



MVP Preferred EPO \$40

Summary of Benefits

New York

SERVICE CATEGORY ¹	COVERAGE INFORMATION ²
Annual Deductible per Contract Year	Not Applicable
Coinsurance	Not Applicable
Lifetime Maximum Benefit Payable	No Maximum (Except for DME/External Prosthetics/Ostomy Supplies Max)
Annual Out-of-Pocket Maximum	Not Applicable
Well-Child Care Services Per MVP Preventive Care Guidelines Adult Physical (One Routine Adult Physical/Contract Year) Screening Mammography, Pap Tests Physician Inpatient Care (Medical/Surgical) Laboratory Services Skilled Nursing Facility (60 Days/Contract Year)	Covered in Full
Hospital	
Hospital Inpatient	\$500 Copay
Hospital Outpatient Surgery	\$150 Copay
Emergency Room (ER) Visit	\$100 Copay/Visit
Ambulance	\$150 Copay
Physician Office Visits Office Surgery Diagnostic X-ray and Other Imaging Services³ Physical/Occupational/Speech Therapy (Office Setting) Requires Prescription 30 Visits/Contract Year Chiropractic Benefit Home Health Care (60 Visits/Contract Year)	\$40 Copay/Visit
High Tech Imaging Services³ (MRI, MRA, CT, etc.)	\$150 Copay (Office) \$300 Copay (Outpatient Facility)/Procedure
Maternity	
Physician Pre/Postnatal Care Office Visits ⁴	Covered in Full
Inpatient Services (facility/physician)	\$500 Copay
Initial Newborn Exam	Covered in Full
Mental Health^{5,6}	
Inpatient – 30 Days/Contract Year	\$500 Copay
Outpatient Office Visits {Up to 20 combined Visits per Contract Year}	\$40 Copay/Visit
Substance Abuse⁶	
Inpatient Detoxification – 7 Days/Contract Year	\$500 Copay
Outpatient Rehabilitation Office Visits {Up to 60 combined Visits per Contract Year}	\$40 Copay/Visit
Durable Medical Equipment (Lifetime Max Benefit \$25,000)	50% Copay
Dependent Care Coverage	Unmarried dependent children to age 23
<i>Standard coverage for small group plans, check with your employer for differences in dependent coverage.</i>	

¹Some services are subject to Notification or Prior Authorization requirements. See your Certificate of Coverage under How This Policy Works for details.

²A network provider must deliver all care.

³X-rays usually require two providers' services, one for taking the X-ray, the other for interpreting results. Payments for each may apply and are based on where the work was done.

⁴Primary Care Provider Office Visit Copay applies to the initial diagnostic visit only. Other services are covered as noted above.

⁵FOR SMALL GROUPS (2-50 employees): MVP offers an optional rider at additional cost that extends coverage for certain biologically based Mental Health conditions and for children with specific emotional disturbances. Please contact your Employer or the Member Services Department for additional information. To verify your group size, check with your Employer/Health Benefits Administrator or call 1-800-825-5687, option #2, and speak with an Account Representative.

⁶Mental Health and Substance Abuse day and visit limits apply only to small groups.

This Summary of Benefits chart 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, Schedules and Rider(s) will be controlling. For details, please call 1-800-TALK-MVP (1-800-825-5687), option #2.