

**New York**  
**Plan Name:** MVP HMO Gold 10  
**Plan Form:** NY-HMO-SG-010 (2023)  
**Plan Status:** Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$600 Person/\$1,200 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$4,200 Person/\$8,400 Family - Embedded	None
Primary Care Physician Office Visits	\$25 copay*	None
Specialist Office Visits	\$40 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>		
Diagnostic Laboratory Services	PCP: \$25 copay*/Spec: \$40 copay*	None
Diagnostic X-ray	PCP: \$25 copay*/Spec: \$40 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: \$140 copay*/Free-Stnd: \$140 copay*	None
Rehabilitative Services (PT/OT/ST)	\$40 copay*	54 visits per condition, per Plan Year combined therapies
Allergy Services	\$40 copay*	None
Chemotherapy Visit	\$40 copay*	None
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	\$1,000 copay*	per continuous confinement
Surgical Services	\$100 copay*	None
Inpatient Physical Rehabilitation	\$1,000 copay*	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
Hospital Rehab Services (PT/OT/ST)	\$40 copay*	54 visits per condition/year combined therapies
Diagnostic Laboratory Services **	\$40 copay*	None
Diagnostic X-ray **	\$40 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs) **	\$140 copay*	None
Ambulatory/Outpatient Surgery **	\$100 copay*	None
<b>Emergency Care</b>		
Emergency Room (ER) Visit	\$300 copay*	None
Urgent Care Centers	\$40 copay*	None
Ambulance (Emergency Medical Transportation)	\$300 copay*	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	\$100 copay*	None
Maternity – Inpatient Hospital Services	\$1,000 copay*	None

\*Deductible applies to this benefit



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
Mental Health Inpatient Hospital	\$1,000 copay*	Including residential treatment
Mental Health Outpatient	\$25 copay*	None
Substance Use Disorder Inpatient Hospital	\$1,000 copay*	Including residential treatment
Substance Use Disorder Outpatient	\$25 copay*	Unlimited; Up to 20 visits per plan year may be used for family counseling
Residential Treatment	\$1,000 copay*	None
<b>Other Services</b>		
Physician Administered Drugs	20% coinsurance*	None
Skilled Nursing Facility	\$1,000 copay*	200 days per plan year
Home Health Care	\$40 copay*	60 visits per plan year
Hospice	Inpt: \$1,000 copay* / Outpt: \$25 copay*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance*	standard equipment covered
Diabetic Supplies & Equipment	\$25 copay*	Not more than \$100 for a 30-day supply of insulin
Chiropractic Benefit	\$40 copay*	None
Acupuncture	50% coinsurance*	12 visits per plan year
<b>Prescription Drug Coverage</b>		
Tier 1	Pharm: \$10 copay/Mail: \$25 copay	30 day retail/90 day mail order
Tier 2	Pharm: \$45 copay/Mail: \$112.50 copay	\$100 max out of pocket on 30 day supply of Insulin
Tier 3	Pharm: \$90 copay/Mail: \$225 copay	30 day retail/90 day mail order
Prescription Drug Deductible	None	None
<b>Vision Care</b>		
Adult Vision Care	Not covered	None
Pediatric Vision Care	\$40 copay*	One exam per 12-month period
<b>Other Plan Features</b>		
Gia® Virtual Care	Covered in Full	None
Wellness Benefits	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement
Plan Highlights	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.	
Pediatric Dental	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>	
**Preferred Provider Facilities	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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