## New York

Plan Name: MVP EPO Bronze 5 HDHP Plan Form: NY-EPOH-SB-005 (2025)

Plan Status: Active



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Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$6,500 Person/\$13,000 Family - Embedded	None
	FOOL Deveen (FOOL Ferrily	None
Co-insurance	50% Person/50% Family	
Annual Out-of-Pocket Maximum	\$7,250 Person/\$14,500 Family - Embedded	None
Primary Care Physician Office Visits	\$0 copay*	None
Specialist Office Visits	50% coinsurance*	None
Preventive & Well Care Services		
Well Child Care & Immunizations		
Adult Annual Physical (One per Contract Year)	Covered in Full.	
Mammography	For a full list of covered preventive care	N
Annual Pap Test & Ob/Gyn Exam Immunizations for Adults	services, visit	None
	mvphealthcare.com.	
Colonoscopy /Sigmoidoscopy Screening Bone Density Tests		
Physician Office Visits		
	PCP: \$0 copay*/Spec: 50% coinsurance*	None
Diagnostic Laboratory Services		None
Diagnostic X-ray	PCP: \$0 copay*/Spec: 50% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 50% coinsurance*/Free-Stnd: 50%	None
	coinsurance* 50% coinsurance*	54 visits per condition, per Plan Year combined
		therapies
Rehabilitative Services (PT/OT/ST)		
	50% coinsurance*	Cost share dependent on location of services
Allergy Services		
Chemotherapy Visit	50% coinsurance*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	50% coinsurance*	Per continuous confinement
	50% coinsurance*	None
Surgical Services		
Inpatient Physical Rehabilitation	50% coinsurance*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	50% coinsurance*	54 visits per condition/year combined therapies
Diagnostic Laboratory Services **	50% coinsurance*	None
Diagnostic X-ray <sup>++</sup>	50% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs) **	50% coinsurance*	None
Ambulatory/Outpatient Surgery **	50% coinsurance*	None
Emergency Care		
Emergency Room (ER) Visit	\$100 copay*	None
Urgent Care Centers	50% coinsurance*	None
Ambulance (Emergency Medical Transportation)	\$100 copay*	None
Maternity Services	_	
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	50% coinsurance*	None
Maternity – Inpatient Hospital Services	50% coinsurance*	None

## New York Plan Name: MVP EPO Bronze 5 HDHP Plan Form: NY-EPOH-SB-005 (2025) Plan Status: Active



Coverage Information         Limits and Exclusions           Behavioral Health Services         50% coinsurance*         Including residential treatment           Mental Health Outpatient Hospital         50% coinsurance*         Including residential treatment           Substance Use Disorder Inpatient Hospital         50% coinsurance*         Including residential treatment           Substance Use Disorder Outpatient         50% coinsurance*         None           Residential Treatment         50% coinsurance*         None           Other ServiceS         50% coinsurance*         None           Physician Administer Drugs         50% coinsurance*         None           Stilled Nursing Facility         50% coinsurance*         Sold coinsurance*           Physician Administer Drugs         50% coinsurance*         Sold coinsurance*           Sold coinsurance*         50% coinsurance*         Sold days per plan year.           Home Health Care         50% coinsurance*         Sold days per plan year.           Durable Medical Equipment         50% coinsurance*         None           Pasercertorion Drug Coverage         50% coinsurance*         None           Prescription Drug Coverage         Sold coinsurance*         Sold day retail/90 day mail order; preventive drugs deductible waived           Tier 3         Sold coinsurance*         <					
Mental Health Inpatient Hospital         50% coinsurance*         Including residential treatment           Substance Use Disorder Inpatient Hospital         50% coinsurance*         Including residential treatment           Substance Use Disorder Outpatient         50% coinsurance*         Unimited; Up to 20 visits per plan year may be used for family counseling           Residential Treatment         50% coinsurance*         None           Other Services         None           Physician Administered Drugs         50% coinsurance*         200 days per plan year           Soldical Administered Drugs         50% coinsurance*         200 days per plan year           Home Health Care         50% coinsurance*         200 days per plan year           Home Health Care         50% coinsurance*         Soldard equipment covered           Diabetic Supplies & Equipment         50% coinsurance*         Sondard equipment covered           Diabetic Supplies & Equipment         50% coinsurance*         None           Accupancture         50% coinsurance*         None           Prescription Drug Coverage         Parm: \$5 copay*/Mail: \$12.50 copay*         30 day retail/90 day mail order; preventive drugs deductible waived           Tre 2         Sold consurance*         Sold corsurance*         Sold corsurance*           Sold consurance*         Sold corsurance*         Sold coreta		Coverage Information	Limits and Exclusions		
