New York Plan Name: MVP EPO Platinum 5 Plan Form: NY-EPO-SP-005 (2025)

Plan Status: Active



Specialist Office Visits \$25 copay None Preventive & Well Care Services Covered in Full. For a full list of covered preventive care services, visit None Mammography Annual Pap Test & Ob/Gyn Exam Immunizations for Adults Covered in Full. For a full list of covered preventive care services, visit None Colonoscopy /Sigmoidoscopy Sreening Bone Density Tests PCP: \$15 copay/Spec: \$25 copay None Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None None Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None None Advanced Imaging Services (CT/PET scans, MRIs) \$25 copay None Sec: \$50 copay/Free-Stnd: \$50 copay None Allergy Services (PT/OT/ST) \$25 copay Cost share dependent on location of servic therapies Inpatient Services - Hospital \$550 copay None Services (PT/OT/ST) Surgical Services S550 copay Per continuous confinement Services (PT/OT/ST) Inpatient Physical Rehabilitation \$550 copay Per continuous confinement Medical/Surgical Admissions \$550 copay 60 days per Plan Year Combined Therapie Surgical Services Stop copay	Idit Status. Active		
Annal Deductible per Contract Year A Noted Below None Co-insurance As Noted Below None Primary Care Physical Office Visits \$15 copay First 3 Combined PCP/MH/SA Visits Cover Speciality Office Visits \$25 copay None Preventrive & Well Care & Immunications Adult Annual Physical (One per Contract Year) None Mammography Preventrive & Well Care & Immunications Covered in Full Annual Pap Test & Ob/Gyn Exam For a full list of covered preventive care services, visit None Preventrive & None PCP: \$15 copay/Spec: \$25 copay None Physician Office Visits PCP: \$15 copay/Spec: \$25 copay None Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None Pagnostic Laboratory Services (CT/PET scans, MRIs) Spec: \$50 copay/Free-Stat: \$50 copay None Advanced Imaging Services (CT/PET scans, MRIs) \$25 copay Cost share dependent on location of servic Allergy Services \$25 copay Cost share dependent on location of servic Impatient Services - Hospital S50 copay Cost share dependent on location of servic Impatient Physical Admissions \$50 copay Sone Impatient Physical Admissions \$50 copay None Impatient Physical Rehabilitation S50 copay None	Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Out-OP-Pocket Maximum \$3,550 Person/\$7,100 Family - Embedded None Primary Care Physician Office Visits \$15 copay First 3 Combined PCP/MH/SA Visits Cover Preventive & Well Carle Services \$25 copay None Well Child Care & Immunizations Adult Annual Physical (One per Contract Year) None Adult Annual Physical (One per Contract Year) Covered in Full. None Mamnography For a full list of covered preventive care services, wist None Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None Advanced Imaging Services (CT/PET scans, MRIs) Spec S50 copay/Free-Stnd: \$50 copay None Rehabilitative Services (PT/OT/ST) S25 copay Cost share dependent on location of servic therapies Surgical Admissions S550 copay/Free-Stnd: \$50 copay None Surgical Admissions S550 copay Cost share dependent on location of servic therapies Surgical Services PLYSIS S25 copay Cost share dependent on location of servic therapies Surgical Services S550 copay None Services (PT/OT/ST) Surgical Services S550 copay None Services (PT/OT/ST) Surgical Services S550 copay None Service Services	Annual Deductible per Contract Year	\$0 Person/\$0 Family - Embedded	None
Annual Curie Proceet Maximum Sister Storage Preventive are Provident Storage Preventive & Well Carl Care Services Well Child Care & Immunizations for Adults Colonecopy / Signodiaccopy Screening Bore Density Tets Dispinoids copy Screening Bore Density Tets Physical Curies Preventive are services, with murphealthcare.com. Colonecopy / Signodiaccopy Screening Bore Density Tets Physical Curies Preventive are services, with murphealthcare.com. Colonecopy / Signodiaccopy Screening Bore Density Tets Physical Curies Preventive are services, with murphealthcare.com. Colonecopy / Signodiaccopy Screening Bore Density Tets Physical Defice Visits Preventive Care Services with murphealthcare.com. Colonecopy / Signodiaccopy Screening Bore Density Tets Physician Office Visits Preventive Care Services (PT/OT/ST) PCP: \$15 copay/Spec: \$25 copay None Preventive Care Services (PT/OT/ST) Screening Services (PT/OT/S	Co-insurance	As Noted Below	None
