

	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	In Network	Out of Network	
Annual Deductible per Contract Year	\$1,750 Person/\$3,500 Family - Aggregate	\$3,500 Person/ \$7,000 Family - Aggregate	None
Co-insurance	20% coinsurance*	50% Coinsurance*	None
Annual Out-of-Pocket Maximum	\$3,500 Person/\$6,999 Family - Aggregate	\$7,000 Person/\$14,000 Family	None
Primary Care Physician Office Visits	20% coinsurance*	50% coinsurance*	0% Coinsurance for members to age 19 after Deductible
Specialist Office Visits	20% coinsurance*	50% coinsurance*	None
Preventive & Well Care Services			
Well Child Care & Immunizations	Covered in Full not subject to Deductible 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.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
Adult Annual Physical (One per Contract Year)			
Mammography			
Annual Pap Test & Ob/Gyn Exam			
Immunizations for Adults			
Colonoscopy /Sigmoidoscopy Screening			
Bone Density Tests			
Physician Office Visits			
Diagnostic Laboratory Services	PCP: 20% coinsurance*/Spec: 20% coinsurance*	PCP: 50% coinsurance*/Spec: 50% coinsurance*	None
Diagnostic X-ray	PCP: 20% coinsurance*/Spec: 20% coinsurance*	PCP: 50% coinsurance*/Spec: 50% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 20% coinsurance*/Free-Stnd: 20% coinsurance*	Spec: 50% coinsurance*/Free-Stnd: 50% coinsurance*	Prior authorization required for non-participating provider
Rehabilitative Services (PT/OT/ST)	20% coinsurance*	50% coinsurance*	60 combined PT/OT/ST visits per year
Allergy Services	20% coinsurance*	50% coinsurance*	None
Chemotherapy Visit	20% coinsurance*	50% coinsurance*	None
Inpatient Services - Hospital			
Medical/Surgical Admissions	20% coinsurance*	50% coinsurance*	Prior Authorization required for non-participating provider
Surgical Services	20% coinsurance*	50% coinsurance*	None
Inpatient Physical Rehabilitation	20% coinsurance*	50% coinsurance*	30 days per Plan Year combined therapies. Prior Auth required for non-participating provider
Outpatient Hospital Services			
Hospital Rehab Services (PT/OT/ST)	20% coinsurance*	50% coinsurance*	60 combined PT/OT/ST visits per year
Diagnostic Laboratory Services **	20% coinsurance*	50% coinsurance*	None
Diagnostic X-ray **	20% coinsurance*	50% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs) **	20% coinsurance*	50% coinsurance*	Prior authorization required for non-participating provider
Ambulatory/Outpatient Surgery **	20% coinsurance*	50% coinsurance*	Prior authorization required for non-participating provider

	Coverage Information		Limits and Exclusions
Infusion Therapy	20% coinsurance*	50% coinsurance*	None
Emergency Care			
Emergency Room (ER) Visit	20% coinsurance*	20% coinsurance*	None
Urgent Care Centers	20% coinsurance*	50% coinsurance*	None
Ambulance (Emergency Medical Transportation)	20% coinsurance*	20% coinsurance*	None
Maternity Services			
Maternity – Prenatal Care Office Visit	Covered in Full not subject to Deductible	50% coinsurance*	None
Maternity – Physician Delivery	20% coinsurance*	50% coinsurance*	None
Maternity – Inpatient Hospital Services	20% coinsurance*	50% coinsurance*	None
Behavioral Health Services			
Mental Health Inpatient Hospital	20% coinsurance*	50% coinsurance*	Including residential treatment. Prior Authorization required for non-participating provider
Mental Health Outpatient	20% coinsurance*	50% coinsurance*	0% Coinsurance for members to age 19 after Deductible
Substance Use Disorder Inpatient Hospital	20% coinsurance*	50% coinsurance*	Including residential treatment. Prior Authorization required for non-participating provider
Substance Use Disorder Outpatient	20% coinsurance*	50% coinsurance*	Up to 20 visits per Plan Year may be used for family counseling. Prior Auth required for non-participating provider
Autism Treatment	20% coinsurance*	50% coinsurance*	0% Coinsurance for members to age 19 after Deductible
Assistive Communication Devices for Autism Spectrum Disorder	20% coinsurance*	50% coinsurance*	0% Coinsurance for members to age 19 after Deductible
Other Services		Other Services	
Physician Administered Drugs Outpatient	20% coinsurance*	50% coinsurance*	None
Skilled Nursing Facility	20% coinsurance*	50% coinsurance*	120 days per Plan Year. Prior Authorization required for non-participating provider
Home Health Care	20% coinsurance*	50% coinsurance*	100 visits per Plan Year. Prior auth required for non-par
Hospice	Inpt: 20% coinsurance*/Outpt: 20% coinsurance*	Inpt: 50% coinsurance*/Outpt: 50% coinsurance*	5 visits for family bereavement counseling
Durable Medical Equipment	20% coinsurance*	50% coinsurance*	None
Diabetic Supplies & Equipment	20% coinsurance*	50% coinsurance*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	20% coinsurance*	50% coinsurance*	None
Acupuncture	20% coinsurance*	50% coinsurance*	10 visits per Plan Year.
Home Infusion	20% coinsurance*	50% coinsurance*	Home Infusion counts towards home health care visit limits

New York
Plan Name: PPO HDHP
Plan Form: NY7PDA130ZLMPNGBL
Plan Status: Pending



		Coverage Information	Limits and Exclusions
Prescription Drug Coverage			
Tier 1	Pharm: Not covered/Mail: Not covered	Pharm: Not covered/Mail: Not covered	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	Pharm: Not covered/Mail: Not covered	See Available Riders	None
Tier 3	Pharm: Not covered/Mail: Not covered	See Available Riders	None
Ancillary Care		Ancillary Care	
Adult Vision Care	Not covered	Not covered	None
Pediatric Vision Care	Not covered	Not covered	None
Pediatric Dental	Not covered	Not covered	None
Other Plan Features		Other Plan Features	
Gia® Virtual Care	Covered in Full not subject to Deductible	Not covered	None
Wellness Benefits	\$800 allowance - Get reimbursed up to \$800 per contract, per calendar year with MVP's Well-Being Reimbursement		
Doula	Get reimbursed up to \$1,500 per plan year for expenses with MVP's Doula Reimbursement Program.		
Plan Highlights	Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.		
**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 are available in all states and counties.