New York

Plan Name: PPO
Plan Form: NY7EYE146XLJEPN (PNEPO703LA)
Plan Status: Active

	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	**In-Network**	**Out-of-Network**	
Annual Deductible per Contract Year	$1,000 Person/$3,000 Family - Embedded	$2,000 Person/$4,000 Family	None
Co-insurance	20% Person/20% Family	40% Person/40% Family	None
Annual Out-of-Pocket Maximum	$3,000 Person/$9,000 Family - Embedded	$6,600 Person/$13,200 Family	None
Primary Care Physician Office Visits	$30 copay	40% coinsurance*	None
Specialist Office Visits	$50 copay	40% 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	PCP: $30 copay/Spec: $50 copay	PCP: 40% coinsurance*/ Spec: 40% coinsurance*	None
Diagnostic X-ray	PCP: $30 copay/Spec: $50 copay	PCP: 40% coinsurance*/ Spec: 40% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $50 copay/Free-Stnd: $50 copay	Spec: 40% coinsurance*/ Free-Stnd: 40% coinsurance*	None
Rehabilitative Services (PT/OT/ST)	$50 copay	40% coinsurance*	30 combined PT/OT/ST visits per Year
Allergy Services	$50 copay	40% coinsurance*	None
Chemotherapy Visit	$50 copay	40% coinsurance*	None
Inpatient Services - Hospital	**In-Network**	**Out-of-Network**	
Medical/Surgical Admissions	20% coinsurance*	40% coinsurance*	Per continuous confinement
Surgical Services	20% coinsurance*	40% coinsurance*	None
Inpatient Physical Rehabilitation	20% coinsurance*	40% coinsurance*	30 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)	$50 copay	40% coinsurance*	30 visits per Plan Year combined therapies
Diagnostic Laboratory Services ++	$50 copay	40% coinsurance*	None
Diagnostic X-ray ++	$50 copay	40% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)++	$50 copay	40% coinsurance*	None
Ambulatory/Outpatient Surgery ++	20% coinsurance*	40% coinsurance*	None
Emergency Care	**In-Network**	**Out-of-Network**	
Emergency Room (ER) Visit	$200 copay	$200 copay	None
Urgent Care Centers	$30 copay	40% coinsurance*	None
Ambulance (Emergency Medical Transportation)	20% coinsurance*	20% coinsurance*	None
Maternity Services	**In-Network**	**Out-of-Network**	
Maternity – Prenatal Care	Covered in Full	40% coinsurance*	None
Maternity – Physician Delivery	20% coinsurance*	40% coinsurance*	None
Maternity – Inpatient Hospital Services	20% coinsurance*	40% coinsurance*	None
Behavioral Health Services	**In-Network**	**Out-of-Network**	
Mental Health Inpatient Hospital	20% coinsurance*	40% coinsurance*	Including Residential Treatment
Mental Health Outpatient	$30 copay	40% coinsurance*	None
Substance Use Disorder Inpatient Hospital	20% coinsurance*	40% coinsurance*	Including Residential Treatment
Substance Use Disorder Outpatient	$30 copay	40% coinsurance*	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
Residential Treatment	20% coinsurance*	40% coinsurance*	None
Other Services	**In-Network**	**Out-of-Network**	
Physician Administered Drugs	$50 copay	40% coinsurance*	None
Skilled Nursing Facility	20% coinsurance*	40% coinsurance*	60 days per Plan Year
Home Health Care	$50 copay	40% coinsurance*	60 visits per Plan Year
Hospice	Inpt: 20% coinsurance* / Outpt: $50 copay	Inpt: 40% coin*/Outpt: 40% coinsurance*	210 days per Plan Year 5 visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance	40% coinsurance*	One pair of custom molded shoe inserts every three Plan Years
Diabetic Supplies & Equipment	$30 copay	40% coinsurance*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$50 copay	40% coinsurance*	None
Acupuncture	Subject to appropriate cost share	Subj to approp cost share	10 visits/year; specialist cost share

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Prescription Drug Coverage	**In-Network**	**Out-of-Network**	
Tier 1	Pharm: $10 copay/Mail: $20 copay	See available Riders	Mail order copay is 2 x retail copay 30/90 day retail/90 day mail order
Tier 2	Pharm: $30 copay/Mail: $60 copay	See available Riders	Mail order copay is 2 x retail copay 30/90 day retail/90 day mail order
Tier 3	Pharm: $50 copay/Mail: $100 copay	See available Riders	Mail order copay is 2 x retail copay 30/90 day retail/90 day mail order
Prescription Drug Deductible	None	None	None
Vision Care	**In-Network**	**Out-of-Network**	
Adult Vision Care	Not covered	Not covered	None
Pediatric Vision Care	Not covered	Not covered	None
Other Plan Features	**In-Network**	**Out-of-Network**	
Gia® Virtual Care	Covered in Full	Not covered	None
Wellness Benefits	$600 allowance	Included in In-Network benefit	Get reimbursed up to $600 per contract, per calendar year with MVP's Well-Being Reimbursement.
Plan Highlights	Specialty virtual care providers included in Gia may be subject to the plan's applicable cost-share.		
++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 available in all states and counties.

***Deductible applies to this benefit**