Specializ Office Visits \$25 copay None Preventive & Well Care Services Covered in Full. None With Child Care & Immunizations Covered in Full. For a full list of covered preventive care services, visit None Aduk Annual Physical (Dne per Contract Year) Covered in Full. For a full list of covered preventive care services, visit None Bone Density Tests Physicital Office Visits PCP: \$15 copay/Spec: \$25 copay None Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None Advanced Imaging Services (CT/PET scans, MRIs) Spec: \$00 copay/Free-Strict \$50 copay None Rehabilitative Services (PT/OT/ST) \$25 copay S4 visits per condition, per Plan Year combiner therapies Allergy Services \$25 copay None Services visits and therapies Inpatient Services - (PT/OT/ST) \$25 copay None Services visits and therapies Surgical Services Sisto copay Per continuous confinement Services visits and therapies Inpatient Physical Rehabilitation \$550 copay 60 days per Plan Year Combined Therapie Surgical Services Proverservices *** \$25 copay None Services visits per condition/year combined therapies	Annual Out-of-Pocket Maximum	\$3,550 Person/\$7,100 Family - Embedded	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 Covered in Full. For a full ist of covered preventive care services, visit myphealthcare.com. Bene Density Tests Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None PCP: \$15 copay/Spec: \$25 copay No	Primary Care Physician Office Visits	\$15 copay	First 3 Combined PCP/MH/SA Visits Covered in
Well Child Care & Immunizations Covered in Full For a full list of covered preventive care services, visit myshealthcare.com. None Mannography For a full list of covered preventive care services, visit myshealthcare.com. None Diagnostic Laboratory Services PCP: \$15 copay/Spc: \$25 copay None Diagnostic Laboratory Services PCP: \$15 copay/Spc: \$25 copay None Diagnostic Laboratory Services PCP: \$15 copay/Spc: \$25 copay None Advanced Imaging Services (CT/PET scans, MRIs) Spc: \$50 copay/Free-Stnd: \$50 copay St visits per condition, per Plan Year comb therapies Rehabilitative Services (PT/OT/ST) \$25 copay Set visits per condition, per Plan Year comb therapies Allergy Services FOP: \$15 copay/Spc: \$25 copay None Allergy Services + Hospital \$25 copay Cost share dependent on location of service Medical/Surgical Admissions \$550 copay Per continuous confinement Surgical Services Hospital Services St50 copay Set visits per condition/year combined Therapic Surgical Services St50 copay Set visits per condition/year combined Therapic Set visits per condition/year combined Therapic Surgical Services St50 copay Set visits per condition/year combined Therapic </td <td>Specialist Office Visits</td> <td>\$25 copay</td> <td>None</td>	Specialist Office Visits	\$25 copay	None
Adult Annual Physical (One per Contract Year) Covered in Full. For a full list of covered preventive care anyoheal thears.com. None Annual Pap Test & Ob/Gyn Exam immunizations for Adults PCP: \$15 copay/Spec: \$25 copay None Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None Advanced Imaging Services (CT/PET scans, MRIs) Spec: \$50 copay/Free-Stnd: \$50 copay None Advanced Imaging Services (PT/OT/ST) Spec: \$50 copay/Free-Stnd: \$50 copay None Allergy Services PCP: \$15 copay/Spec: \$25 copay None Allergy Services Spec: \$50 copay None Allergy Services Spec: \$50 copay None Chemotherapy Visit \$25 copay None Inpatient Services - Hospital Spec: \$50 copay None Medical/Surgical Admissions Spec: copay Spec: copay Spec: copay Surgical Services Spec: copay Spec: copay Spec: copay Spec: copay Medical/Surgical Admissions Spec: copay Spec: copay Spec: copay Spec: copay Surgical Services Spec: copay Spec: copay	Preventive & Well Care Services		
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Diagnostic Laboratory Services PCP: \$15 copay/Spec: \$25 copay None Advanced Imaging Services (CT/PET scans, MRIs) Spec: \$50 copay/Free-Stnd: \$50 copay None Rehabilitative Services (PT/OT/ST) \$25 copay S4 visits per condition, per Plan Year comb therapies Allergy Services \$25 copay Cost share dependent on location of servic Chemotherapy Visit \$25 copay None Inpatient Services - Hospital \$250 copay None Medical/Surgical Admissions \$550 copay Per continuous confinement Surgical Services Covered in Full None Surgical Services (PT/OT/ST) \$25 copay 60 days per Plan Year Combined Therapie Outpatient Hospital Services Covered in Full None Surgical Services (PT/OT/ST) \$25 copay S4 visits per condition/year combined therapie Outpatient Hospital Rehabilitation \$550 copay 60 days per Plan Year Combined Therapie Outpatient Hospital Rehabilitation \$550 copay S4 visits per condition/year combined therapie Diagnostic Laboratory Services (PT/OT/ST) \$25 copay None Diagnostic Laboratory Services (TT/PET, scans, MRIs) ** \$300 copay None Emergency Care Emergency Care Emergency Care Emergency Care Emergency Care \$200 copay None <td>Physician Office Visits</td> <td></td> <td>Nene</td>	Physician Office Visits		Nene
