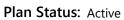
**New York** 

Plan Name: MVP Premier Plus Gold 2 HDHP Plan Form: NY-HMOH-DG-002-N (2025)





Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$1,650 Person/\$3,300 Family - Aggregate	None
		M
Co-insurance	As Noted Below \$6,900 Person/\$13,800 Family - Embedded	None None
Annual Out-of-Pocket Maximum	\$0,300 Person/\$13,000 Family - Embedded	None
Primary Care Physician Office Visits	\$5 copay*	None
Specialist Office Visits	\$25 copay*	None
Preventive & Well Care Services		
Well Child Care & Immunizations		
Adult Annual Physical (One per Contract Year)	Covered in Full.	
Mammography	For a full list of covered preventive care	
Annual Pap Test & Ob/Gyn Exam	services, visit	None
Immunizations for Adults	mvphealthcare.com.	
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits	DCD: \$5 consult (Cross \$25 consult)	None
Diagnostic Laboratory Services	PCP: \$5 copay*/Spec: \$25 copay*	None
Diagnostic X-ray	PCP: \$5 copay*/Spec: \$25 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: \$125 copay*/Free-Stnd: \$125 copay*	None
	\$2E conqu*	54 visits per condition, per Plan Year combined
	\$25 copay*	
Rehabilitative Services (PT/OT/ST)		therapies
	\$25 copay*	Cost share dependent on location of services
Allergy Services		
Chemotherapy Visit	\$25 copay*	None
Inpatient Services - Hospital	\$400 copay*	Per continuous confinement
Medical/Surgical Admissions	3400 сорау	rer continuous commentent
	\$100 copay*	None
Surgical Services		
Inpatient Physical Rehabilitation	\$400 copay*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	\$25 copay*	54 visits per condition/year combined therapie
Diagnostic Laboratory Services **	\$25 copay*	None
Diagnostic X-ray **	\$25 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	\$125 copay*	None
Ambulatory/Outpatient Surgery **	\$100 copay*	None
Emergency Care		
Emergency Room (ER) Visit	\$75 copay*	None
Urgent Care Centers	\$25 copay*	None
Ambulance (Emergency Medical Transportation)	\$75 copay*	None
Maternity Services		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	\$100 copay*	None
	\$400 copay*	None
Maternity – Inpatient Hospital Services		

**New York** 

**Plan Name:** MVP Premier Plus Gold 2 HDHP **Plan Form:** NY-HMOH-DG-002-N (2025)

Plan Status: Active



	Coverage Information	Limits and Exclusions	
Behavioral Health Services			
Mental Health Inpatient Hospital	\$400 copay*	Including residential treatment	
Mental Health Outpatient	\$5 copay*	None	
Substance Use Disorder Inpatient Hospital	\$400 copay*	Including residential treatment	
Substance Use Disorder Outpatient	\$5 copay*	Unlimited; Up to 20 visits per calendar year may be used for family counseling	
Residential Treatment	\$400 copay*	None	
Other Services			
Physician Administered Drugs	20% coinsurance*	None	
Skilled Nursing Facility	\$400 copay*	200 days per plan year	
Home Health Care	\$25 copay*	60 visits per plan year	
Hospice	Inpt: \$400 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	\$5 copay*	Diabetic Insulin Covered in full In Network	
Chiropractic Benefit	\$25 copay*	None	
Acupuncture	50% coinsurance*	12 visits per plan year	
Prescription Drug Coverage	Pharm: \$5 copay*/Mail: \$12.50 copay*	30 day retail/90 day mail order; preventive drugs deductible	
Tier 1		waived	
Tier 2	Pharm: \$15 copay*/Mail: \$37.50 copay*	30 day retail/90 day mail order; preventive drugs deductible waived	
Tier 3	Pharm: \$25 copay*/Mail: \$62.50 copay*	30 day retail/90 day mail order; preventive drugs deductible waived	
Prescription Drug Deductible	Subject to annual deductible	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	0% coinsurance*	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.		
**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.