New York

Plan Name: PPO HDHP
Plan Form: NY7PDA023XLKPNFLR
Plan Status: Pending

Pending Approval by the New York State Department of Financial Services

	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	**In-Network**	**Out-of-Network**	
Annual Deductible per Contract Year	$3,000 Person/$6,000 Family - Aggregate	$6,000 Person/$12,000 Family	None
Co-insurance	As Noted Below	40% Person/40% Family	None
Annual Out-of-Pocket Maximum	$3,000 Person/$6,000 Family - Aggregate	$12,000 Person/$24,000 Family	None
Primary Care Physician Office Visits	0% coinsurance*	40% coinsurance*	None
Specialist Office Visits	0% coinsurance*	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: 0% coinsurance*/Spec: 0% coinsurance*	PCP: 40% coinsurance*/ Spec: 40% coinsurance*	None
Diagnostic X-ray	PCP: 0% coinsurance*/Spec: 0% coinsurance*	PCP: 40% coinsurance*/ Spec: 40% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 0% coinsurance*/Free-Stnd: 0% coinsurance*	Spec: 40% coinsurance*/ Free-Stnd: 40% coinsurance*	None
Rehabilitative Services (PT/OT/ST)	0% coinsurance*	40% coinsurance*	365 combined PT/OT/ST visits per year
Allergy Services	0% coinsurance*	40% coinsurance*	None
Chemotherapy Visit	0% coinsurance*	40% coinsurance*	None
Inpatient Services - Hospital	**In-Network**	**Out-of-Network**	
Medical/Surgical Admissions	0% coinsurance*	40% coinsurance*	None
Surgical Services	0% coinsurance*	40% coinsurance*	None
Inpatient Physical Rehabilitation	0% coinsurance*	40% coinsurance*	30 days per Plan Year

*Deductible applies to this benefit

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Outpatient Hospital Services	**In-Network**	**Out-of-Network**	
Hospital Rehab Services (PT/OT/ST)	0% coinsurance*	40% coinsurance*	365 PT/OT/ST visits per plan year
Diagnostic Laboratory Services ++	0% coinsurance*	40% coinsurance*	None
Diagnostic X-ray ++	0% coinsurance*	40% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)++	0% coinsurance*	40% coinsurance*	None
Ambulatory/Outpatient Surgery ++	0% coinsurance*	40% coinsurance*	None
Emergency Care	**In-Network**	**Out-of-Network**	
Emergency Room (ER) Visit	0% coinsurance*	0% coinsurance*	None
Urgent Care Centers	0% coinsurance*	40% coinsurance*	None
Ambulance (Emergency Medical Transportation)	0% coinsurance*	0% coinsurance*	None
Maternity Services	**In-Network**	**Out-of-Network**	
Maternity – Prenatal Care	Covered in Full	40% coinsurance*	None
Maternity – Physician Delivery	0% coinsurance*	40% coinsurance*	None
Maternity – Inpatient Hospital Services	0% coinsurance*	40% coinsurance*	None
Behavioral Health Services	**In-Network**	**Out-of-Network**	
Mental Health Inpatient Hospital	0% coinsurance*	40% coinsurance*	Including residential treatment
Mental Health Outpatient	0% coinsurance*	40% coinsurance*	None
Substance Use Disorder Inpatient Hospital	0% coinsurance*	40% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	0% coinsurance*	40% coinsurance*	Unlimited; Up to 20 visits per plan year may be used for family counseling
Residential Treatment	0% coinsurance*	40% coinsurance*	None
Other Services	**In-Network**	**Out-of-Network**	
Physician Administered Drugs	0% coinsurance*	40% coinsurance*	None
Skilled Nursing Facility	0% coinsurance*	40% coinsurance*	120 days per plan year
Home Health Care	0% coinsurance*	40% coinsurance*	60 visits per year
Hospice	0% coinsurance*	Inpt: 40% coin*/Outpt: 40% coinsurance*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	0% coinsurance*	40% coinsurance*	None
Diabetic Supplies & Equipment	0% coinsurance*	40% coinsurance*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	0% coinsurance*	40% coinsurance*	None
Acupuncture	0% coinsurance*	40% coinsurance*	10 visits per year

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Prescription Drug Coverage	**In-Network**	**Out-of-Network**	
Tier 1	0% coinsurance*	See available Riders	30/90 day retail; 90 day mail order Preventive Rx Not Subject to Deductible
Tier 2	0% coinsurance*	See available Riders	30/90 day retail/90 day mail order Preventive Rx Not Subject to Deductible
Tier 3	0% coinsurance*	See available Riders	30/90 day retail/90 day mail order Preventive Rx Not Subject to Deductible
Prescription Drug Deductible	Subject to annual deductible	Subject to annual deductible	None
Vision Care	**In-Network**	**Out-of-Network**	
Adult Vision Care	Covered in Full	40% coinsurance*	One eye exam per plan year
Pediatric Vision Care	Covered in Full	40% coinsurance*	One eye exam per plan year
Other Plan Features	**In-Network**	**Out-of-Network**	
Gia® Virtual Care	0% coinsurance	Not covered	None
Wellness Benefits	$600 allowance	Included in In-Network benefit	Up to $400 in rewards and $200 reimbursements with Well Being Rewards per contract per calendar year
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**.

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***Deductible applies to this benefit**