New York Plan Name: MVP Healthy New York Gold

Plan Form: NY-HNY-SG-001 (2025)

# Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
	\$600 Person/\$1,200 Family - Embedded	None
Annual Deductible per Contract Year		None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$7,900 Person/\$15,800 Family - Embedded	None
Primary Care Physician Office Visits	\$25 copay*	None
Specialist Office Visits	\$40 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 Physician Office Visits	Covered in Full. For a full list of covered preventive care services, visit <u>mvphealthcare.com</u> .	None
	PCP: \$25 copay*/Spec: \$40 copay*	None
Diagnostic Laboratory Services		None
Diagnostic X-ray	PCP: \$40 copay*/Spec: \$40 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: \$40 copay*/Free-Stnd: \$40 copay*	None
Rehabilitative Services (PT/OT/ST)	\$30 copay*	60 visits per condition, per Plan Year combined therapies
Allergy Services	\$40 copay*	None
Chemotherapy Visit	\$25 copay*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	\$1,000 copay*	None
Surgical Services	\$100 copay*	None
Inpatient Physical Rehabilitation	\$1,000 copay*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	\$30 copay*	60 visits per condition/year combined therapies
Diagnostic Laboratory Services ** Diagnostic V row **	\$40 copay*	None
Diagnostic X-ray ** Advanced Imaging Services (CT/PET, scans, MRIs) **	\$40 copay* \$40 copay*	None
Andvanced imaging Services (CT/PET, scans, WRIS) Ambulatory/Outpatient Surgery **	\$40 copay* \$100 copay*	None None
Emergency Care	\$100 copay	None
Emergency Room (ER) Visit	\$150 copay*	None
Urgent Care Centers	\$60 copay*	None
Ambulance (Emergency Medical Transportation)	\$150 copay*	None
Maternity Services		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	\$100 copay*	None
Maternity – Inpatient Hospital Services	\$1,000 copay*	None

# \*Deductible applies to this benefit

# New York Plan Name: MVP Healthy New York Gold Plan Form: NY-HNY-SG-001 (2025) Plan Status: Active



Coverage Information         Limits and Exclusions           Behavioral Health Services         51,000 copay*         Including residential treatment           Mental Health Inpatient Hospital         525 copay*         None           Substance Use Disorder Inpatient Hospital         51,000 copay*         Including residential treatment           Substance Use Disorder Outpatient         51,000 copay*         Unlimited; Up to twenty (20) visits per plan year may be used for Family counseling           Residential Treatment         51,000 copay*         None           Other Services         755 copay*         None           Physicina Administered Drugs         525 copay*         None           Subled Nursing Facility         51,000 copay*/ Outpt \$25 copay         None           Subled Nursing Facility         525 copay*         None           Home Heath Care         525 copay*         None           Hospice         1nt 51,000 copay*/ Outpt \$25 copay         200 days per plan year, 5 visits for family bereavement           Datable Medical Equipment         525 copay*         None         counseling           Prescription Drug Coverage         Pharm: \$10 copay/Mail: \$25 copay         None           Ter 1         Pharm: \$10 copay/Mail: \$87,500 copay         30 day retail/90 day mail order           Ter 2         None         No				
Mental Health Inpatient Hospital         \$1,000 copay*         Including residential treatment           Substance Use Disorder Inpatient Hospital         \$25 copay*         Including residential treatment           Substance Use Disorder Outpatient         \$25 copay*         Unlimited: Up to twenty (20) visits per plan year may be used for family counseling           Residential Treatment         \$25 copay*         None           Other Services         Stood copay*         None           Physician Administered Drugs         \$25 copay*         None           Stilled Nursing Facility         \$25 copay*         None           Home Health Care         \$25 copay*         None           Home Health Care         \$25 copay*         You with per year           Home Health Care         \$25 copay*         You with per year           Home Health Care         \$26 copay*         You with per year           Home Health Care         \$26 copay*         You with per year           Home Health Care         \$26 copay*         None           None         None         You with per year           Home Health Care         \$26 copay*         None           Purscind Tompone         None         You with per year           Chiropractic Benefit         \$30 copay*         You with per year		Coverage Information	Limits and Exclusions	
Mental Health Inpatient Hospital         Fund Health Outpatient         Section of the section of th	Behavioral Health Services			
Mental Health Outpatient         Including residential treatment           Substance Use Disorder Outpatient         25 copay"         Including residential treatment           Substance Use Disorder Outpatient         25 copay"         None           Residential Treatment         51.000 copay"         None           Other Services         Image: Compage: Comp	Mental Health Inpatient Hospital	\$1,000 copay*	Including residential treatment	
