New York

Plan Name: PPO
Plan Form: NY7EPC049XLKNPNFLR (PNEPB705L)
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	$0 Person/$0 Family	$1,000 Person/$3,000 Family	None
Co-insurance	As Noted Below	40% Person/40% Family	None
Annual Out-of-Pocket Maximum	$6,600 Person/$13,200 Family - Embedded	$6,600 Person/$13,200 Family	None
Primary Care Physician Office Visits	$25 copay	40% coinsurance*	Covered in full to age 26
Specialist Office Visits	$40 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	Covered in Full	PCP: 40% coinsurance*/ Spec: 40% coinsurance*	Covered in full to age 26
Diagnostic X-ray	PCP: $25 copay/Spec: $40 copay	PCP: 40% coinsurance*/ Spec: 40% coinsurance*	PCP: Covered in full to age 26
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $40 copay/Free-Stnd: $40 copay	Spec: 40% coinsurance*/ Free-Stnd: 40% coinsurance*	None
Rehabilitative Services (PT/OT/ST)	$40 copay	40% coinsurance*	365 combined PT/OT/ST visits per year
Allergy Services	$40 copay	40% coinsurance*	Covered in full to age 26
Chemotherapy Visit	$25 copay	40% coinsurance*	Covered in full to age 26
Inpatient Services - Hospital	**In-Network**	**Out-of-Network**	
Medical/Surgical Admissions	$300 copay	40% coinsurance*	None
Surgical Services	$300 copay	40% coinsurance*	20% or $300, whichever is less
Inpatient Physical Rehabilitation	$300 copay	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)	$40 copay	40% coinsurance*	365 PT/OT/ST visits per plan year
Diagnostic Laboratory Services ++	Covered in Full	40% coinsurance*	None
Diagnostic X-ray ++	$40 copay	40% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)++	$40 copay	40% coinsurance*	None
Ambulatory/Outpatient Surgery ++	$75 copay	40% coinsurance*	None
Emergency Care	**In-Network**	**Out-of-Network**	
Emergency Room (ER) Visit	$75 copay	$75 copay	None
Urgent Care Centers	$25 copay	40% coinsurance*	None
Ambulance (Emergency Medical Transportation)	$50 copay	$50 copay	None
Maternity Services	**In-Network**	**Out-of-Network**	
Maternity – Prenatal Care	Covered in Full	40% coinsurance*	None
Maternity – Physician Delivery	Covered in Full	40% coinsurance*	None
Maternity – Inpatient Hospital Services	$300 copay	40% coinsurance*	None
Behavioral Health Services	**In-Network**	**Out-of-Network**	
Mental Health Inpatient Hospital	$300 copay	40% coinsurance*	None
Mental Health Outpatient	$25 copay	40% coinsurance*	covered in full to age 26
Substance Use Disorder Inpatient Hospital	$300 copay	40% coinsurance*	None
Substance Use Disorder Outpatient	$25 copay	40% coinsurance*	Covered in full to age 26, 20 visits for family counseling
Residential Treatment	$300 copay	40% coinsurance*	None
Other Services	**In-Network**	**Out-of-Network**	
Physician Administered Drugs	$40 copay	40% coinsurance*	None
Skilled Nursing Facility	$300 copay	40% coinsurance*	120 days per year
Home Health Care	Covered in Full	40% coinsurance*	60 visits per year
Hospice	Covered in Full	Inpt: 40% coin*/Outpt: 40% coinsurance*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	20% coinsurance	40% coinsurance*	None
Diabetic Supplies & Equipment	$25 copay	40% coinsurance*	Diabetic Insulin Covered in full In Network; Covered in full to age 26
Chiropractic Benefit	$25 copay	40% coinsurance*	None
Acupuncture	$40 copay	40% coinsurance*	10 visits per year

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Prescription Drug Coverage	**In-Network**	**Out-of-Network**	
Tier 1	Pharm: $5 copay/Mail: $10 copay	See available Riders	30/90 day retail; 90 day mail order
Tier 2	Pharm: $30 copay/Mail: $60 copay	See available Riders	30/90 day retail/90 day mail order
Tier 3	Pharm: $50 copay/Mail: $100 copay	See available Riders	30/90 day retail/90 day mail order
Prescription Drug Deductible	None	None	None
Vision Care	**In-Network**	**Out-of-Network**	
Adult Vision Care	$25 copay	40% coinsurance*	One eye exam per plan year
Pediatric Vision Care	$25 copay	40% coinsurance*	One eye exam per plan year
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	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**.

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**