New York

Plan Name: PPO
Plan Form: NY2EYE011ZLB (PNEPO209LB)
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/$2,500 Family - Embedded	$6,500 Person/$13,000 Family	None
Co-insurance	15% Person/15% Family	40% Person/40% Family	None
Annual Out-of-Pocket Maximum	$3,000 Person/$7,500 Family - Embedded	$13,000 Person/$26,000 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	Covered in Full	PCP: 40% coinsurance*/Spec: 40%	None
Diagnostic X-ray	PCP: $30 copay/Spec: $50 copay	PCP: 40% coinsurance*/Spec: 40%	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $150 copay/Free-Stnd: $150 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	$50 copay	40% coinsurance*	None
Inpatient Services - Hospital	**In-Network**	**Out-of-Network**	
Medical/Surgical Admissions	15% coinsurance*	40% coinsurance*	None
Surgical Services	15% coinsurance*	40% coinsurance*	None
Inpatient Physical Rehabilitation	15% 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)	15% coinsurance*	40% coinsurance*	30 combined PT/OT/ST visits per year
Diagnostic Laboratory Services	Covered in Full	40% coinsurance*	None
Diagnostic X-ray	15% coinsurance*	40% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	15% coinsurance*	40% coinsurance*	None
Ambulatory/Outpatient Surgery	15% 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)	15% coinsurance*	15% coinsurance*	None
Maternity Services	**In-Network**	**Out-of-Network**	
Maternity – Prenatal Care	Covered in Full	40% coinsurance*	None
Maternity – Physician Delivery	15% coinsurance*	40% coinsurance*	None
Maternity – Inpatient Hospital Services	15% coinsurance*	40% coinsurance*	None
Behavioral Health Services	**In-Network**	**Out-of-Network**	
Mental Health Inpatient Hospital	15% coinsurance*	40% coinsurance*	None
Mental Health Outpatient	$30 copay	40% coinsurance*	None
Substance Use Disorder Inpatient Hospital	15% coinsurance*	40% coinsurance*	None
Substance Use Disorder Outpatient	$30 copay	40% coinsurance*	Unlimited; Up to 20 visits per plan year may be used for family counseling
Residential Treatment	15% coinsurance*	40% coinsurance*	None
Other Services	**In-Network**	**Out-of-Network**	
Skilled Nursing Facility	15% coinsurance*	40% coinsurance*	60 days per year
Home Health Care	15% coinsurance	40% coinsurance*	60 visits per year
Hospice	15% coinsurance*	Inpt: 40% coinsurance*/Outpt: 40% coinsurance*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	20% coinsurance	40% coinsurance*	Plan Deductible may apply
Diabetic Supplies & Equipment	$30 copay	40% coinsurance*	None
Chiropractic Benefit	$50 copay	40% coinsurance*	None
Acupuncture	Not covered	Not covered	None

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Prescription Drug Coverage	**In-Network**	**Out-of-Network**	
Tier 1	Pharm: $5 copay/Mail: $12.50 copay	Not covered	None
Tier 2	Pharm: $20 copay/Mail: $50 copay	Not covered	None
Tier 3	Pharm: $40 copay/Mail: $100 copay	Not covered	None
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**	
myVisitNow®– 24/7 Online Doctor Visits	$30 copay	Not covered	None
Wellness Benefits	$600 allowance	Included in In-Network benefit	Up to $600 in rewards and reimbursements with WellBeing Rewards per contract per calendar year
Plan Highlights	Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.		

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Call us today at **1-800-TALK-MVP** (825-5687) for more information.

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***Deductible applies to this benefit**