

**New York**  
**Plan Name:** MVP Premier Plus Silver 13 94  
**Plan Form:** FRNY-HMO-DS1-013-N-94 (2023)  
**Plan Status:** Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$300 Person/\$600 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$600 Person/\$1,200 Family - Embedded	None
Primary Care Physician Office Visits	\$5 copay*	None
Specialist Office Visits	\$20 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: \$5 copay*/Spec: \$20 copay*	None
Diagnostic X-ray	PCP: \$5 copay*/Spec: \$20 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: \$50 copay*/Free-Stnd: \$50 copay*	None
Rehabilitative Services (PT/OT/ST)	\$20 copay*	54 combined PT/OT/ST visits per year
Allergy Services	\$20 copay*	None
Chemotherapy Visit	\$20 copay*	None
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	\$200 copay*	Per continuous confinement
Surgical Services	\$75 copay*	None
Inpatient Physical Rehabilitation	\$200 copay*	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
Hospital Rehab Services (PT/OT/ST)	\$20 copay*	54 visits per condition/year combined therapies
Diagnostic Laboratory Services **	\$20 copay*	None
Diagnostic X-ray **	\$20 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs) **	\$50 copay*	None
Ambulatory/Outpatient Surgery **	\$75 copay*	None
<b>Emergency Care</b>		
Emergency Room (ER) Visit	\$75 copay*	None
Urgent Care Centers	\$20 copay*	None
Ambulance (Emergency Medical Transportation)	\$75 copay*	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	\$75 copay*	None
Maternity – Inpatient Hospital Services	\$200 copay*	None

\*Deductible applies to this benefit



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	\$200 copay*	Including residential treatment
<b>Mental Health Outpatient</b>	\$5 copay*	None
<b>Substance Use Disorder Inpatient Hospital</b>	\$200 copay*	Including residential treatment
<b>Substance Use Disorder Outpatient</b>	\$5 copay*	None
<b>Residential Treatment</b>	\$200 copay*	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	20% coinsurance*	None
<b>Skilled Nursing Facility</b>	\$200 copay*	200 days per plan year
<b>Home Health Care</b>	\$20 copay*	60 visits per plan year
<b>Hospice</b>	Inpt: \$200 copay* / Outpt: \$20 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>	\$20 copay*	None
<b>Acupuncture</b>	50% coinsurance*	12 visits per plan year
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	Covered in Full	30 day retail/90 day mail order
<b>Tier 2</b>	Pharm: \$10 copay/Mail: \$25 copay	\$100 max out of pocket on 30 day supply of Insulin
<b>Tier 3</b>	Pharm: \$30 copay/Mail: \$75 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>	\$20 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>**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).

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.