

**New York**  
**Plan Name:** MVP EPO Silver 7  
**Plan Form:** NY-EPO-SS-007 (2025)  
**Plan Status:** Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
<b>Annual Deductible per Contract Year</b>	\$3,100 Person/\$6,200 Family - Embedded	None
<b>Co-insurance</b>	As Noted Below	None
<b>Annual Out-of-Pocket Maximum</b>	\$8,700 Person/\$17,400 Family - Embedded	None
<b>Primary Care Physician Office Visits</b>	\$35 copay	First 3 Combined PCP/MH/SA Visits Covered in None
<b>Specialist Office Visits</b>	\$50 copay*	
<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: \$35 copay/Spec: \$50 copay	None
<b>Diagnostic X-ray</b>	PCP: \$35 copay/Spec: \$50 copay*	None
<b>Advanced Imaging Services (CT/PET scans, MRIs)</b>	Spec: \$150 copay*/Free-Stnd: \$150 copay*	None
<b>Rehabilitative Services (PT/OT/ST)</b>	\$50 copay*	54 visits per condition, per Plan Year combined therapies
<b>Allergy Services</b>	\$50 copay*	Cost share dependent on location of services
<b>Chemotherapy Visit</b>	\$50 copay*	None
<b>Inpatient Services - Hospital</b>		
<b>Medical/Surgical Admissions</b>	\$750 copay*	Per continuous confinement
<b>Surgical Services</b>	\$150 copay*	None
<b>Inpatient Physical Rehabilitation</b>	\$750 copay*	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
<b>Hospital Rehab Services (PT/OT/ST)</b>	\$50 copay*	54 visits per condition/year combined therapies
<b>Diagnostic Laboratory Services **</b>	\$50 copay	None
<b>Diagnostic X-ray **</b>	\$50 copay*	None
<b>Advanced Imaging Services (CT/PET, scans, MRIs) **</b>	\$150 copay*	None
<b>Ambulatory/Outpatient Surgery **</b>	\$250 copay*	None
<b>Emergency Care</b>		
<b>Emergency Room (ER) Visit</b>	\$250 copay*	None
<b>Urgent Care Centers</b>	\$50 copay	None
<b>Ambulance (Emergency Medical Transportation)</b>	\$250 copay*	None
<b>Maternity Services</b>		
<b>Maternity – Prenatal Care</b>	Covered in Full	None
<b>Maternity – Physician Delivery</b>	\$150 copay*	None
<b>Maternity – Inpatient Hospital Services</b>	\$750 copay*	None

\*Deductible applies to this benefit

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<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	\$750 copay*	Including residential treatment
<b>Mental Health Outpatient</b>	\$35 copay	First 3 Combined PCP/MH/SA Visits Covered in Full
<b>Substance Use Disorder Inpatient Hospital</b>	\$750 copay*	Including residential treatment
<b>Substance Use Disorder Outpatient</b>	\$35 copay	First 3 Combined PCP/MH/SA Visits Covered in Full.
<b>Residential Treatment</b>	\$750 copay*	Unlimited; Up to 20 visits per plan year may be used for None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	20% coinsurance*	None
<b>Skilled Nursing Facility</b>	\$750 copay*	200 days per plan year
<b>Home Health Care</b>	\$50 copay*	60 visits per year
<b>Hospice</b>	Inpt: \$750 copay* / Outpt: \$50 copay*	210 days per plan year, 5 visits for family bereavement counseling
<b>Durable Medical Equipment</b>	50% coinsurance*	Standard equipment covered
<b>Diabetic Supplies &amp; Equipment</b>	\$35 copay	Diabetic Insulin Covered in full In Network
<b>Chiropractic Benefit</b>	\$50 copay*	None
<b>Acupuncture</b>	50% coinsurance*	12 visits per plan year
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	Pharm: \$15 copay/Mail: \$37.50 copay	30 day retail/90 day mail order
<b>Tier 2</b>	Pharm: \$45 copay/Mail: \$112.50 copay	30 day retail/90 day mail order
<b>Tier 3</b>	Pharm: \$90 copay/Mail: \$225 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>	\$50 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.	
<b>Pediatric Dental</b>	Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. <i>Services can be obtained from any licensed provider.</i>	
<b>**Preferred Provider Facilities</b>	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 <a href="http://mvphealthcare.com">mvphealthcare.com</a> .	

Gia virtual care services are available at no member cost-share for medical plans, including qualified high-deductible health plans (QHDHPs), upon enrollment and plan renewal in 2023. Members enrolled in a 2022 QHDHP must meet the plan's annual deductible before Gia services are available at no member cost share.

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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