New York
Plan Name: PPO
Plan Form: NY8PYE128ZLKNPNGBL
Plan Status: Active

	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	**In-Network**	**Out-of-Network**	
Annual Deductible per Contract Year	$1,000 Person/$2,000 Family - Embedded	$2,000 Person/$4,000 Family	None
Co-insurance	10% Person/10% Family	40% Person/40% Family	None
Annual Out-of-Pocket Maximum	$2,500 Person/$5,000 Family - Embedded	$5,000 Person/$10,000 Family	None
Primary Care Physician Office Visits	$20 copay	40% coinsurance*	$0 Copay to age 19
Specialist Office Visits	$50 copay	40% coinsurance*	None
Preventive & Well Care Services	**In-Network**	**Out-of-Network**	
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 **mvphealthcare.com**.	Well Child Care & Immunizations Covered in Full; Subject to out-of-network cost share for all other services.	None
Physician Office Visits	**In-Network**	**Out-of-Network**	
Diagnostic Laboratory Services	PCP: 10% coinsurance*/Spec: 10% coinsurance*	PCP: 40% coinsurance*/ Spec: 40% coinsurance*	$0 Copayment not subject to Deductible to age 19
Diagnostic X-ray	PCP: 10% coinsurance*/Spec: 10% coinsurance*	PCP: 40% coinsurance*/ Spec: 40% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 10% coinsurance*/Free-Stnd: 10% coinsurance*	Spec: 40% coinsurance*/ Free-Stnd: 40% coinsurance*	Prior authorization required for non-participating provider
Rehabilitative Services (PT/OT/ST)	10% coinsurance*	40% coinsurance*	60 combined PT/OT/ST visits per year
Allergy Services	10% coinsurance*	40% coinsurance*	None
Chemotherapy Visit	10% coinsurance*	40% coinsurance*	None
Inpatient Services - Hospital	**In-Network**	**Out-of-Network**	
Medical/Surgical Admissions	10% coinsurance*	40% coinsurance*	Prior Authorization required for non-participating provider
Surgical Services	10% coinsurance*	40% coinsurance*	Prior auth required for non-par
Inpatient Physical Rehabilitation	10% coinsurance*	40% coinsurance*	30 days per Plan Year combined therapies. Prior Auth required for non-participating provider

*Deductible applies to this benefit

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Outpatient Hospital Services	**In-Network**	**Out-of-Network**	
Hospital Rehab Services (PT/OT/ST)	10% coinsurance*	40% coinsurance*	60 combined PT/OT/ST visits per year
Diagnostic Laboratory Services ++	10% coinsurance*	40% coinsurance*	None
Diagnostic X-ray ++	10% coinsurance*	40% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)++	10% coinsurance*	40% coinsurance*	Prior authorization required for
Ambulatory/Outpatient Surgery ++	10% coinsurance*	40% coinsurance*	Prior authorization required for non-participating provider
Emergency Care	**In-Network**	**Out-of-Network**	
Emergency Room (ER) Visit	$200 copay	$200 copay	None
Urgent Care Centers	$50 copay	$50 copay	None
Ambulance (Emergency Medical Transportation)	$200 copay	$200 copay	None
Maternity Services	**In-Network**	**Out-of-Network**	
Maternity – Prenatal Care	Covered in Full	40% coinsurance*	None
Maternity – Physician Delivery	10% coinsurance*	40% coinsurance*	None
Maternity – Inpatient Hospital Services	10% coinsurance*	40% coinsurance*	None
Behavioral Health Services	**In-Network**	**Out-of-Network**	
Mental Health Inpatient Hospital	10% coinsurance*	40% coinsurance*	Prior authorization required for non-participating provider
Mental Health Outpatient	$20 copay	40% coinsurance*	Prior Authorization required for non-participating provider
Substance Use Disorder Inpatient Hospital	10% coinsurance*	40% coinsurance*	Prior authorization required for non-participating provider
Substance Use Disorder Outpatient	$20 copay	40% coinsurance*	20 visits per plan year may be used for family counseling. Prior Auth required for non-par
Residential Treatment	10% coinsurance*	40% coinsurance*	None
Other Services	**In-Network**	**Out-of-Network**	
Physician Administered Drugs	10% coinsurance*	40% coinsurance*	None
Skilled Nursing Facility	10% coinsurance*	40% coinsurance*	120 days per Plan Year. Prior Authorization required for non-participating provider
Home Health Care	10% coinsurance*	40% coinsurance*	100 visits per Plan Year. Prior auth required for non-par
Hospice	10% coinsurance*	Inpt: 40% coinsurance*/Outpt: 40% coinsurance*	Five (5) visits for family bereavement counseling
Durable Medical Equipment	10% coinsurance*	40% coinsurance*	None
Diabetic Supplies & Equipment	$20 copay	40% coinsurance*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$50 copay	40% coinsurance*	None
Acupuncture	$50 copay	Not covered	None

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Prescription Drug Coverage	**In-Network**	**Out-of-Network**	
Tier 1	See available Riders	See available Riders	SUD and Fertility Drugs only - 30 day supply retail takes PCP Copay; Mail Order, takes 3 x PCP Copay, Up to a 90-day supply
Tier 2	See available Riders	See available Riders	None
Tier 3	See available Riders	See available Riders	None
Prescription Drug Deductible	None	None	None
Vision Care	**In-Network**	**Out-of-Network**	
Adult Vision Care	Not covered	Not covered	None
Pediatric Vision Care	Not covered	Not covered	None
Other Plan Features	**In-Network**	**Out-of-Network**	
Gia® Virtual Care	Covered in Full	Not covered	None
Wellness Benefits	$800 allowance	Included in In-Network benefit	Get reimbursed up to $800 per contract, per calendar year with MVP's Well-Being Reimbursement
Plan Highlights	Specialty virtual care providers included in Gia may be subject to the plan's applicable cost-share.		
++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 mvphealthcare.com.		

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**.

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.

***Deductible applies to this benefit**