New York
Plan Name: MVP Premier Gold 1 Child Only
Plan Form: NY-HMO-DG-001-S-CO – (2027)
Plan Status: Active

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
Annual Deductible per Contract Year	$1,200 Person/$2,400 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	$12,000 Person/$24,000 Family - Embedded	None
Primary Care Physician Office Visits	$25 copay*	None
Specialist Office Visits	$40 copay*	None
Preventive & Well Care Services		
Well Child Care & Immunizations	Covered in Full not subject to Deductible 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: $25 copay*/Spec: $40 copay*	None
Diagnostic X-ray	PCP: $40 copay*/Spec: $40 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $40 copay*/Free-Stnd: $40 copay*	None
Rehabilitative Services (PT/OT/ST)	$30 copay*	60 visits per condition, per Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery
Allergy Services	Not covered	None
Chemotherapy Visit	$25 copay*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	$1,000 copay*	Per continuous confinement
Surgical Services	$100 copay*	None
Inpatient Physical Rehabilitation	$1,000 copay*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehabilitation Services (PT/OT/ST)	$30 copay*	60 visits per condition, per plan year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery
Diagnostic Laboratory Services ++	$40 copay*	None
Diagnostic X-ray ++	$40 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	$40 copay*	None
Ambulatory/Outpatient Surgery ++	$100 copay*	None
Infusion Therapy	$25 copay*	None
Emergency Care		
Emergency Room (ER) Visit	$150 copay*	None
Urgent Care Centers	$60 copay*	None
Ambulance (Emergency Medical Transportation)	$150 copay*	None
Maternity Services		
Maternity – Prenatal Care Office Visit	Covered in Full not subject to Deductible	None
Maternity – Physician Delivery	$100 copay*	None
Maternity – Inpatient Hospital Services	$1,000 copay*	None
Behavioral Health Services		
Mental Health Inpatient Hospital	$1,000 copay*	Including residential treatment
Mental Health Outpatient	Not covered	None
Substance Use Disorder Inpatient Hospital	$1,000 copay*	Including residential treatment
Substance Use Disorder Outpatient	$25 copay*	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
Autism Treatment	$25 copay*	None

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Assistive Communication Devices for Autism Spectrum Disorder	$25 copay*	None
Other Services		
Physician Administered Drugs Outpatient	$25 copay*	None
Skilled Nursing Facility	$1,000 copay*	200 days per Plan Year
Home Health Care	$25 copay*	40 visits per Plan year
Hospice	Inpt: $1,000 copay*/Outpt: $25 copay*	210 days per Plan Year, 5 visits for family bereavement counseling
Durable Medical Equipment	20% coinsurance*	None
Diabetic Supplies & Equipment	$25 copay*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$40 copay*	None
Acupuncture	Not covered	None
Home Infusion	$25 copay*	Home infusion counts toward 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: $10 copay not subject to Deductible /Mail: $25 copay not subject to Deductible	30 day retail/90 day mail order
Tier 2 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: $35 copay not subject to Deductible /Mail: $87.50 copay not subject to Deductible	30 day retail/90 day mail order
Tier 3 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: $70 copay not subject to Deductible /Mail: $175 copay not subject to Deductible	30 day retail/90 day mail order
Ancillary Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	$25 copay*	One (1) exam per 12-month period
Pediatric Dental	Not covered	None
Other Plan Features		
Gia® Virtual Care	Covered in Full not subject to Deductible	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**.

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 are available in all states and counties.

***Deductible applies to this benefit**