

New York
Plan Name: MVP Premier Silver 1 87
Plan Form: FRNY-HMO-DS1-001-S-87 (2024)
Plan Status: Active



| Plan Cost-Sharing Highlights | Coverage Information | Limits and Exclusions |
|--|---|---|
| Annual Deductible per Contract Year | \$275 Person/\$550 Family - Embedded | None |
| Co-insurance | As Noted Below | None |
| Annual Out-of-Pocket Maximum | \$3,150 Person/\$6,300 Family - Embedded | None |
| Primary Care Physician Office Visits | \$15 copay* | First visit for either PCP/MH/SA or SP before DD |
| Specialist Office Visits | \$35 copay* | First visit for either PCP/MH/SA or SP before DD |
| 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 | PCP: \$15 copay*/Spec: \$35 copay* | None |
| Diagnostic X-ray | PCP: \$35 copay*/Spec: \$35 copay* | None |
| Advanced Imaging Services (CT/PET scans, MRIs) | Spec: \$35 copay*/Free-Stnd: \$35 copay* | None |
| Rehabilitative Services (PT/OT/ST) | \$25 copay* | 60 visits per condition, per Plan Year combined therapies |
| Allergy Services | \$35 copay* | Cost share dependent on location of services |
| Chemotherapy Visit | \$15 copay* | None |
| Inpatient Services - Hospital | | |
| Medical/Surgical Admissions | \$250 copay* | Per continuous confinement |
| Surgical Services | \$75 copay* | None |
| Inpatient Physical Rehabilitation | \$250 copay* | 60 days per Plan Year Combined Therapies |
| Outpatient Hospital Services | | |
| Hospital Rehab Services (PT/OT/ST) | \$25 copay* | 60 visits per condition/year combined therapies |
| Diagnostic Laboratory Services | \$35 copay* | None |
| Diagnostic X-ray | \$35 copay* | None |
| Advanced Imaging Services (CT/PET, scans, MRIs) | \$35 copay* | None |
| Ambulatory/Outpatient Surgery | \$75 copay* | None |
| Emergency Care | | |
| Emergency Room (ER) Visit | \$75 copay* | None |
| Urgent Care Centers | \$50 copay* | None |
| Ambulance (Emergency Medical Transportation) | \$75 copay* | None |
| Maternity Services | | |
| Maternity – Prenatal Care | Covered in Full | None |
| Maternity – Physician Delivery | \$75 copay* | None |
| Maternity – Inpatient Hospital Services | \$250 copay* | None |

*Deductible applies to this benefit

New York
Plan Name: MVP Premier Silver 1 87
Plan Form: FRNY-HMO-DS1-001-S-87 (2024)
Plan Status: Active



| | Coverage Information | Limits and Exclusions |
|--|---|---|
| Behavioral Health Services | | |
| Mental Health Inpatient Hospital | \$250 copay* | Including residential treatment |
| Mental Health Outpatient | \$15 copay* | First visit for either PCP/MH/SA or SP before DD |
| Substance Use Disorder Inpatient Hospital | \$250 copay* | Including residential treatment |
| Substance Use Disorder Outpatient | \$15 copay* | First visit for either PCP/MH/SA or SP before DD; 20 visits per plan year may be used for family counseling |
| Residential Treatment | \$250 copay* | None |
| Other Services | | |
| Physician Administered Drugs | \$15 copay* | None |
| Skilled Nursing Facility | \$250 copay* | 200 days per plan year |
| Home Health Care | \$15 copay* | 40 visits per year |
| Hospice | Inpt: \$250 copay* / Outpt: \$15 copay* | 210 days per plan year, 5 visits for family bereavement counseling |
| Durable Medical Equipment | 10% coinsurance* | Standard equipment covered |
| Diabetic Supplies & Equipment | \$15 copay* | Not more than \$100 for a 30-day supply of insulin |
| Chiropractic Benefit | \$35 copay* | None |
| Acupuncture | Not covered | None |
| Prescription Drug Coverage | | |
| Tier 1 | Pharm: \$9 copay/Mail: \$22.50 copay | 30 day retail/90 day mail order |
| Tier 2 | Pharm: \$20 copay/Mail: \$50 copay | \$100 max out of pocket on 30 day supply of Insulin |
| Tier 3 | Pharm: \$40 copay/Mail: \$100 copay | 30 day retail/90 day mail order |
| Prescription Drug Deductible | None | None |
| Vision Care | | |
| Adult Vision Care | Not covered | None |
| Pediatric Vision Care | \$15 copay* | One exam per 12-month period |
| 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. | |

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.

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.