatric Dental</b>	Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. <i>Services can be obtained from any licensed provider.</i>	
<b>**Preferred Provider Facilities</b>	Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after deductible (if applicable). Find a preferred provider facility in your area at <a href="http://mvphealthcare.com">mvphealthcare.com</a> .	

Gia virtual care services are available at no member cost-share for medical plans, including qualified high-deductible health plans (QHDHPs), upon enrollment and plan renewal in 2023. Members enrolled in a 2022 QHDHP must meet the plan's annual deductible before Gia services are available at no member cost share.

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 (COC), Schedule, and any applicable Rider(s), your COC, Schedule, and Rider(s) will be controlling. For plan details, please call 1-800-TALK-MVP (825-5687), or visit [mvphealthcare.com](http://mvphealthcare.com).

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