**New York**
**Plan Name:** PPO HDHP
**Plan Form:** NY7EDB015XLHPN (PNEPO704L)
**Plan Status:** Active

| | Coverage Information | | Limits and Exclusions |
|---|---|---|---|
| **Plan Cost-Sharing Highlights** | **In-Network** | **Out-of-Network** | |
| Annual Deductible per Contract Year | $2,500 Person/$5,000 Family - Aggregate | $4,000 Person/$8,000 Family | None |
| Co-insurance | As Noted Below | 40% Person/40% Family | None |
| Annual Out-of-Pocket Maximum | $2,500 Person/$5,000 Family - Embedded | $8,000 Person/$16,000 Family | None |
| Primary Care Physician Office Visits | 0% coinsurance* | 40% coinsurance* | None |
| Specialist Office Visits | 0% coinsurance* | 40% coinsurance* | None |
| **Preventive & Well Care Services** | **In-Network** | **Out-of-Network** | |
| Well Child Care & Immunizations<br>Adult Annual Physical (One per Contract Year)<br>Mammography<br>Annual Pap Test & Ob/Gyn Exam<br>Immunizations for Adults<br>Colonoscopy /Sigmoidoscopy Screening<br>Bone Density Tests | Covered in Full.<br>For a full list of covered preventive care services, visit **mvphealthcare.com**. | Well Child Care & Immunizations<br>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: 0% coinsurance*/Spec: 0% coinsurance* | PCP: 40% coinsurance*/ Spec: 40% coinsurance* | None |
| Diagnostic X-ray | PCP: 0% coinsurance*/Spec: 0% coinsurance* | PCP: 40% coinsurance*/ Spec: 40% coinsurance* | None |
| Advanced Imaging Services (CT/PET scans, MRIs) | Spec: 0% coinsurance*/Free-Stnd: 0% coinsurance* | Spec: 40% coinsurance*/ Free-Stnd: 40% coinsurance* | None |
| Rehabilitative Services (PT/OT/ST) | 0% coinsurance* | 40% coinsurance* | 30 combined PT/OT/ST visits per Year |
| Allergy Services | 0% coinsurance* | 40% coinsurance* | None |
| Chemotherapy Visit | 0% coinsurance* | 40% coinsurance* | None |
| **Inpatient Services - Hospital** | **In-Network** | **Out-of-Network** | |
| Medical/Surgical Admissions | 0% coinsurance* | 40% coinsurance* | Per continuous confinement |
| Surgical Services | 0% coinsurance* | 40% coinsurance* | None |
| Inpatient Physical Rehabilitation | 0% 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) | 0% coinsurance* | 40% coinsurance* | 30 visits per Plan Year combined therapies |
| Diagnostic Laboratory Services ++ | 0% coinsurance* | 40% coinsurance* | None |
| Diagnostic X-ray ++ | 0% coinsurance* | 40% coinsurance* | None |
| Advanced Imaging Services (CT/PET, scans, MRIs)++ | 0% coinsurance* | 40% coinsurance* | None |
| Ambulatory/Outpatient Surgery ++ | 0% coinsurance* | 40% coinsurance* | None |
| **Emergency Care** | **In-Network** | **Out-of-Network** | |
| Emergency Room (ER) Visit | 0% coinsurance* | 0% coinsurance* | None |
| Urgent Care Centers | 0% coinsurance* | 40% coinsurance* | None |
| Ambulance (Emergency Medical Transportation) | 0% coinsurance* | 0% coinsurance* | None |
| **Maternity Services** | **In-Network** | **Out-of-Network** | |
| Maternity – Prenatal Care | Covered in Full | 40% coinsurance* | None |
| Maternity – Physician Delivery | 0% coinsurance* | 40% coinsurance* | None |
| Maternity – Inpatient Hospital Services | 0% coinsurance* | 40% coinsurance* | One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early |
| **Behavioral Health Services** | **In-Network** | **Out-of-Network** | |
| Mental Health Inpatient Hospital | 0% coinsurance* | 40% coinsurance* | Including Residential Treatment |
| Mental Health Outpatient | 0% coinsurance* | 40% coinsurance* | None |
| Substance Use Disorder Inpatient Hospital | 0% coinsurance* | 40% coinsurance* | Including Residential Treatment |
| Substance Use Disorder Outpatient | 0% coinsurance* | 40% coinsurance* | Unlimited; Up to 20 visits per Plan Year may be used for family counseling |
| Residential Treatment | 0% coinsurance* | 40% coinsurance* | None |
| **Other Services** | **In-Network** | **Out-of-Network** | |
| Physician Administered Drugs | 0% coinsurance* | 40% coinsurance* | None |
| Skilled Nursing Facility | 0% coinsurance* | 40% coinsurance* | 60 days per Plan Year |
| Home Health Care | 0% coinsurance* | 40% coinsurance* | 60 visits per Plan Year |
| Hospice | 0% coinsurance* | Inpt: 40% coinsurance*/Outpt: 40% | 210 days per Plan Year; Five (5) visits for family bereavement |
| Durable Medical Equipment | 0% coinsurance* | 40% coinsurance* | None |
| Diabetic Supplies & Equipment | 0% coinsurance* | 40% coinsurance* | None |
| Chiropractic Benefit | 0% coinsurance* | 40% coinsurance* | None |
| Acupuncture | Not covered | Not covered | None |

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| **Prescription Drug Coverage** | **In-Network** | **Out-of-Network** | |
| Tier 1 | 0% coinsurance* | See available Riders | 30 day retail/90 day mail order |
| Tier 2 | 0% coinsurance* | See available Riders | $100 max out of pocket on 30 day supply of Insulin |
| Tier 3 | 0% coinsurance* | See available Riders | 30 day retail/90 day mail order |
| Prescription Drug Deductible | Subject to annual deductible | Subject to annual deductible | 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** | |
| Gia® Virtual Care | 0% coinsurance | Not covered | None |
| Wellness Benefits | $600 allowance | Included in In-Network benefit | Get reimbursed up to $600 per contract, per calendar year with MVP's Well-Being Reimbursement |
| Plan Highlights | Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits. | | |
| ++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. | | |

Gia virtual care services are available at no member cost-share for medical plans, including qualified high-deductible health plans (QHDHPs), upon enrollment and plan renewal in 2023. Members enrolled in a 2022 QHDHP must meet the plan's annual deductible before Gia services are available at no member cost share.

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**