New York
**Plan Name:** MVP POS
**Plan Form:** NY-POS-DP-001-S (2025)
**Plan Status:** Active

| | Coverage Information | | Limits and Exclusions |
|---|---|---|---|
| **Plan Cost-Sharing Highlights** | **In-Network** | **Out-of-Network** | |
| Annual Deductible per Contract Year | $0 Person/$0 Family - Embedded | $1,000 Person/$2,000 Family | None |
| Co-insurance | As Noted Below | 20% Person/20% Family | None |
| Annual Out-of-Pocket Maximum | $2,000 Person/$4,000 Family - Embedded | $3,000 Person/$5,000 Family | None |
| Primary Care Physician Office Visits | $15 copay | Not covered | None |
| Specialist Office Visits | $35 copay | 20% coinsurance* | None |
| **Preventive & Well Care Services** | **In-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: $15 copay/Spec: $35 copay | Not covered/ Spec: 20% coinsurance* | None |
| Diagnostic X-ray | PCP: $35 copay/Spec: $35 copay | Not covered/ Spec: 20% coinsurance* | None |
| Advanced Imaging Services (CT/PET scans, MRIs) | Spec: $35 copay/Free-Stnd: $35 copay | Spec: 20% coinsurance*/ Free-Stnd: 20% coinsurance* | None |
| Rehabilitative Services (PT/OT/ST) | $25 copay | 20% coinsurance* | 60 visits per condition, per Plan Year combined therapies |
| Allergy Services | $35 copay | 20% coinsurance* | None |
| Chemotherapy Visit | $15 copay | 20% coinsurance* | None |
| **Inpatient Services - Hospital** | **In-Network** | **Out-of-Network** | |
| Medical/Surgical Admissions | $500 copay | 20% coinsurance* | per continuous confinement |
| Surgical Services | $100 copay | 20% coinsurance* | None |
| Inpatient Physical Rehabilitation | $500 copay | 20% coinsurance* | 60 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) | $25 copay | 20% coinsurance* | 60 visits per condition/year combined therapies |
| Diagnostic Laboratory Services | $35 copay | 20% coinsurance* | None |
| Diagnostic X-ray | $35 copay | 20% coinsurance* | None |
| Advanced Imaging Services (CT/PET, scans, MRIs) | $35 copay | 20% coinsurance* | None |
| Ambulatory/Outpatient Surgery | $100 copay | 20% coinsurance* | None |
| **Emergency Care** | **In-Network** | **Out-of-Network** | |
| Emergency Room (ER) Visit | $100 copay | $100 copay | None |
| Urgent Care Centers | $55 copay | 20% coinsurance* | None |
| Ambulance (Emergency Medical Transportation) | $100 copay | 20% coinsurance* | None |
| **Maternity Services** | **In-Network** | **Out-of-Network** | |
| Maternity – Prenatal Care | Covered in Full | 20% coinsurance* | None |
| Maternity – Physician Delivery | $100 copay | 20% coinsurance* | None |
| Maternity – Inpatient Hospital Services | $500 copay | 20% coinsurance* | None |
| **Behavioral Health Services** | **In-Network** | **Out-of-Network** | |
| Mental Health Inpatient Hospital | $500 copay | 20% coinsurance* | Including residential treatment |
| Mental Health Outpatient | $15 copay | 20% coinsurance* | None |
| Substance Use Disorder Inpatient Hospital | $500 copay | 20% coinsurance* | Including residential treatment |
| Substance Use Disorder Outpatient | $15 copay | 20% coinsurance* | Unlimited; Up to 20 visits per calendar year may be used for family counseling |
| Residential Treatment | $500 copay | 20% coinsurance* | None |
| **Other Services** | **In-Network** | **Out-of-Network** | |
| Physician Administered Drugs | $15 copay | 20% coinsurance* | None |
| Skilled Nursing Facility | $500 copay | 20% coinsurance* | 200 days per plan year |
| Home Health Care | $15 copay | 20% coinsurance* | 40 Visits per Plan Year |
| Hospice | Inpt: $500 copay / Outpt: $15 copay | Inpt: 20% coinsurance*/Outpt: 20% coinsurance* | 210 days per plan year, 5 visits for family bereavement counseling |
| Durable Medical Equipment | 10% coinsurance | 20% coinsurance* | standard equipment covered |

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| | | | |
|---|---|---|---|
| Diabetic Supplies & Equipment | $15 copay | 20% coinsurance* | Diabetic Insulin Covered in full In Network |
| Chiropractic Benefit | $35 copay | 20% coinsurance* | None |
| Acupuncture | Not covered | Not covered | None |

| | Coverage Information | | Limits and Exclusions |
|---|---|---|---|
| **Prescription Drug Coverage** | **In-Network** | **Out-of-Network** | |
| Tier 1 | Pharm: $10 copay/Mail: $25 copay | See available Riders | 30 day retail/90 day mail order |
| Tier 2 | Pharm: $30 copay/Mail: $75 copay | See available Riders | 30 day retail/90 day mail order |
| Tier 3 | Pharm: $60 copay/Mail: $150 copay | See available Riders | 30 day retail/90 day mail order |
| Prescription Drug Deductible | None | None | None |
| **Vision Care** | **In-Network** | **Out-of-Network** | |
| Adult Vision Care | Not covered | Not covered | None |
| Pediatric Vision Care | $15 copay | 20% coinsurance* | One exam per 12-month period |
| **Other Plan Features** | **In-Network** | **Out-of-Network** | |
| Gia® Virtual Care | Covered in Full | 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. | | |

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**