Mental Health Inpatient Hospital         So copay         None           Substance Use Disorder Inpatient Hospital         So <sup>k</sup> coinsurance*         Including residential treatment           Substance Use Disorder Outpatient         So <sup>k</sup> coinsurance*         Unlimited; Up to 20 visits per plan year may be used for family counseling           Residential Treatment         So <sup>k</sup> coinsurance*         None           Other Services         Induction of the services         None           Physician Administered Drugs         So <sup>k</sup> coinsurance*         None           Subled Nursing Facility         So <sup>k</sup> coinsurance*         None           Stilled Nursing Facility         So <sup>k</sup> coinsurance*         60 visits per year           Durable Medical Equipment         So <sup>k</sup> coinsurance*         So <sup>k</sup> coinsurance*           Diabetic Supplies & Equipment         So <sup>k</sup> coinsurance*         None           Acquancture         So <sup>k</sup> coinsurance*         None           Tier 1         Part: S0 copay'/Mail: S12 S0 copay*         30 day retail/90 day mail order, preventive drugs deductible waived           Tier 2         So <sup>k</sup> coinsurance*         30 day retail/90	Behavioral Health Services				
Mental Health Outpatient         Soft Coinsurance*         Including residential treatment           Substance Use Disorder Outpatient         50 copay*         Unlimited: Up to 20 visits per plan year may be used for family counseling.           Residential Treatment         50% coinsurance*         None           Other Services         Physician Administered Drugs         50% coinsurance*         200 days per plan year           Skilled Nursing Facility         50% coinsurance*         200 days per plan year         50% coinsurance*           Home Health Care         50% coinsurance*         200 days per plan year         50% coinsurance*           Durable Medical Equipment         50% coinsurance*         210 days per plan year         50% coinsurance*           Diabetic Supplies & Equipment         50% coinsurance*         None         200 days per plan year           Prescription Drug Coverage         50% coinsurance*         None         200 days retail/90 day mail order; preventive drugs dedouctible waived           Tier 1         Pharm: \$30 copay*/Mail: \$12.50 copay*         30 day retail/90 day mail order; preventive drugs dedouctible waived           Tier 2         Soft coinsurance*         None         200 days retail/90 day mail order; preventive drugs dedouctible waived           Yision Care         Soft coinsurance*         None         200 day retail/90 day mail order; preventive drugs dedouctible waived	Mental Health Inpatient Hospital	50% coinsurance*	Including residential treatment		
Substance Use Disorder Impatient Hospital Substance Use Disorder Outpatient Substance Use Disorder Outpatient Solk coinsurance* Solk coinsurance* None Other Services Physician Administered Drugs Solk coinsurance* None Other Services Physician Administered Drugs Solk coinsurance* Standard equipment covered Solk coinsurance* Solk coinsurance* None Courseling Courseling Solk coinsurance* Standard equipment covered Solk coinsurance* Standard equipment covered Solk coinsurance* Standard equipment covered Solk coinsurance* None Courseling Prescription Drug Coverage Prescription Drug Coverage Pharm: S3 copay*/Mail: \$12.50 copay* Sol day retail/90 day mail order; preventive drugs deductible waived Solk coinsurance* Solk c	Mental Health Outpatient	\$0 copay*	None		
Substance Use Disorder Outpatient         family counseling           Residential Treatment         50% coinsurance*         None           Other Services         None         None           Physician Administered Drugs         50% coinsurance*         None           Sol% coinsurance         200 days per plan year         Sol% coinsurance*         200 days per plan year           Home Health Care         50% coinsurance*         200 days per plan year         Sol% coinsurance*           Durable Medical Equipment         50% coinsurance*         Standard equipment covered         Sol% coinsurance*           Diabetic Supplies & Equipment         50% coinsurance*         None         Sol% coinsurance*         None           Acquuncture         50% coinsurance*         None         Sol% coinsurance*         None           Tier 1         50% coinsurance*         None         Sol% coinsurance*         None           Tier 2         Pharm: \$20 copay*/Mail: \$12:50 copay*         30 day retail/90 day mail order; preventive drugs deductible waived           Vision Care         Sol% coinsurance*         30 day retail/90 day mail order; preventive drugs deductible waived           Vision Care         None         None         None           Pediativ Kision Care         Sol% coinsurance*         One exam per 12-month period      <	Substance Use Disorder Inpatient Hospital	50% coinsurance*	Including residential treatment		
Residencial freatment         Mone           Other Services         None           Skilled Nursing Facility         50% coinsurance*         200 days per plan year           Home Health Care         50% coinsurance*         200 days per year           Home Health Care         50% coinsurance*         200 days per year           Durable Medical Equipment         50% coinsurance*         200 days per plan year, 5 visits for family bereavement courseling           Durable Medical Equipment         50% coinsurance*         Standard equipment covered           Diabetic Supplies & Equipment         50% coinsurance*         None           Accupancture         50% coinsurance*         None           Accupancture         50% coinsurance*         None           Prescription Drug Coverage         12 visits per plan year           Tier 1         Pharm: \$5 copay*/Mail: \$12.50 copay*         30 day retail/90 day mail order; preventive drugs deductible waived           Tier 2         So% coinsurance*         30 day retail/90 day mail order; preventive drugs deductible waived           Vision Care         None         None           Prescription Drug Deductible         Subject to annual deductible         None           Vision Care         Not covered         None           Pediatric Vision Care         50% coinsurance*	Substance Use Disorder Outpatient	\$0 copay*			
