**New York**
**Plan Name:** POS
**Plan Form:** COC15+LGF (POSPS4LGF3)
**Plan Status:** Grandfathered

| | Coverage Information | | Limits and Exclusions |
|---|---|---|---|
| **Plan Cost-Sharing Highlights** | **In-Network** | **Out-of-Network** | |
| Annual Deductible per Contract Year | $0 Person/$0 Family | $250 Person/$500 Family | None |
| Co-insurance | As Noted Below | As Noted Below | None |
| Annual Out-of-Pocket Maximum | $0 Person/$0 Family | $2,500 Person/$5,000 Family | None |
| Primary Care Physician Office Visits | $15 copay | 30% coinsurance* | None |
| Specialist Office Visits | $15 copay | 30% coinsurance* | None |
| **Preventive & Well Care Services** | **In-Network** | **Out-of-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 | Covered in Full | PCP: 30% coinsurance*/<br>Spec: 30% coinsurance* | None |
| Diagnostic X-ray | PCP: $15 copay/Spec: $15 copay | PCP: 30% coinsurance*/<br>Spec: 30% coinsurance* | None |
| Advanced Imaging Services (CT/PET scans, MRIs) | Spec: $15 copay/Free-Stnd: $15 copay | Spec: 30% coinsurance*/<br>Free-Stnd: 30% coinsurance* | None |
| Rehabilitative Services (PT/OT/ST) | $15 copay | 30% coinsurance* | 30 combined PT/OT/ST visits per year |
| Allergy Services | $15 copay | 30% coinsurance* | None |
| Chemotherapy | $15 copay | 30% coinsurance* | None |
| **Inpatient Services - Hospital** | **In-Network** | **Out-of-Network** | |
| Medical/Surgical Admissions | Covered in Full | 30% coinsurance* | None |
| Surgical Services | Covered in Full | 30% coinsurance* | None |
| Inpatient Physical Rehabilitation | Covered in Full | 30% coinsurance* | None |

***Deductible applies to this benefit**

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|---|---|---|---|
| **Outpatient Hospital Services** | **In-Network** | **Out-of-Network** | |
| Hospital Rehab Services (PT/OT/ST) | $15 copay | 30% coinsurance* | None |
| Diagnostic Laboratory Services | Covered in Full | 30% coinsurance* | None |
| Diagnostic X-ray | $15 copay | 30% coinsurance* | None |
| Advanced Imaging Services (CT/PET, scans, MRIs) | $15 copay | 30% coinsurance* | None |
| Ambulatory/Outpatient Surgery | $15 copay | 30% coinsurance* | None |
| **Emergency Care** | **In-Network** | **Out-of-Network** | |
| Emergency Room (ER) Visit | $50 copay | $50 copay | None |
| Urgent Care Centers | $15 copay | 30% coinsurance* | None |
| Ambulance (Emergency Medical Transportation) | Covered in Full | 30% coinsurance* | None |
| **Maternity Services** | **In-Network** | **Out-of-Network** | |
| Maternity – Prenatal Care | $15 copay | 30% coinsurance* | None |
| Maternity – Physician Delivery | Covered in Full | 30% coinsurance* | None |
| Maternity – Inpatient Hospital Services | Covered in Full | 30% coinsurance* | None |
| **Behavioral Health Services** | **In-Network** | **Out-of-Network** | |
| Mental Health Inpatient Hospital | Covered in Full | 30% coinsurance* | None |
| Mental Health Outpatient | $15 copay | 30% coinsurance* | None |
| Substance Use Disorder Inpatient Hospital | Covered in Full | 30% coinsurance* | None |
| Substance Use Disorder Outpatient | $15 copay | 30% coinsurance* | 20 visits for family counseling |
| Residential Treatment | Covered in Full | 30% coinsurance* | None |
| **Other Services** | **In-Network** | **Out-of-Network** | |
| Skilled Nursing Facility | Covered in Full | 30% coinsurance* | 60 days per year |
| Home Health Care | $15 copay | 30% coinsurance* | 60 visits per year |
| Hospice | Covered in Full | Inpt: 30% coinsurance*/Outpt: 30% coinsurance* | 210 days per lifetime |
| Durable Medical Equipment | 20% coinsurance | 50% coinsurance | None |
| Diabetic Supplies & Equipment | $15 copay | 30% coinsurance* | None |
| Chiropractic Benefit | $15 copay | 30% coinsurance* | None |
| Acupuncture | Not covered | Not covered | None |

*Deductible applies to this benefit

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| | Coverage Information | | Limits and Exclusions |
|---|---|---|---|
| **Prescription Drug Coverage** | **In-Network** | **Out-of-Network** | |
| Tier 1 | Pharm: $5 copay/Mail: $12.50 copay | Not Covered | None |
| Tier 2 | Pharm: $20 copay/Mail: $50 copay | Not Covered | None |
| Tier 3 | Pharm: $40 copay/Mail: $100 copay | Not Covered | None |
| Prescription Drug Deductible | None | None | None |
| **Vision Care** | **In-Network** | **Out-of-Network** | |
| Adult Vision Care | $15 copay | Not covered | None |
| Pediatric Vision Care | $15 copay | Not covered | one exam every two years |
| **Other Plan Features** | **In-Network** | **Out-of-Network** | |
| Telemedicine Services | Covered in Full | Not covered | None |
| Wellness Benefits | Not covered | Not covered | None |
| Plan Highlights | Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits. | | |

MVP's $0 telemedicine services include emergency, urgent and primary care, as well as mental health and psychiatry. All from your smartphone, tablet, or computer. Access the tools, support, and resources you need at **mvphealthcare.com** or call the MVP Customer Care Center phone number listed on the back of your MVP Member ID card.

Telemedicine services from MVP Health Care are powered by Amwell, UCM Digital Health, and Physera. Virtual physical therapy through Physera is available on large group plans only. Regulatory restrictions may apply.

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**