New York
Plan Name: HMO
Plan Form: NYSHIP07HMO025XLDPN
Plan Status: Active

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
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	Covered in Full For a full list of covered preventive care services, visit mvphealthcare.com.	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: Covered in Full/Spec: 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 condition, per Plan Year combined therapies
Allergy Services	Covered in Full	None
Chemotherapy Visit	$25 copay	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	Covered in Full	Per continuous confinement
Surgical Services	Covered in Full	None
Inpatient Physical Rehabilitation	Covered in Full	60 visits per condition, per Plan Year combined therapies
Outpatient Hospital Services		
Hospital Rehabilitation Services (PT/OT/ST)	$25 copay	30 visits per condition, per Plan 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
Infusion Therapy	$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 Office Visit	Covered in Full	None
Maternity – Physician Delivery	Covered in Full	None
Maternity – Inpatient Hospital Services	Covered in Full	None
Behavioral Health Services		
Mental Health Inpatient Hospital	Covered in Full	Per continuous confinement
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	. None
Autism Treatment	Covered in Full	None
Assistive Communication Devices for Autism Spectrum Disorder	Covered in Full	None

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	Coverage Information	Limits and Exclusions
Other Services		
Physician Administered Drugs Outpatient	Covered in Full	None
Skilled Nursing Facility	Covered in Full	45 days per Calendar Year
Home Health Care	$25 copay	None
Hospice	Inpt: Covered in Full/Outpt: 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	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$25 copay	None
Acupuncture	Not covered	None
Home Infusion	Covered in Full	Home Infusion counts towards home health care visit limits
Prescription Drug Coverage		
Tier 1 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: Covered in Full /Mail: Covered in Full	30 day retail; 90 day mail order
Tier 2 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: $30 copay /Mail: $75 copay	30 day retail; 90 day mail order
Tier 3 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: $50 copay /Mail: $125 copay	30 day retail; 90 day mail order
Ancillary Care		
Adult Vision Care	$25 copay	One exam every 2 Calendar Years
Pediatric Vision Care	$25 copay	One exam every 2 Calendar Years
Pediatric Dental	$25 copay	preventive dental services to age 19
Other Plan Features		
Gia® Virtual Care	Covered in Full	None
Wellness Benefits	Get reimbursed up to $600 per contract, per calendar year for expenses associated with activities, tools, and apps that enhance your overall well-being with MVP's Well-Being Reimbursement	
Doula Program	Get reimbursed up to $1,500 per plan year for doula 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**.

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