Physician Administered Drugs         5% coinsurance*         None           Skilled Nursing Facility         5% coinsurance*         200 days per plan year, 5 visits for family bereavement. Counseling           Hong Heatth Care         5% coinsurance*         201 days per plan year, 5 visits for family bereavement. Counseling           Duable Medical Equipment         5% coinsurance*         201 days per plan year, 5 visits for family bereavement. Counseling           Diabetic Supplies & Equipment         5% coinsurance*         None           Acquancture         5% coinsurance*         None           Acquancture         5% coinsurance*         None           Acquancture         5% coinsurance*         None           Argunet Covered in full In Network         20 days per plan year, 5 visits for family bereavement.           Firescription Drug Coverage         None         20 days per plan year.           Tier 1         5% coinsurance*         None           Tier 2         Pharm: \$20 copay*/Mail: \$75 copay*         30 day retai/90 day mail order; preventive drugs deductible waived           Fire 3         Sy coinsurance*         None         None           Vision Care         None         None         None           Vision Care         None         None         None           Other Plan Features         Sind coinsur	Residential Treatment	50% coinsurance*	None		
Skilled Nursing Facility     50% coinsurance*     200 days per plan year       Home Health Care     50% coinsurance*     60 visits per year       Hospice     50% coinsurance*     210 days per plan year, 5 visits for family bereavement counseling       Durable Medical Equipment     50% coinsurance*     Standard equipment covered       Diabetic Supplies & Equipment     50% coinsurance*     None       Acupuncture     50% coinsurance*     None       Acupuncture     50% coinsurance*     None       Prescription Drug Coverage     Visits per plan year       Tier 1     Pharm: \$5 copay*/Mail: \$12.50 copay*     30 day retail/90 day mail order; preventive drugs deductible waived       Tier 2     S0% coinsurance*     30 day retail/90 day mail order; preventive drugs deductible waived       Yision Care     S0% coinsurance*     30 day retail/90 day mail order; preventive drugs deductible waived       Vision Care     Not covered     None       Adult Vision Care     Not covered     None       Other Plan Features     S0% coinsurance*     None       Gias Virtual Care     0% coinsurance*     None       Visit myphealthcare.com for more informAtion Myr's Well-Being Reimbursement     Yiser care information. Wise water complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.       Preventive Routine, and Major (including medicalary envider, Earlitips     Visit myphealt	Other Services				
Home Health Care       50% coinsurance*       60 visits per year         Hospice       50% coinsurance*       210 days per plan year, 5 visits for family bereavement counseling         Durable Medical Equipment       50% coinsurance*       Standard equipment covered         Diabetic Supplies & Equipment       50% coinsurance*       None         Chiropractic Benefit       50% coinsurance*       None         Acupuncture       50% coinsurance*       12 visits per plan year         Prescription Drug Coverage       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 1       Pharm: \$50 copay*/Mail: \$12.50 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 2       So% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Prescription Drug Deductible       Subject to annual deductible       None         Vision Care       Subject to annual deductible       None         Vision Care       Subject to annual deductible       None         Glas Virtual Care       O% coinsurance*       One exam per 12-month period         Other Plan Features       Subject to annual deductible       None         Glas Virtual Care       O% coinsurance*       None         Visit myphealthcare.com for more information. View a complete Glosay of Terms and Member FAQs to	Physician Administered Drugs	50% coinsurance*	None		
Hospice       50% coinsurance*       210 days per plan year, 5 visits for family bereavement counseling         Durable Medical Equipment       50% coinsurance*       Standard equipment covered         Diabetic Supplies & Equipment       50% coinsurance*       None         Acupancture       50% coinsurance*       None         Acupancture       50% coinsurance*       None         Prescription Drug Coverage       I2 visits per plan year, preventive drugs deductible waived         Tier 1       Pharm: \$5 copay*/Mail: \$12.50 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 2       S0% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 3       50% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Vision Care       S0% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Vision Care       Not covered       None         Adult Vision Care       S0% coinsurance*       0 ne exam per 12-month period         Gia® Virtual Care       0% coinsurance*       None         Gia® Virtual Care       0% coinsurance*       None         Gia® Virtual Care       0% coinsurance*       None         Visit mythealthcare.com for more information. View a complete Glossary of Terms and Member FAQs t	Skilled Nursing Facility	50% coinsurance*	200 days per plan year		