Substance Use Disorder impatient Hospital         S25 copay*         Unlimited: Up to twenty (20) visits per plan year may be used for family counseling           Residential Treatment         \$1,000 copay*         None           Other Services         None           Physician Administered Drugs         \$25 copay*         None           Substance Use Drogs         \$20 days per plan year         None           Other Services         200 days per plan year         None           Home Health Care         \$25 copay*         40 visits per year         210 days per plan year           Home Health Care         \$25 copay*         40 visits per year         210 days per plan year.           Durable Medical Equipment         20% coinsurance*         standard equipment covered         Standard equipment covered           Diabetic Supplies & Equipment         \$25 copay*         None         None           Prescription Drug Coverage         None         None         None           Tier 2         Pharm: \$10 copay/Mail: \$25 copay         30 day retail/90 day mail order         Standard           Tier 3         Pharm: \$25 copay*         30 day retail/90 day mail order         Standard           Prescription Drug Deductible         None         None         None           Vision Care         Not covered         None	Mental Health Outpatient	\$25 copay*	None	
Substance Use Disorder Outpatient         used for family counseling           Residential Treatment         \$1,000 copay*         None           Other Services         Image: Second Se	Substance Use Disorder Inpatient Hospital	\$1,000 copay*	Including residential treatment	
Residential Treatment         \$1,000 copay*         None           Other Services         S25 copay*         None           Physician Administered Drugs         \$25 copay*         None           Skilled Nursing Facility         \$1,000 copay*         200 days per plan year           Home Health Care         \$25 copay*         400 visits per year           Home Health Care         \$25 copay*         210 days per plan year, 5 visits for family bereavement counseling           Durable Medical Equipment         20% coinsurance*         standard equipment covered           Diabetic Supplies & Equipment         \$40 copay*         None           Acupuncture         None         None           Prescription Drug Coverage         None         None           Tier 2         Pharm: \$10 copay/Mail: \$25 copay         30 day retail/90 day mail order           Tier 3         Pharm: \$10 copay/Mail: \$25 copay         30 day retail/90 day mail order           Prescription Drug Deductible         None         None           Vision Care         \$25 copay*         One exam per 12-month period           Prescription Care         \$25 copay*         One exam per 12-month period           Prescription Care         \$25 copay*         One exam per 12-month period           Prescription Care         \$25 copay*	Substance Use Disorder Outpatient	\$25 copay*		
Physician Administered Drugs         \$25 copy*         None           Skilled Nursing Facility         51000 copay*         200 days per plan year           Home Health Care         \$25 copy*         40 visits per year           Horpice         200 days per plan year, 5 visits for family bereavement conserving           Durable Medical Equipment         20% coinsurance*         210 days per plan year, 5 visits for family bereavement conserving           Diabetic Supplies & Equipment         20% coinsurance*         Standard equipment covered           Diabetic Supplies & Equipment         \$40 copay*         None           Accupancture         None         None           Accupancture         None         None           Prescription Drug Coverage         Vision Care         None           Tier 2         Parm: \$10 copay/Mail: \$25 copay         30 day retail/90 day mail order           Tier 3         Parm: \$10 copay/Mail: \$25 copay         30 day retail/90 day mail order           Tier 4         None         None           Vision Care         None         None           Adult Vision Care         None         None           Prescription Drug Deductible         None         None           Vision Care         Not covered         None           Adult Vision Care	Residential Treatment	\$1,000 copay*		
Skiled Nursing Facility     \$1,000 copay*     200 days per plan year       Home Health Care     \$25 copay*     40 visits per year       Hospice     Int: \$1,000 copay* / Outpt: \$25 copay*     210 days per plan year, 5 visits for family bereavement counseling       Durable Medical Equipment     20% coinsurance*     standard equipment covered       Diabetic Supplies & Equipment     \$20 copay*     None       Accupancture     Not covered     None       Prescription Drug Coverage     None     None       Tier 1     Pharm: \$10 copay/Mail: \$25 copay     30 day retail/90 day mail order       Tier 2     Pharm: \$10 copay/Mail: \$25 copay     30 day retail/90 day mail order       Tier 3     Pharm: \$10 copay/Mail: \$25 copay     30 day retail/90 day mail order       Prescription Drug Deductible     None     None       Vision Care     None     None       Adult Vision Care     Not covered     None       Vision Care     S2 copay*     One exam per 12-month period       Other Plan Features     Get reimbursed up to \$600 per contract, per calendar year with MP's Well-Being Reimbursement       Visit myphealthcare.com for more information. Wiew a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.       Pediatric Dental     Visit myphealthcare.com for more information. Wiew a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits. <td>Other Services</td> <td></td> <td></td>	Other Services			
Home Health Care       \$25 copay*       40 visits per year         Hospice       Inpt: \$1,000 copay* / Outpt: \$25 copay*       210 days per plan year, 5 visits for family bereavement counseling, standard equipment covered         Durable Medical Equipment       20% coinsurance*       standard equipment covered         Diabetic Supplies & Equipment       \$25 copay*       Diabetic Insulin Covered in full In Network         Chiropractic Benefit       \$40 copay*       None         Acupuncture       Not covered       None         Prescription Drug Coverage       Pharm: \$10 copay/Mail: \$25 copay       30 day retail/90 day mail order         Tier 1       Pharm: \$10 copay/Mail: \$25 copay       30 day retail/90 day mail order         Tier 2       Pharm: \$10 copay/Mail: \$175 copay       30 day retail/90 day mail order         Yision Care       None       None       None         Vision Care       \$25 copay*       One exam per 12-month period         Other Plan Features       Gaia* Virtual Care       \$600 allowance       Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.       See Schedule of Benefits for Cost Share Details. Services and bedutinet from any licereed provider facility will be covered in full, after	Physician Administered Drugs	\$25 copay*	None	
