

New York
Plan Name: MVP EPO Platinum 1
Plan Form: NY-EPO-SP-001 (2025)
Plan Status: Active



| Plan Cost-Sharing Highlights | Coverage Information | Limits and Exclusions |
|--|---|---|
| Annual Deductible per Contract Year | \$0 Person/\$0 Family - Embedded | None |
| Co-insurance | As Noted Below | None |
| Annual Out-of-Pocket Maximum | \$2,450 Person/\$4,900 Family - Embedded | None |
| Primary Care Physician Office Visits | \$5 copay | First 3 Combined PCP/MH/SA Visits Covered in |
| Specialist Office Visits | \$45 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: \$5 copay/Spec: \$45 copay | None |
| Diagnostic X-ray | PCP: \$5 copay/Spec: \$45 copay | None |
| Advanced Imaging Services (CT/PET scans, MRIs) | Spec: \$100 copay/Free-Stnd: \$100 copay | None |
| Rehabilitative Services (PT/OT/ST) | \$45 copay | 54 visits per condition, per Plan Year combined therapies |
| Allergy Services | \$45 copay | Cost share dependent on location of services |
| Chemotherapy Visit | \$45 copay | None |
| Inpatient Services - Hospital | | |
| Medical/Surgical Admissions | \$300 copay | Per continuous confinement |
| Surgical Services | \$100 copay | None |
| Inpatient Physical Rehabilitation | \$300 copay | 60 days per Plan Year Combined Therapies |
| Outpatient Hospital Services | | |
| Hospital Rehab Services (PT/OT/ST) | \$45 copay | 54 visits per condition/year combined therapies |
| Diagnostic Laboratory Services ** | \$45 copay | None |
| Diagnostic X-ray ** | \$45 copay | None |
| Advanced Imaging Services (CT/PET, scans, MRIs) ** | \$100 copay | None |
| Ambulatory/Outpatient Surgery ** | \$100 copay | None |
| Emergency Care | | |
| Emergency Room (ER) Visit | \$100 copay | None |
| Urgent Care Centers | \$45 copay | None |
| Ambulance (Emergency Medical Transportation) | \$100 copay | None |
| Maternity Services | | |
| Maternity – Prenatal Care | Covered in Full | None |
| Maternity – Physician Delivery | \$100 copay | None |
| Maternity – Inpatient Hospital Services | \$300 copay | None |

*Deductible applies to this benefit



| | Coverage Information | Limits and Exclusions |
|--|--|--|
| Behavioral Health Services | | |
| Mental Health Inpatient Hospital | \$300 copay | Including residential treatment |
| Mental Health Outpatient | \$5 copay | First 3 Combined PCP/MH/SA Visits Covered in Full |
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| Substance Use Disorder Inpatient Hospital | \$300 copay | Including residential treatment |
| Substance Use Disorder Outpatient | \$5 copay | First 3 Combined PCP/MH/SA Visits Covered in Full; 20 visits per plan year may be used for family counseling |
| Residential Treatment | \$300 copay | None |
| Other Services | | |
| Physician Administered Drugs | 20% coinsurance | None |
| Skilled Nursing Facility | \$300 copay | 200 days per plan year |
| Home Health Care | \$45 copay | 60 visits per plan year |
| Hospice | Inpt: \$300 copay / Outpt: \$45 copay | 210 days per plan year, 5 visits for family bereavement counseling |
| Durable Medical Equipment | 50% coinsurance | Standard equipment covered |
| Diabetic Supplies & Equipment | \$5 copay | Diabetic Insulin Covered in full In Network |
| Chiropractic Benefit | \$45 copay | None |
| Acupuncture | 50% coinsurance | 12 visits per plan year |
| Prescription Drug Coverage | | |
| Tier 1 | Pharm: \$5 copay/Mail: \$12.50 copay | 30 day retail/90 day mail order |
| Tier 2 | Pharm: \$30 copay/Mail: \$75 copay | 30 day retail/90 day mail order |
| Tier 3 | Pharm: \$50 copay/Mail: \$125 copay | 30 day retail/90 day mail order |
| Prescription Drug Deductible | None | None |
| Vision Care | | |
| Adult Vision Care | Not covered | None |
| Pediatric Vision Care | \$45 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. <i>Services can be obtained from any licensed provider.</i> | |
| **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**