Hospice       counseling         Durable Medical Equipment       50% coinsurance*       Standard equipment covered         Diabetic Supplies & Equipment       50 copay*       Diabetic Insulin Covered in full In Network         Chiropractic Benefit       50% coinsurance*       None         Acupuncture       50% coinsurance*       12 visits per plan year         Prescription Drug Coverage       Pharm: \$5 copay*/Mail: \$12.50 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 1       Pharm: \$30 copay*/Mail: \$75 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 2       So% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Prescription Drug Deductible       So% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Vision Care       Subject to annual deductible       None       None         Pediatric Vision Care       None       One exam per 12-month period       Other Plan Features         Gia® Virtual Care       0% coinsurance*       None       Seb0 allowance       Get reimbursed up to 5600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit myphealthcare.com for more information. View a complete Glosary of Terms and Member FAQs to better understand your MVP plan benefits.       Preventive, Routine, and	Home Health Care	50% coinsurance*	60 visits per year		
Hospice       counseling         Durable Medical Equipment       50% coinsurance*       Standard equipment covered         Diabetic Supplies & Equipment       50 copay*       Diabetic Insulin Covered in full In Network         Chiropractic Benefit       50% coinsurance*       None         Acupuncture       50% coinsurance*       12 visits per plan year         Prescription Drug Coverage       Pharm: \$5 copay*/Mail: \$12.50 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 1       Pharm: \$30 copay*/Mail: \$75 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 2       So% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Prescription Drug Deductible       So% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Vision Care       Subject to annual deductible       None       None         Pediatric Vision Care       None       One exam per 12-month period       Other Plan Features         Gia® Virtual Care       0% coinsurance*       None       Seb0 allowance       Get reimbursed up to 5600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit myphealthcare.com for more information. View a complete Glosary of Terms and Member FAQs to better understand your MVP plan benefits.       Preventive, Routine, and		50% coinsurance*	210 days per plan year, 5 visits for family bereavement		
Durable Medical Equipment         50% coinsurance*         Standard equipment covered           Diabetic Supplies & Equipment         50 copay*         Diabetic Insulin Covered in full In Network           Chiropractic Benefit         50% coinsurance*         None           Acupuncture         50% coinsurance*         12 visits per plan year           Prescription Drug Coverage         2000 and an and an analysis of a standard equipment covered in full In Network           Tier 1         Pharm: \$5 copay*/Mail: \$12.50 copay*         30 day retail/90 day mail order; preventive drugs deductible waived           Tier 2         Pharm: \$30 copay*/Mail: \$75 copay*         30 day retail/90 day mail order; preventive drugs deductible waived           Tier 3         50% coinsurance*         30 day retail/90 day mail order; preventive drugs deductible waived           Vision Care         Subject to annual deductible         None           Vision Care         Not covered         None           Gia® Virtual Care         0% coinsurance*         One exam per 12-month period           Other Plan Features         Stoo ansurance*         None           Gia® Virtual Care         0% coinsurance*         None           Wellness Benefits         Stoo ansurance*         None           Gia® Virtual Care         0% coinsurance*         None           Gia® Virtual Care	Ноѕрісе				
Diabetic Supplies & Equipment         \$0 copay*         Diabetic Insulin Covered in full In Network           Chiropractic Benefit         50% coinsurance*         None           Acupuncture         50% coinsurance*         12 visits per plan year           Prescription Drug Coverage         Visits per plan year         Visits per plan year           Tier 1         Pharm: \$5 copay*/Mail: \$12.50 copay*         30 day retail/90 day mail order; preventive drugs deductible waived           Tier 2         Pharm: \$30 copay*/Mail: \$75 copay*         30 day retail/90 day mail order; preventive drugs deductible waived           Tier 3         S0% coinsurance*         30 day retail/90 day mail order; preventive drugs deductible waived           Vision Care         S0% coinsurance*         30 day retail/90 day mail order; preventive drugs deductible waived           Vision Care         S0% coinsurance*         None           Pediatric Vision Care         Not covered         None           Other Plan Features         S0% coinsurance*         One exam per 12-month period           Other Plan Features         S0% coinsurance*         None           Gia* Virtual Care         9% coinsurance*         None           Vealiness Benefits         Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.           Plan Highlights	Durable Medical Equipment	50% coinsurance*			
