

New York
Plan Name: PPO HDHP
Plan Form: NY7PDA022XLKPNFLR
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	\$1,800 Person/\$3,600 Family - Aggregate	\$4,000 Person/\$8,000 Family	None
Co-insurance	20% Person/20% Family	40% Person/40% Family	None
Annual Out-of-Pocket Maximum	\$3,000 Person/\$6,000 Family - Aggregate	\$8,000 Person/\$16,000 Family	None
Primary Care Physician Office Visits	20% coinsurance*	40% coinsurance*	None
Specialist Office Visits	20% 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: 20% coinsurance*/Spec: 20% coinsurance*	PCP: 40% coinsurance*/Spec: 40% coinsurance*	None
Diagnostic X-ray	PCP: 20% coinsurance*/Spec: 20% coinsurance*	PCP: 40% coinsurance*/Spec: 40% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 20% coinsurance*/Free-Stnd: 20% coinsurance*	Spec: 40% coinsurance*/Free-Stnd: 40% coinsurance*	Prior authorization required for non-participating provider
Rehabilitative Services (PT/OT/ST)	20% coinsurance*	40% coinsurance*	365 combined PT/OT/ST visits per year
Allergy Services	20% coinsurance*	40% coinsurance*	None
Chemotherapy Visit	20% coinsurance*	40% coinsurance*	None
Inpatient Services - Hospital	In-Network	Out-of-Network	
Medical/Surgical Admissions	20% coinsurance*	40% coinsurance*	None
Surgical Services	20% coinsurance*	40% coinsurance*	None
Inpatient Physical Rehabilitation	20% 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)	20% coinsurance*	40% coinsurance*	365 PT/OT/ST visits per plan year
Diagnostic Laboratory Services **	20% coinsurance*	40% coinsurance*	None
Diagnostic X-ray **	20% coinsurance*	40% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)**	20% coinsurance*	40% coinsurance*	None
Ambulatory/Outpatient Surgery **	20% coinsurance*	40% coinsurance*	None
Emergency Care	In-Network	Out-of-Network	
Emergency Room (ER) Visit	20% coinsurance*	20% coinsurance*	None
Urgent Care Centers	20% coinsurance*	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	20% coinsurance*	40% coinsurance*	None
Substance Use Disorder Inpatient Hospital	20% coinsurance*	40% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	20% coinsurance*	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	20% coinsurance*	40% coinsurance*	None
Skilled Nursing Facility	20% coinsurance*	40% coinsurance*	120 days per Plan Year
Home Health Care	20% coinsurance*	40% coinsurance*	60 visits per plan year
Hospice	20% coinsurance*	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	20% coinsurance*	40% coinsurance*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	20% coinsurance*	40% coinsurance*	None
Acupuncture	20% coinsurance*	40% coinsurance*	10 visits per year

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Prescription Drug Coverage	In-Network	Out-of-Network	
Tier 1	10% coinsurance*	See available Riders	30/90 day retail; 90 day mail order Preventive Rx Not Subject to Deductible
Tier 2	30% coinsurance*	See available Riders	30/90 day retail/90 day mail order Preventive Rx Not Subject to Deductible
Tier 3	50% 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 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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