Hospice       Inpt: \$1,000 copay* / Outpt: \$25 copay*       210 days per plan year, 5 visits for family bereavement counseling         Durable Medical Equipment       20% coinsurance*       standard equipment covered         Diabetic Supplies & Equipment       525 copay*       Diabetic Insulin Covered in full In Network         Chiropractic Benefit       540 copay*       None         Acupuncture       Not covered       None         Prescription Drug Coverage       Pharm: \$10 copay/Mail: \$25 copay       30 day retail/90 day mail order         Tier 1       Pharm: \$10 copay/Mail: \$25 copay       30 day retail/90 day mail order         Tier 2       Pharm: \$70 copay/Mail: \$175 copay       30 day retail/90 day mail order         Vision Care       None       None         Adult Vision Care       Not covered       None         Vision Care       S25 copay*       One exam per 12-month period         Other Plan Features       Covered in Full       None         Gia* Virtual Care       Covered in Full       None         Wellness Benefits       Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.       Visit myphealthcare.com for mary licensed provider.         Padiatric Dental       Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understa	Skilled Nursing Facility	\$1,000 copay*	200 days per plan year	
Hospice     Local data data data data data data data da	Home Health Care	\$25 copay*	40 visits per year	
Durable Medical Equipment         20% coinsurance*         connesting           Diabetic Supplies & Equipment         20% coinsurance*         Diabetic Insulin Covered in full In Network           Chiropractic Benefit         \$40 copay*         None           Acupunctive         None         None           Prescription Drug Coverage         None         None           Tier 1         Pharm: \$10 copay/Mail: \$25 copay         30 day retail/90 day mail order           Tier 2         Pharm: \$10 copay/Mail: \$25 copay         30 day retail/90 day mail order           Tier 3         Pharm: \$70 copay/Mail: \$27 copay         30 day retail/90 day mail order           Prescription Drug Deductible         None         None           Vision Care         None         None           Vision Care         Not covered         None           Pediatic Vision Care         S2 copay*         One exam per 12-month period           Other Plan Features         Covered in Full         None           Gia® Virtual Care         Covered in Full         None           Pediatic Vision Care         S600 allowance         Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement           Plan Highlights         Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your M	Useria		210 days per plan year, 5 visits for family bereavement	
Durable Medical Equipment         20% coinsurance*         standard equipment covered           Diabetic Supplies & Equipment         \$25 copay*         Diabetic Insulin Covered in full In Network           Chiropractic Benefit         \$40 copay*         None           Acupuncture         Not covered         None           Prescription Drug Coverage         Image: Standard Equipment covered         Standard Equipment covered           Tier 1         Pharm: \$10 copay/Mail: \$25 copay         30 day retail/90 day mail order           Tier 2         Pharm: \$35 copay/Mail: \$25 copay         30 day retail/90 day mail order           Tier 3         Pharm: \$70 copay/Mail: \$175 copay         30 day retail/90 day mail order           Vision Care         None         None           Adult Vision Care         Not covered         None           Other Plan Features         Covered in Full         None           Gia® Virtual Care         Covered in Full         None           Wellness Benefits         S600 allowance         Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement           Plan Highlights         Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.           Preventive, Routine, and Major (including medically-necessary orthodonta) – See Schedule of Benefits or Cost Shar	ноѕрісе		counseling	
Diabetic Supplies & Equipment     Value       Chiropractic Benefit     \$40 copay*     None       Acupuncture     Not covered     None       Prescription Drug Coverage     Image: State Details State Details State Details.     State S	Durable Medical Equipment	20% coinsurance*		
Acupuncture       Not covered       None         Prescription Drug Coverage       Image: State S	Diabetic Supplies & Equipment	\$25 copay*	Diabetic Insulin Covered in full In Network	
Acupuncture         Not covered         None           Prescription Drug Coverage         Pharm: \$10 copay/Mail: \$25 copay         30 day retail/90 day mail order           Tier 1         Pharm: \$10 copay/Mail: \$87.50 copay         30 day retail/90 day mail order           Tier 2         Pharm: \$70 copay/Mail: \$87.50 copay         30 day retail/90 day mail order           Tier 3         Pharm: \$70 copay/Mail: \$175 copay         30 day retail/90 day mail order           Prescription Drug Deductible         None         30 day retail/90 day mail order           Vision Care         None         None           Adult Vision Care         Not covered         None           Pediatric Vision Care         Covered in Full         None           Gia® Virtual Care         S00 allowance         Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement           Wellness Benefits         Visit myphealthcare com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.           Preventive, Routine, and Major (including medically-necessary onthodontia) – See Schedule of Benefits         Preventive, Routine, and Major (including medically-necessary onthodontia) – See Schedule of Benefits	Chiropractic Benefit	\$40 copay*	None	