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Outpatient Hospital Services 4 Hospital Rehab Services (PT/OT/ST) \$25 copay Diagnostic Laboratory Services ** \$25 copay None None Diagnostic X-ray ** \$25 copay Advanced Imaging Services (CT/PET, scans, MRIs) ** \$50 copay Ambulatory/Outpatient Surgery ** \$300 copay Emergency Care 225 copay Emergency Room (ER) Visit \$200 copay Vigent Care Centers \$25 copay Ambulance (Emergency Medical Transportation) \$200 copay Maternity – Prenatal Care Covered in Full Maternity – Physician Delivery Covered in Full Maternity – Physician Delivery Covered in Full	Surgical Services	Covered in Full	None
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Diagnostic Laboratory Services **\$25 copayNoneDiagnostic X-ray **\$25 copayNoneAdvanced Imaging Services (CT/PET, scans, MRIs) **\$50 copayNoneAmbulatory/Outpatient Surgery **\$300 copayNoneEmergency CareImage: CopaySoneEmergency Room (ER) Visit\$200 copayNoneUrgent Care Centers\$25 copayNoneAmbulance (Emergency Medical Transportation)\$200 copayNoneMaternity - Prenatal CareCovered in FullNoneMaternity - Physician DeliveryCovered in FullNoneS50 copayNoneS50 copayNone	Outpatient Hospital Services		
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Advanced Imaging Services (CT/PET, scans, MRIs) **\$50 copayNoneAmbulatory/Outpatient Surgery **\$300 copayNoneEmergency CareEmergency Room (ER) Visit\$200 copayNoneUrgent Care Centers\$25 copayNoneAmbulance (Emergency Medical Transportation)\$200 copayNoneMaternity ServicesCovered in FullNoneMaternity – Prenatal CareCovered in FullNoneMaternity – Physician DeliveryCovered in FullNoneS550 copayNoneNone			
Ambulatory/Outpatient Surgery ** \$300 copay None Emergency Care			
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Urgent Care Centers \$25 copay None Ambulance (Emergency Medical Transportation) \$200 copay None Maternity Services Covered in Full None Maternity – Prenatal Care Covered in Full None Maternity – Physician Delivery Covered in Full None \$550 copay None None		4222	
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Maternity Services None Maternity – Prenatal Care Covered in Full None Maternity – Physician Delivery Covered in Full None \$550 copay None			
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Maternity – Prenatal Care Covered in Full None Maternity – Physician Delivery \$550 copay None	Maternity Services		
\$550 copay None	Maternity – Prenatal Care	Covered in Full	None
Maternity – Inpatient Hospital Services \$550 copay None	Maternity – Physician Delivery	Covered in Full	None
	Maternity – Inpatient Hospital Services	\$550 copay	None

New York Plan Name: MVP EPO Platinum 5 Plan Form: NY-EPO-SP-005 (2025) Plan Status: Active



	Coverage Information	Limits and Exclusions	
Behavioral Health Services			
Mental Health Inpatient Hospital	\$550 copay	Including residential treatment	
Mental Health Outpatient	\$15 сорау	First 3 Combined PCP/MH/SA Visits Covered in Full	
Substance Use Disorder Inpatient Hospital	\$550 copay	Including residential treatment	
Substance Use Disorder Outpatient	\$15 copay	First 3 Combined PCP/MH/SA Visits Covered in Full. Unlimited; Up to 20 visits per plan year may be used for	
Residential Treatment	\$550 copay	None	
Other Services			
Physician Administered Drugs	20% coinsurance	None	
Skilled Nursing Facility	\$550 copay	200 days per plan year	
Home Health Care	\$25 copay	60 visits per year	
Hospice	Inpt: \$550 copay / Outpt: \$25 copay	210 days per plan year, 5 visits for family bereavement	
		counseling	
Durable Medical Equipment	50% coinsurance	Standard equipment covered	
Diabetic Supplies & Equipment	\$15 copay	Diabetic Insulin Covered in full In Network	
Chiropractic Benefit	\$25 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	\$25 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 informatio better understand your MVP plan benefits.	n. View a complete Glossary of Terms and Member FAQs to	
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.