New York
Plan Name: MVP EPO Gold 2 HDHP
Plan Form: NY-EPOH-SG-002 – (2027)
Plan Status: Active

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
Annual Deductible per Contract Year	$1,850 Person/$3,700 Family - Aggregate	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	$5,250 Person/$10,500 Family - Embedded	None
Primary Care Physician Office Visits	$10 copay*	None
Specialist Office Visits	$20 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: $10 copay*/Spec: $20 copay*	None
Diagnostic X-ray	PCP: $10 copay*/Spec: $20 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $120 copay*/Free-Stnd: $120 copay*	None
Rehabilitative Services (PT/OT/ST)	$20 copay*	54 visits per condition, per Plan Year combined therapies
Allergy Services	$20 copay*	Cost share dependent on location of services
Chemotherapy Visit	$20 copay*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	$300 copay*	Per continuous confinement
Surgical Services	$50 copay*	None
Inpatient Physical Rehabilitation	$300 copay*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehabilitation Services (PT/OT/ST)	$20 copay*	54 visits per condition, per Plan Year combined therapies
Diagnostic Laboratory Services ++	$20 copay*	None
Diagnostic X-ray ++	$20 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	$120 copay*	None
Ambulatory/Outpatient Surgery ++	$250 copay*	None
Infusion Therapy	$20 copay*	None
Emergency Care		
Emergency Room (ER) Visit	$150 copay*	None
Urgent Care Centers	$20 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	$50 copay*	None
Maternity – Inpatient Hospital Services	$300 copay*	None
Behavioral Health Services		
Mental Health Inpatient Hospital	$300 copay*	Including residential treatment
Mental Health Outpatient	$10 copay*	None
Substance Use Disorder Inpatient Hospital	$300 copay*	Including residential treatment
Substance Use Disorder Outpatient	$10 copay*	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
Autism Treatment	$10 copay*	None
Assistive Communication Devices for Autism Spectrum Disorder	$10 copay*	None

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Other Services		
Physician Administered Drugs Outpatient	20% coinsurance*	None
Skilled Nursing Facility	$300 copay*	200 days per Plan Year
Home Health Care	$20 copay*	60 visits per Plan Year
Hospice	Inpt: $300 copay*/Outpt: $20 copay*	210 days per Plan Year, Five (5) visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance*	None
Diabetic Supplies & Equipment	$10 copay*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$20 copay*	None
Acupuncture	50% coinsurance*	12 visits per Plan Year.
Home Infusion	$20 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* /Mail: $25 copay*	30 day retail/90 day mail order; preventive drugs deductible waived
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; preventive drugs deductible waived
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; preventive drugs deductible waived
Ancillary Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	$20 copay*	One (1) exam per 12-month periodNone
Pediatric Dental	$25 copay*	One (1) dental exam and cleaning per six (6) month period
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**