

**New York**  
**Plan Name:** MVP Premier Plus Gold 1 AI-AN  
**Plan Form:** FRNY-HMO-DGA1-001-N (2024)  
**Plan Status:** Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
<b>Annual Deductible per Contract Year</b>	\$0 Person/\$0 Family - Embedded	None
<b>Co-insurance</b>	As Noted Below	None
<b>Annual Out-of-Pocket Maximum</b>	\$0 Person/\$0 Family	None
<b>Primary Care Physician Office Visits</b>	Covered in Full	None
<b>Specialist Office Visits</b>	Covered in Full	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>		
<b>Diagnostic Laboratory Services</b>	Covered in Full	None
<b>Diagnostic X-ray</b>	Covered in Full	None
<b>Advanced Imaging Services (CT/PET scans, MRIs)</b>	Covered in Full	None
<b>Rehabilitative Services (PT/OT/ST)</b>	Covered in Full	54 visits per condition, per Plan Year combined therapies
<b>Allergy Services</b>	Covered in Full	Cost share dependent on location of services
<b>Chemotherapy Visit</b>	Covered in Full	None
<b>Inpatient Services - Hospital</b>		
<b>Medical/Surgical Admissions</b>	Covered in Full	Per continuous confinement
<b>Surgical Services</b>	Covered in Full	None
<b>Inpatient Physical Rehabilitation</b>	Covered in Full	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
<b>Hospital Rehab Services (PT/OT/ST)</b>	Covered in Full	54 visits per condition/year combined therapies
<b>Diagnostic Laboratory Services</b>	Covered in Full	None
<b>Diagnostic X-ray</b>	Covered in Full	None
<b>Advanced Imaging Services (CT/PET, scans, MRIs)</b>	Covered in Full	None
<b>Ambulatory/Outpatient Surgery</b>	Covered in Full	None
<b>Emergency Care</b>		
<b>Emergency Room (ER) Visit</b>	Covered in Full	None
<b>Urgent Care Centers</b>	Covered in Full	None
<b>Ambulance (Emergency Medical Transportation)</b>	Covered in Full	None
<b>Maternity Services</b>		
<b>Maternity – Prenatal Care</b>	Covered in Full	None
<b>Maternity – Physician Delivery</b>	Covered in Full	None
<b>Maternity – Inpatient Hospital Services</b>	Covered in Full	None

\*Deductible applies to this benefit

**New York**  
**Plan Name:** MVP Premier Plus Gold 1 AI-AN  
**Plan Form:** FRNY-HMO-DGA1-001-N (2024)  
**Plan Status:** Active



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	Covered in Full	Including residential treatment
<b>Mental Health Outpatient</b>	Covered in Full	None
<b>Substance Use Disorder Inpatient Hospital</b>	Covered in Full	Including residential treatment
<b>Substance Use Disorder Outpatient</b>	Covered in Full	Unlimited; Up to 20 visits per calendar year may be used for family counseling
<b>Residential Treatment</b>	Covered in Full	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	Covered in Full	None
<b>Skilled Nursing Facility</b>	Covered in Full	200 days per plan year
<b>Home Health Care</b>	Covered in Full	60 visits per plan year
<b>Hospice</b>	Covered in Full	210 days per plan year, 5 visits for family bereavement counseling
<b>Durable Medical Equipment</b>	Covered in Full	Standard equipment covered
<b>Diabetic Supplies &amp; Equipment</b>	Covered in Full	Not more than \$100 for a 30-day supply of insulin
<b>Chiropractic Benefit</b>	Covered in Full	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>	Covered in Full	\$100 max out of pocket on 30 day supply of Insulin
<b>Tier 3</b>	Covered in Full	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>	Covered in Full	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.	

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.