

New York
Plan Name: HMO
Plan Form: NYSHIP07HMO025XLBPN
Plan Status: Custom



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$0 Person/\$0 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$6,350 Person/\$12,700 Family - Embedded	None
Primary Care Physician Office Visits	Covered in Full	None
Specialist Office Visits	\$25 copay	None
Preventive & Well Care Services		
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 .	None
Physician Office Visits		
Diagnostic Laboratory Services	Covered in Full	None
Diagnostic X-ray	PCP: \$15 copay/Spec: \$25 copay	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: \$25 copay/Free-Stnd: \$25 copay	None
Rehabilitative Services (PT/OT/ST)	\$25 copay	30 visits per Calendar Year combined therapies
Allergy Services	Covered in Full	None
Chemotherapy Visit	\$25 copay	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	Covered in Full	None
Surgical Services	Covered in Full	None
Inpatient Physical Rehabilitation	Covered in Full	60 days per Calendar Year combined therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	\$25 copay	30 visits per Calendar Year combined therapies
Diagnostic Laboratory Services **	Covered in Full	None
Diagnostic X-ray **	\$25 copay	None
Advanced Imaging Services (CT/PET, scans, MRIs) **	\$25 copay	None
Ambulatory/Outpatient Surgery **	\$25 copay	None
Emergency Care		
Emergency Room (ER) Visit	\$75 copay	None
Urgent Care Centers	\$15 copay	None
Ambulance (Emergency Medical Transportation)	\$50 copay	None
Maternity Services		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	Covered in Full	None
Maternity – Inpatient Hospital Services	Covered in Full	None

	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	Covered in Full	Including residential treatment
Mental Health Outpatient	Covered in Full	None
Substance Use Disorder Inpatient Hospital	Covered in Full	Including residential treatment
Substance Use Disorder Outpatient	Covered in Full	Unlimited; Up to 20 visits per calendar year may be used for family counseling
Residential Treatment	Covered in Full	None
Other Services		
Physician Administered Drugs	Covered in Full	None
Skilled Nursing Facility	Covered in Full	45 days per Calendar Year
Home Health Care	\$25 copay	None
Hospice	Covered in Full	210 days per Calendar year, 5 visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance	None
Diabetic Supplies & Equipment	Covered in Full	None
Chiropractic Benefit	\$25 copay	None
Acupuncture	Not covered	None
Prescription Drug Coverage		
Tier 1	Covered in Full	None
Tier 2	Pharm: \$30 copay/Mail: \$75 copay	None
Tier 3	Pharm: \$50 copay/Mail: \$125 copay	None
Prescription Drug Deductible	None	None
Vision Care		
Adult Vision Care	\$25 copay	One exam every 2 Calendar Years
Pediatric Vision Care	\$25 copay	One exam every 2 Calendar Years
Other Plan Features		
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 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 .	

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.

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