



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

\*Deductible applies to this benefit

**New York**  
**Plan Name:** MVP Premier Gold 1  
**Plan Form:** NY-HMO-DG-001-S (2025)  
**Plan Status:** Active



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	\$1,000 copay*	Including residential treatment
<b>Mental Health Outpatient</b>	\$25 copay*	None
<b>Substance Use Disorder Inpatient Hospital</b>	\$1,000 copay*	Including residential treatment
<b>Substance Use Disorder Outpatient</b>	\$25 copay*	Unlimited; Up to 20 visits per plan year may be used for family counseling
<b>Residential Treatment</b>	\$1,000 copay*	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	\$25 copay*	None
<b>Skilled Nursing Facility</b>	\$1,000 copay*	200 days per plan year
<b>Home Health Care</b>	\$25 copay*	40 visits per year
<b>Hospice</b>	Inpt: \$1,000 copay* / Outpt: \$25 copay*	210 days per plan year, 5 visits for family bereavement counseling
<b>Durable Medical Equipment</b>	20% coinsurance*	standard equipment covered
<b>Diabetic Supplies &amp; Equipment</b>	\$25 copay*	Diabetic Insulin Covered in full In Network
<b>Chiropractic Benefit</b>	\$40 copay*	None
<b>Acupuncture</b>	Not covered	None
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	Pharm: \$10 copay/Mail: \$25 copay	30 day retail/90 day mail order
<b>Tier 2</b>	Pharm: \$35 copay/Mail: \$87.50 copay	30 day retail/90 day mail order
<b>Tier 3</b>	Pharm: \$70 copay/Mail: \$175 copay	30 day retail/90 day mail order
<b>Prescription Drug Deductible</b>	None	None
<b>Vision Care</b>		
<b>Adult Vision Care</b>	Not covered	None
<b>Pediatric Vision Care</b>	\$25 copay*	One exam per 12-month period
<b>Other Plan Features</b>		
<b>Gia® Virtual Care</b>	Covered in Full	None
<b>Wellness Benefits</b>	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement
<b>Plan Highlights</b>	Visit <a href="http://mvphealthcare.com">mvphealthcare.com</a> 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](http://mvphealthcare.com).

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