New York
Plan Name: MVP EPO Platinum 1
Plan Form: NY-EPO-SP-001 – (2027)
Plan Status: Active

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
Annual Deductible per Contract Year	$0 Person/$0 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	$3,100 Person/$6,200 Family - Embedded	None
Primary Care Physician Office Visits	$5 copay	First Three (3) visits Covered in full
Specialist Office Visits	$45 copay	None
Preventive & Well Care Services		
Well Child Care & Immunizations	Covered in Full 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: $5 copay/Spec: $45 copay	None
Diagnostic X-ray	PCP: $5 copay/Spec: $45 copay	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $100 copay/Free-Stnd: $100 copay	None
Rehabilitative Services (PT/OT/ST)	$45 copay	54 visits per condition, per Plan Year combined therapies
Allergy Services	$45 copay	
Chemotherapy Visit	$45 copay	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	$300 copay	Per continuous confinement
Surgical Services	$100 copay	None
Inpatient Physical Rehabilitation	$300 copay	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehabilitation Services (PT/OT/ST)	$45 copay	54 visits per condition, per Plan Year combined therapies
Diagnostic Laboratory Services ++	$45 copay	None
Diagnostic X-ray ++	$45 copay	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	$100 copay	None
Ambulatory/Outpatient Surgery ++	$100 copay	None
Infusion Therapy	$45 copay	None
Emergency Care		
Emergency Room (ER) Visit	$150 copay	None
Urgent Care Centers	$45 copay	None
Ambulance (Emergency Medical Transportation)	$150 copay	None
Maternity Services		
Maternity – Prenatal Care Office Visit	Covered in Full	None
Maternity – Physician Delivery	$100 copay	None
Maternity – Inpatient Hospital Services	$300 copay	None
Behavioral Health Services		
Mental Health Inpatient Hospital	$300 copay	Including residential treatment
Mental Health Outpatient	$5 copay	First Three (3) visits Covered in full
Substance Use Disorder Inpatient Hospital	$300 copay	Including residential treatment
Substance Use Disorder Outpatient	$5 copay	First Three (3) visits Covered in full Unlimited; Up to 20 visits per Plan Year may be used for family counseling
Autism Treatment	$5 copay	First Three (3) visits Covered in full
Assistive Communication Devices for Autism Spectrum	$5 copay	None

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	Coverage Information	Limits and Exclusions
Disorder		
Other Services		
Physician Administered Drugs Outpatient	20% coinsurance	None
Skilled Nursing Facility	$300 copay	200 days per Plan Year
Home Health Care	$45 copay	60 visits per Plan Year
Hospice	Inpt: $300 copay/Outpt: $45 copay	210 days per Plan Year, Five (5) visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance	None
Diabetic Supplies & Equipment	$5 copay	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$45 copay	None
Acupuncture	50% coinsurance	12 visits per Plan Year.
Home Infusion	$45 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: $5 copay /Mail: $12.50 copay	30 day retail/90 day mail order
Tier 2 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: 20% coinsurance /Mail: 20% coinsurance	30 day retail/90 day mail order
Tier 3 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: 30% coinsurance /Mail: 30% coinsurance	30 day retail/90 day mail order
Ancillary Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	$45 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	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**.

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