New York
Plan Name: MVP POS
Plan Form: NY-POS-DP-001-S (2026)
Plan Status: Active

	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	**In-Network**	**Out-of-Network**	
Annual Deductible per Contract Year	$0 Person/$0 Family - Embedded	$1,000 Person/$2,000 Family	None
Co-insurance	As Noted Below	20% Person/20% Family	None
Annual Out-of-Pocket Maximum	$2,000 Person/$4,000 Family - Embedded	$3,000 Person/$5,000 Family	None
Primary Care Physician Office Visits	$15 copay	Not covered	None
Specialist Office Visits	$35 copay	20% coinsurance*	None
Preventive & Well Care Services	**In-Network**	**Out-of-Network**	
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**.	Well Child Care & Immunizations Covered in Full; Subject to out-of-network cost share for all other services.	None
Physician Office Visits	**In-Network**	**Out-of-Network**	
Diagnostic Laboratory Services	PCP: $15 copay/Spec: $35 copay	Not covered/ Spec: 20% coinsurance*	None
Diagnostic X-ray	PCP: $35 copay/Spec: $35 copay	Not covered/ Spec: 20% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $35 copay/Free-Stnd: $35 copay	Spec: 20% coinsurance*/ Free-Stnd: 20% coinsurance*	None
Rehabilitative Services (PT/OT/ST)	$25 copay	20% coinsurance*	60 visits per condition, per Plan Year combined therapies
Allergy Services	$35 copay	20% coinsurance*	None
Chemotherapy Visit	$15 copay	20% coinsurance*	None
Inpatient Services - Hospital	**In-Network**	**Out-of-Network**	
Medical/Surgical Admissions	$500 copay	20% coinsurance*	per continuous confinement
Surgical Services	$100 copay	20% coinsurance*	None
Inpatient Physical Rehabilitation	$500 copay	20% coinsurance*	60 days per Plan Year Combined Therapies

***Deductible applies to this benefit**

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Outpatient Hospital Services	**In-Network**	**Out-of-Network**	
Hospital Rehab Services (PT/OT/ST)	$25 copay	20% coinsurance*	60 visits per condition/year combined therapies
Diagnostic Laboratory Services	$35 copay	20% coinsurance*	None
Diagnostic X-ray	$35 copay	20% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	$35 copay	20% coinsurance*	None
Ambulatory/Outpatient Surgery	$100 copay	20% coinsurance*	None
Emergency Care	**In-Network**	**Out-of-Network**	
Emergency Room (ER) Visit	$100 copay	$100 copay	None
Urgent Care Centers	$55 copay	20% coinsurance*	None
Ambulance (Emergency Medical Transportation)	$100 copay	20% coinsurance*	None
Maternity Services	**In-Network**	**Out-of-Network**	
Maternity – Prenatal Care	Covered in Full	20% coinsurance*	None
Maternity – Physician Delivery	$100 copay	20% coinsurance*	None
Maternity – Inpatient Hospital Services	$500 copay	20% coinsurance*	None
Behavioral Health Services	**In-Network**	**Out-of-Network**	
Mental Health Inpatient Hospital	$500 copay	20% coinsurance*	Including residential treatment
Mental Health Outpatient	$15 copay	20% coinsurance*	None
Substance Use Disorder Inpatient Hospital	$500 copay	20% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	$15 copay	20% coinsurance*	Unlimited; Up to 20 visits per calendar year may be used for family counseling
Residential Treatment	$500 copay	20% coinsurance*	None
Other Services	**In-Network**	**Out-of-Network**	
Physician Administered Drugs	$15 copay	20% coinsurance*	None
Skilled Nursing Facility	$500 copay	20% coinsurance*	200 days per plan year
Home Health Care	$15 copay	20% coinsurance*	40 Visits per Plan Year
Hospice	Inpt: $500 copay / Outpt: $15 copay	Inpt: 20% coinsurance*/Outpt: 20% coinsurance*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	10% coinsurance	20% coinsurance*	standard equipment covered
Diabetic Supplies & Equipment	$15 copay	20% coinsurance*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$35 copay	20% coinsurance*	None
Acupuncture	Not covered	Not covered	None

*Deductible applies to this benefit

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Prescription Drug Coverage	**In-Network**	**Out-of-Network**	
Tier 1	Pharm: $10 copay/Mail: $25 copay	See available Riders	30 day retail/90 day mail order
Tier 2	Pharm: $30 copay/Mail: $75 copay	See available Riders	30 day retail/90 day mail order
Tier 3	Pharm: $60 copay/Mail: $150 copay	See available Riders	30 day retail/90 day mail order
Prescription Drug Deductible	None	None	None
Vision Care	**In-Network**	**Out-of-Network**	
Adult Vision Care	Not covered	Not covered	None
Pediatric Vision Care	$15 copay	20% coinsurance*	One exam per 12-month period
Other Plan Features	**In-Network**	**Out-of-Network**	
Gia® Virtual Care	Covered in Full	Not covered	None
Wellness Benefits	$600 allowance	Included in In-Network benefit	Get reimbursed up to $600 per contract, per calendar year with MVP's Well-Being Reimbursement
Plan Highlights	Specialty virtual care providers included in Gia may be subject to the plan's applicable 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.

***Deductible applies to this benefit**