New York
Plan Name: MVP EPO Gold 8
Plan Form: NY-EPO-SG-008 (2025)
Plan Status: Active

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$4,000 Person/$8,000 Family - Embedded	None
Co-insurance	20% Person/20% Family	None
Annual Out-of-Pocket Maximum	$8,000 Person/$16,000 Family - Embedded	None
Primary Care Physician Office Visits	$40 copay	First 3 Combined PCP/MH/SA Visits Covered in
Specialist Office Visits	$60 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: $40 copay/Spec: $60 copay	None
Diagnostic X-ray	PCP: $40 copay/Spec: $60 copay	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $150 copay/Free-Stnd: $150 copay	None
Rehabilitative Services (PT/OT/ST)	$60 copay	54 visits per condition, per Plan Year combined therapies
Allergy Services	$60 copay	Cost share dependent on location of services
Chemotherapy Visit	$60 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)	$60 copay	54 visits per condition/year combined therapies
Diagnostic Laboratory Services ++	$60 copay	None
Diagnostic X-ray ++	$60 copay	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	$150 copay	None
Ambulatory/Outpatient Surgery ++	20% coinsurance*	None
Emergency Care		
Emergency Room (ER) Visit	$300 copay	None
Urgent Care Centers	$60 copay	None
Ambulance (Emergency Medical Transportation)	$300 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	$40 copay	First 3 Combined PCP/MH/SA Visits Covered in Full
Substance Use Disorder Inpatient Hospital	20% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	$40 copay	First 3 Combined PCP/MH/SA Visits Covered in Full.
Residential Treatment	20% coinsurance*	Unlimited; Up to 20 visits per plan year may be used for None
Other Services		
Physician Administered Drugs	20% coinsurance*	None
Skilled Nursing Facility	20% coinsurance*	200 days per plan year
Home Health Care	$60 copay	60 visits per year
Hospice	Inpt: 20% coinsurance* / Outpt: $60 copay	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance*	Standard equipment covered
Diabetic Supplies & Equipment	$40 copay	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$60 copay	None
Acupuncture	50% coinsurance*	12 visits per plan year
Prescription Drug Coverage		
Tier 1	Pharm: $10 copay/Mail: $25 copay	30 day retail/90 day mail order
Tier 2	Pharm: $40 copay/Mail: $100 copay	30 day retail/90 day mail order
Tier 3	Pharm: $60 copay/Mail: $150 copay	30 day retail/90 day mail order
Prescription Drug Deductible	None	None
Vision Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	$60 copay	One exam per 12-month period
Other Plan Features		
Gia® Virtual Care	Covered in Full	None
Wellness Benefits	$600 allowance	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.	
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**.	

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**