Prescription Drug Coverage         Image: State Stat	Acupuncture		None	
Tier 1Pharm: \$10 copay/Mail: \$25 copay30 day retail/90 day mail orderTier 2Pharm: \$35 copay/Mail: \$87.50 copay30 day retail/90 day mail orderTier 3Pharm: \$70 copay/Mail: \$175 copay30 day retail/90 day mail orderTier 3Pharm: \$70 copay/Mail: \$175 copay30 day retail/90 day mail orderPrescription Drug DeductibleNoneNoneVision CareNoneNoneAdult Vision CareNot coveredNonePediatric Vision Care\$25 copay*One exam per 12-month periodOther Plan FeaturesCovered in FullNoneGia® Virtual CareCovered in FullNoneWellness Benefits\$600 allowanceGet reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being ReimbursementPlan HighlightsVisit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.Pediatric DentalPreventive, Routine, and Major (including medically-necessary orthodontia) - See Schedule of Benefits or better understand your MVP plan benefits.*** Preferred Provider FacilitiesLaboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Prescription Drug Coverage			
Tier 2Pharm: \$70 copay/Mail: \$175 copay30 day retail/90 day mail orderTier 3Pharm: \$70 copay/Mail: \$175 copay30 day retail/90 day mail orderPrescription Drug DeductibleNoneNoneVision CareNoneNoneAdult Vision CareNot coveredNonePediatric Vision Care\$25 copay*One exam per 12-month periodOther Plan FeaturesCovered in FullNoneGia® Virtual CareCovered in FullNoneWellness BenefitsS600 allowanceGet reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being ReimbursementPlan HighlightsVisit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.Pediatric DentalPreventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.+*Defeared Provider FacilitiesLaboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Tier 1	Pharm: \$10 copay/Mail: \$25 copay	30 day retail/90 day mail order	
Tier 3     None       Prescription Drug Deductible     None       Vision Care     None       Adult Vision Care     Not covered       Adult Vision Care     None       Pediatric Vision Care     Not covered       State     None       Other Plan Features     One       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 myphealthcare.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.       transferred Provider Facilities     Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Tier 2	Pharm: \$35 copay/Mail: \$87.50 copay	30 day retail/90 day mail order	
Prescription Drug Deductible       Vision Care       Not covered       None         Adult Vision Care       Not covered       None         Pediatric Vision Care       \$25 copay*       One exam per 12-month period         Other Plan Features       Image: Covered in Full       None         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 myphealthcare.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.         Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Tier 3	Pharm: \$70 copay/Mail: \$175 copay	30 day retail/90 day mail order	
Adult Vision Care       Not covered       None         Pediatric Vision Care       \$25 copay*       One exam per 12-month period         Other Plan Features       Image: Covered in Full       None         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 myphealthcare.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.         trepreferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Prescription Drug Deductible	None	None	
Pediatric Vision Care       \$25 copay*       One exam per 12-month period         Other Plan Features       Covered in Full       None         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.         transferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Vision Care			
Other Plan Features       Covered in Full       None         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.         t*Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Adult Vision Care	Not covered	None	
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 myphealthcare.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 metally-necessary orthodontia) – See Schedule of Benefits for cost Share Details. Services can be obtained provider.         transferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Pediatric Vision Care	\$25 copay*	One exam per 12-month period	
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 myphealthcare.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 metally-necessary orthodontia) – See Schedule of Benefits for cost Share Details. Services can be obtained provider.         transferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Other Plan Features			
Wellness Benefits       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.         ttPreferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after		Covered in Full	None	
Plan Highlights       Visit myphealthcare.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	Wellness Benefits	\$600 allowance		
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	Plan Highlights			
Pediatric DentalPreventive, 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 FacilitiesLaboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after				
	Pediatric Dental	Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for		
	**Preferred Provider Facilities			

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