New York
Plan Name: Preferred PPO
Plan Form: NY8STUXCAUC25 (PNYSTU001A)
Plan Status: Active

	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	**In-Network**	**Out-of-Network**	
Annual Deductible per Contract Year	$0 Person	$500 Person	None
Co-insurance	As Noted Below	As Noted Below	None
Annual Out-of-Pocket Maximum	$5,000 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	$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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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	$200 copay	$200 copay	None
Urgent Care Centers	$25 copay	$25 copay	None
Ambulance (Emergency Medical Transportation)	$200 copay	$200 copay	None
Maternity Services	**In-Network**	**Out-of-Network**	
Maternity – Prenatal Care	Covered in Full	30% coinsurance*	None
Maternity – Physician Delivery	10% coinsurance	30% coinsurance*	None
Maternity – Inpatient Hospital Services	10% coinsurance	30% coinsurance*	
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**	
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	10% coinsurance	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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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: $45 copay/Mail: $112.50 copay	See available Riders	$100 max out of pocket on 30 day supply of Insulin
Tier 3	Pharm: $75 copay/Mail: $187.50 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	$25 copay	30% coinsurance*	One exam per plan year
Pediatric Vision Care	$25 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	Telemedicine Sevices – 24/7 Online Doctor Visits, myMVP Mobile App		

Virtual care services from MVP Health Care are provided by UCM Digital Health, Amwell and Omada at no cost-share for members. (Plan exceptions may apply.) Members' direct or digital provider visits may be subject to co-pay/cost-share per plan.

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**