New York
Plan Name: MVP Premier Plus HDHP Gold 2
Plan Form: NY-HMOH-DG-002-N (2016)
Plan Status: Active

MVP Premier Plus HDHP Gold 2	COVERAGE INFORMATION
Plan Cost-Sharing Highlights	
Annual Deductible	$1,400 Person/$2,800 Family - Aggregate
Coinsurance	As Noted Below
Annual Out-of-Pocket Maximum	$6,350 Person/$12,700 Family - Embedded
Primary Care Physician Office Visits	$5 copay*
Specialist Office Visits	$15 copay*
Preventive & Well Care Services	
Well Child Care & Immunizations	Covered in Full For a full list of covered preventive care services, visit www.mvphealthcare.com
Adult Annual Physical	
Mammography	
Annual Pap Test & Ob/Gyn Exam	
Immunizations for Adults	
Colonoscopy/Sigmoidoscopy Screening	
Bone Density Tests	
Physician Office Services	
Diagnostic Laboratory Services	PCP: $5 copay*/Spec: $15 copay*
Diagnostic X-ray	PCP: $5 copay*/Spec: $15 copay*
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $75 copay*/Free-Stnd: $75 copay*
Rehabilitative Services (PT/OT/ST)	$15 copay*
Allergy Services	$15 copay*
Chemotherapy	$15 copay*
Inpatient Services - Hospital	
Medical/Surgical Admissions	$200 copay*
Surgical Services	$25 copay*
Inpatient Physical Rehabilitation	$200 copay*
Outpatient Hospital Services	
Hospital Rehab Services (PT/OT/ST)	$15 copay*
Diagnostic Laboratory Services	$15 copay*
Diagnostic X-ray	$15 copay*
Advanced Imaging Services (CT/PET scans, MRIs)	$75 copay*
Ambulatory/Outpatient Surgery	$100 copay*
Emergency Care	
Emergency Room (ER) Visit	$75 copay*
Urgent Care Centers	$15 copay*
Ambulance (Emergency Medical Transportation)	$75 copay*
Behavioral Health Services	
Mental Health Inpatient Hospital	$200 copay*
Mental Health Outpatient	$5 copay*
Substance Abuse Inpatient Hospital	$200 copay*
Substance Abuse Outpatient	$5 copay*
Residential Treatment	$200 copay*
Psychiatry Office Visits	$5 copay*

*** Denotes that a deductible applies to this benefit**

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MVP Premier Plus HDHP Gold 2	COVERAGE INFORMATION
Maternity Services	
Prenatal Office Visit	Covered in Full
Physician Delivery	$25 copay*
Inpatient Hospital Services	$200 copay*
Other Services	
Skilled Nursing Facility	$200 copay*
Home Health Care	$15 copay*
Hospice	Inpt: $200 copay* / Outpt: $15 copay*
Durable Medical Equipment	50% coinsurance*
Diabetic Supplies & Equipment	$5 copay*
Chiropractic Benefit	$15 copay*
Prescription Coverage	
Tier 1	Pharm: $5 copay*/Mail: Not covered
Tier 2	Pharm: $15 copay*/Mail: Not covered
Tier 3	Pharm: $25 copay*/Mail: Not covered
Prescription Drug Deductible	Subject to annual deductible
Vision Care	
Adult Vision Care	Not covered
Pediatric Vision Care	$15 copay*
Other Plan Features	
Wellness Benefits	$125 allowance
Plan Highlights	Acupuncture, preventive drugs no ded, $1,000 out of area coverage for dependents, and domestic partner

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