New York
Plan Name: PPO
Plan Form: NY8STUXDAKC25 (PNYSTU001A)
Plan Status: Active

	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	**In-Network**	**Out-of-Network**	
Annual Deductible per Contract Year	$100 Person	$500 Person	None
Co-insurance	As Noted Below	As Noted Below	None
Annual Out-of-Pocket Maximum	$2,500 Person	$10,000 Person	None
Primary Care Physician Office Visits	$25 copay	30% coinsurance*	None
Specialist Office Visits	$25 copay	30% 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	Covered in Full	PCP: 30% coinsurance*/ Spec: 30% coinsurance*	None
Diagnostic X-ray	Covered in Full	PCP: 30% coinsurance*/ Spec: 30% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Covered in Full	Spec: 30% coinsurance*/ Free-Stnd: 30% coinsurance*	None
Rehabilitative Services (PT/OT/ST)	$25 copay	30% coinsurance*	60 visits per condition, per Plan Year combined therapies
Allergy Services	$25 copay	30% coinsurance*	None
Chemotherapy Visit	$25 copay	30% coinsurance*	None
Inpatient Services - Hospital	**In-Network**	**Out-of-Network**	
Medical/Surgical Admissions	10% coinsurance*	30% coinsurance*	None
Surgical Services	10% coinsurance*	30% coinsurance*	None
Inpatient Physical Rehabilitation	10% coinsurance*	30% coinsurance*	60 days per Plan Year Combined Therapies

***Deductible applies to this benefit**

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	Coverage Information		Limits and Exclusions
Outpatient Hospital Services	**In-Network**	**Out-of-Network**	
Hospital Rehab Services (PT/OT/ST)	$25 copay	30% coinsurance*	60 visits per condition, per Plan Year combined therapies
Diagnostic Laboratory Services	Covered in Full	30% coinsurance*	None
Diagnostic X-ray	Covered in Full	30% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	Covered in Full	30% coinsurance*	None
Ambulatory/Outpatient Surgery	10% coinsurance*	30% coinsurance*	None
Emergency Care	**In-Network**	**Out-of-Network**	
Emergency Room (ER) Visit	$100 copay	$100 copay	None
Urgent Care Centers	$25 copay	$25 copay	None
Ambulance (Emergency Medical Transportation)	$100 copay	$100 copay	None
Maternity Services	**In-Network**	**Out-of-Network**	
Maternity – Prenatal Care	$0 copay	30% coinsurance*	None
Maternity – Physician Delivery	10% coinsurance*	30% coinsurance*	None
Maternity – Inpatient Hospital Services	10% coinsurance*	30% coinsurance*	None
Behavioral Health Services	**In-Network**	**Out-of-Network**	
Mental Health Inpatient Hospital	10% coinsurance*	30% coinsurance*	including residential treatment
Mental Health Outpatient	$25 copay	30% coinsurance*	None
Substance Use Disorder Inpatient Hospital	10% coinsurance*	30% coinsurance*	including residential treatment
Substance Use Disorder Outpatient	$25 copay	30% coinsurance*	Unlimited; Up to 20 visits per plan year may be used for family counseling
Residential Treatment	10% coinsurance*	30% coinsurance*	None
Other Services	**In-Network**	**Out-of-Network**	
Physician Administered Drugs	10% coinsurance*	30% coinsurance*	None
Skilled Nursing Facility	10% coinsurance*	30% coinsurance*	200 days per plan year
Home Health Care	$25 copay	30% coinsurance*	60 visits per plan year
Hospice	Inpt: 10% coinsurance* / Outpt: $25 copay	Inpt: 30% coinsurance*/Outpt: 30% coinsurance*	210 days per Plan Year; Five (5) visits for family bereavement counseling
Durable Medical Equipment	10% coinsurance*	30% coinsurance*	None
Diabetic Supplies & Equipment	$25 copay	30% coinsurance*	None
Chiropractic Benefit	$25 copay	30% coinsurance*	None
Acupuncture	Not covered	Not covered	None

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New York
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	Coverage Information		Limits and Exclusions
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	$100 max out of pocket on 30 day supply of Insulin
Tier 3	Pharm: $50 copay/Mail: $125 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	$20 copay	30% coinsurance*	One exam per plan year
Pediatric Vision Care	$20 copay	30% coinsurance*	One exam per plan year
Other Plan Features	**In-Network**	**Out-of-Network**	
Gia® Virtual Care	Covered in Full	Not covered	None
Wellness Benefits	$125 allowance	Included in In-Network benefit	Reimbursement for gym, kids sports or weight management.
Plan Highlights	Access $0 Gia® virtual care services for 24/7 emergency and urgent care, primary care, and mental health; 20% off CVS brand health items.		

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.

***Deductible applies to this benefit**