New York

Plan Name: MVP EPO Silver 1

Plan Form: NY-EPO-SS-001 (2021)

Plan Status: Pending

Pending Approval by the New York State Department of Financial Services

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$2,100 Person/$4,200 Family - Embedded	None
Co-insurance	20% Person/20% Family	None
Annual Out-of-Pocket Maximum	$7,800 Person/$15,600 Family - Embedded	None
Primary Care Physician Office Visits	$30 copay	None
Specialist Office Visits	$50 copay*	None
Preventive & Well Care Services		
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**.	None
Physician Office Visits		
Diagnostic Laboratory Services	PCP: $30 copay/Spec: $50 copay	None
Diagnostic X-ray	PCP: $30 copay/Spec: $50 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $150 copay*/Free-Stnd: $150 copay*	None
Rehabilitative Services (PT/OT/ST)	$50 copay*	54 visits per condition, per Plan Year combined therapies
Allergy Services	$50 copay*	Cost share dependent on location of services
Chemotherapy	$50 copay*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	20% coinsurance*	Per continuous confinement
Surgical Services	20% coinsurance*	None
Inpatient Physical Rehabilitation	20% coinsurance*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	$50 copay*	54 visits per condition/year combined therapies
Diagnostic Laboratory Services ++	$50 copay	None
Diagnostic X-ray ++	$50 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	$150 copay*	None
Ambulatory/Outpatient Surgery ++	$300 copay*	None
Emergency Care		
Emergency Room (ER) Visit	$350 copay*	None
Urgent Care Centers	$50 copay	None
Ambulance (Emergency Medical Transportation)	$350 copay*	None
Maternity Services		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	20% coinsurance*	None
Maternity – Inpatient Hospital Services	20% coinsurance*	None

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	20% coinsurance*	Including residential treatment
Mental Health Outpatient	$30 copay	None
Substance Use Disorder Inpatient Hospital	20% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	$30 copay	Unlimited; Up to 20 visits per plan year may be used for family counseling
Residential Treatment	20% coinsurance*	200 days per plan year
Other Services		
Skilled Nursing Facility	20% coinsurance*	200 days per plan year
Home Health Care	$50 copay*	60 visits per year
Hospice	Inpt: 20% coinsurance* / Outpt: $50 copay*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance*	Standard equipment covered
Diabetic Supplies & Equipment	$30 copay	None
Chiropractic Benefit	$50 copay*	None
Acupuncture	50% coinsurance*	12 visits per plan year
Prescription Drug Coverage		
Tier 1	Pharm: $15 copay/Mail: $37.50 copay	30 day retail/90 day mail order
Tier 2	Pharm: $35 copay*/Mail: $87.50 copay*	$100 max out of pocket on 30 day supply of Insulin
Tier 3	Pharm: $70 copay*/Mail: $175 copay*	30 day retail/90 day mail order
Prescription Drug Deductible	Rx Brand - $100 individual / $200 family	None
Vision Care		
Adult Vision Care	$50 copay*	One exam per every other Plan Year
Pediatric Vision Care	$50 copay*	One exam per 12-month period
Other Plan Features		
myVisitNow®– 24/7 Online Doctor Visits	Covered in Full	None
Wellness Benefits	$600 allowance	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.	
Pediatric Dental	Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. *Services can be obtained from any licensed provider.*	
++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**.	

As an MVP member, you can be sure you will always get the care, support, tools, and information you need. You will have access to top-rated customer care representatives, **myVisitNow®** – 24/7 online doctor visits, online wellness tools and activities, FREE Care Management programs, a 24/7 Nurse Advice Line, and more!

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

Already an MVP member? You can call the MVP Customer Care Center phone number listed on the back of your MVP Member ID card. MVP is making health insurance more convenient. More supportive. More personal.

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**