New York
Plan Name: PPO
Plan Form: RPI $0 Ded 10% Coins
Plan Status: Draft

	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	**In-Network**	**Out-of-Network**	
Annual Deductible per Contract Year	$0 Person	$1,000 Person	None
Co-insurance	10% Coinsurance	30% Coinsurance	None
Annual Out-of-Pocket Maximum	$2,500 Person	$4,000 Person	None
Primary Care Physician Office Visits	10% coinsurance	30% coinsurance*	None
Specialist Office Visits	10% coinsurance	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)	10% coinsurance	30% coinsurance*	60 visits per condition, per Plan Year combined therapies
Allergy Services	10% coinsurance	30% coinsurance*	None
Chemotherapy Visit	10% coinsurance	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)	10% coinsurance	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	10% coinsurance	30% coinsurance	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*	None
Behavioral Health Services	**In-Network**	**Out-of-Network**	
Mental Health Inpatient Hospital	10% coinsurance	30% coinsurance*	including residential treatment
Mental Health Outpatient	Covered in Full	30% coinsurance*	None
Substance Use Disorder Inpatient Hospital	10% coinsurance	30% coinsurance*	including residential treatment
Substance Use Disorder Outpatient	Covered in Full	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**	
Physician Administered Drugs	10% coinsurance	30% coinsurance*	None
Skilled Nursing Facility	10% coinsurance	30% coinsurance*	200 days per plan year
Home Health Care	10% coinsurance	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	10% coinsurance	30% coinsurance*	None
Chiropractic Benefit	10% coinsurance	30% coinsurance*	None
Acupuncture	10% coinsurance	30% coinsurance*	12 visits per plan year

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	Coverage Information		Limits and Exclusions
Prescription Drug Coverage	**In-Network**	**Out-of-Network**	
Tier 1	Pharm: $10 copay/Mail: $20 copay	See available Riders	30 day retail/90 day mail order; mail order is 2x retail copay
Tier 2	Pharm: $30 copay/Mail: $60 copay	See available Riders	$100 max out of pocket on 30 day supply of Insulin; mail order is 2x retail copay
Tier 3	Pharm: $50 copay/Mail: $100 copay	See available Riders	30 day retail/90 day mail order; mail order is 2x retail copay
Prescription Drug Deductible	None	None	None
Vision Care	**In-Network**	**Out-of-Network**	
Adult Vision Care	10% coinsurance	30% coinsurance*	One exam per plan year
Pediatric Vision Care	10% coinsurance	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	Access $0 Gia® virtual care services for 24/7 emergency and urgent care, primary care, and mental health; 20% off CVS brand health items.		

MVP virtual care services through Gia are available at no cost-share for most members, except those enrolled in a qualified high-deductible health plan (QHDHP). QHDHP members must meet the annual deductible before Gia services are covered in full. In-person visits and referrals are subject to cost-share per plan. Members enrolled in a Medicare Rx plan without additional MVP medical coverage do not have access to MVP virtual care services through Gia.

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**