

**New York**  
**Plan Name:** NY1HMO008ZL  
**Plan Status:** Pending  
**Plan Effective Date:** 1/1/2015

**Pending Approval  
by the New York State  
Department of  
Financial Services**



<b>PLAN NAME</b>	<b>COVERAGE INFORMATION</b>
<b>Plan Cost-Sharing Highlights</b>	
<b>Annual Deductible</b>	\$0 Person/\$0 Family - Embedded
<b>Coinsurance</b>	As Noted Below
<b>Annual Out-of-Pocket Maximum</b>	\$4,600 Person/\$9,200 Family
<b>Primary Care Physician Office Visits</b>	\$25 copay
<b>Specialist Office Visits</b>	\$40 copay
<b>Preventive &amp; Well Care Services</b>	
<b>Well Child Care &amp; Immunizations</b>	Covered in Full For a full list of covered preventive care services, visit <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a>
<b>Adult Annual Physical</b>	
<b>Mammography</b>	
<b>Prostate Cancer Screening</b>	
<b>Annual Pap Test &amp; Ob/Gyn Exam</b>	
<b>Immunizations for Adults</b>	
<b>Colonoscopy/Sigmoidoscopy Screening</b>	
<b>Bone Density Tests</b>	
<b>Physician Office Services</b>	
<b>Diagnostic Laboratory Services</b>	Covered in full
<b>Diagnostic X-ray</b>	PCP: \$25 copay/Spec: \$40 copay
<b>Advanced Imaging Services</b> (CT/PET scans, MRIs)	PCP: \$25 copay/Spec: \$40 copay
<b>Rehabilitative Services</b> (PT/OT/ST)	\$40 copay
<b>Allergy Services</b>	\$40 copay
<b>Chemotherapy</b>	\$25 copay
<b>Inpatient Services - Hospital</b>	
<b>Medical/Surgical Admissions</b>	\$250 copay
<b>Surgical Services</b>	\$100 copay
<b>Inpatient Physical Rehabilitation</b>	\$250 copay
<b>Outpatient Hospital Services</b>	
<b>Hospital Rehab Services</b> (PT/OT/ST)	\$40 copay
<b>Diagnostic Laboratory Services</b>	Covered in Full
<b>Diagnostic X-ray</b>	\$40 copay
<b>Advanced Imaging Services</b> (CT/PET scans, MRIs)	\$40 copay
<b>Ambulatory/Outpatient Surgery</b>	\$75 copay
<b>Emergency Care</b>	
<b>Emergency Room (ER) Visit</b>	\$100 copay
<b>Urgent Care Centers</b>	\$25 copay
<b>Ambulance</b> (Emergency Medical Transportation)	\$100 copay
<b>Behavioral Health Services</b>	
<b>Mental Health Inpatient Hospital</b>	\$250 copay
<b>Mental Health Outpatient</b>	\$25 copay
<b>Substance Abuse Inpatient Hospital</b>	\$250 copay
<b>Substance Abuse Outpatient</b>	\$25 copay
<b>Residential Treatment</b>	Covered in Full
<b>Psychiatry Office Visits</b>	\$40 copay

**\*Deductible applies to this benefit**

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<b>PLAN NAME</b>	<b>COVERAGE INFORMATION</b>
<b>Maternity Services</b>	
<b>Prenatal Care</b>	Covered in Full
<b>Physician Delivery</b>	\$200 copay
<b>Inpatient Hospital Services</b>	\$250 copay
<b>Other Services</b>	
<b>Skilled Nursing Facility</b>	Covered in Full
<b>Home Health Care</b>	\$25 copay
<b>Hospice</b>	Covered in full
<b>Durable Medical Equipment</b>	50% coinsurance
<b>Diabetic Supplies &amp; Equipment</b>	\$25 copay
<b>Chiropractic Benefit</b>	\$40 copay
<b>Prescription Coverage</b>	
<b>Tier 1</b>	See available Riders
<b>Tier 2</b>	See available Riders
<b>Tier 3</b>	See available Riders
<b>Prescription Drug Deductible</b>	None
<b>Vision Care</b>	
<b>Adult Vision Care</b>	\$40 copay
<b>Pediatric Vision Care</b>	\$40 copay
<b>Other Plan Features</b>	
<b>Wellness Benefits</b>	Not covered
<b>Plan Highlights</b>	\$2500 out of area for Dependent Students

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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, Schedule and any applicable Rider(s), your Certificate of Coverage, Schedule and Rider(s) will be controlling. For plan details, call **1-800-TALK-MVP (825-5687)** or visit **DiscoverMVP.com**.

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