Acupuncture       50% coinsurance*       12 visits per plan year         Prescription Drug Coverage       Pharm: \$5 copay*/Mail: \$12.50 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 1       Pharm: \$30 copay*/Mail: \$75 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 2       S0% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 3       S0% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Vision Care       Subject to annual deductible       None         Vision Care       None       One exam per 12-month period         Other Plan Features       S600 allowance       None         Gia Virtual Care       None       S600 allowance       Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit mwphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.       View a complete Glossary of the soft of any vice.sast or worder.         Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for cost Share Details. Services can be obtained from any lice.sesary orthodontia) – See Schedule of Benefits for cost Share Details. Services can be obtained from any lice.sesary orthodontia) – See Schedule of Benefits for cost Share Details. Services can be ob					
Prescription Drug Coverage       Pharm: \$5 copay*/Mail: \$12.50 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 1       Pharm: \$30 copay*/Mail: \$12.50 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 2       Pharm: \$30 copay*/Mail: \$75 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 3       50% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Prescription Drug Deductible       Subject to annual deductible       None         Vision Care       Not covered       None         Adult Vision Care       50% coinsurance*       One exam per 12-month period         Other Plan Features       0% coinsurance*       None         Gia® Virtual Care       0% coinsurance*       None         Wellness Benefits       Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         ** Drefered Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Chiropractic Benefit	50% coinsurance*	None		
Prescription Drug Coverage       So day retail/90 day mail order; preventive drugs deductible waived         Tier 1       Pharm: \$5 copay*/Mail: \$12.50 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 2       Pharm: \$30 copay*/Mail: \$75 copay*       30 day retail/90 day mail order; preventive drugs deductible waived         Tier 3       50% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Prescription Drug Deductible       50% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Vision Care       Subject to annual deductible       None         Pediatric Vision Care       Not covered       None         Gia® Virtual Care       0% coinsurance*       One exam per 12-month period         Other Plan Features       9% coinsurance*       None         Gia® Virtual Care       0% coinsurance*       None         Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services are be obtained from any licensed provider.         Plan Highlights       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.	Acupuncture	50% coinsurance*	12 visits per plan year		
Tier 1Pharm: \$5 copay*/Mail: \$12.50 copay*30 day retail/90 day mail order; preventive drugs deductible waivedTier 2Pharm: \$30 copay*/Mail: \$75 copay*30 day retail/90 day mail order; preventive drugs deductible waivedTier 350% coinsurance*30 day retail/90 day mail order; preventive drugs deductible waivedPrescription Drug Deductible50% coinsurance*30 day retail/90 day mail order; preventive drugs deductible waivedVision CareSubject to annual deductibleNoneAdult Vision CareNot coveredNonePediatric Vision Care50% coinsurance*One exam per 12-month periodOther Plan Features0% coinsurance*NoneGia® Virtual Care0% coinsurance*NoneWellness Benefits\$600 allowanceGet reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being ReimbursementPlan HighlightsVisit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.Pediatric DentalCost Share Details. Services can be obtained from any licensed provider."typefered Provider FacilitiesLaboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Prescription Drug Coverage				
Tier 1deductible waivedTier 2Pharm: \$30 copay*/Mail: \$75 copay*30 day retail/90 day mail order; preventive drugs deductible waivedTier 350% coinsurance*30 day retail/90 day mail order; preventive drugs deductible waivedPrescription Drug Deductible50% coinsurance*30 day retail/90 day mail order; preventive drugs deductible waivedVision CareSubject to annual deductibleNonePediatric Vision Care50% coinsurance*NoneAdult Vision Care50% coinsurance*One exam per 12-month periodOther Plan Features0% coinsurance*NoneGia® Virtual Care0% coinsurance*NoneWellness Benefits\$600 allowanceGet reimbursed up to \$600 per contract, per calendar year 		Pharm: \$5 conay*/Mail: \$12.50 conay*	30 day retail/90 day mail order: preventive drugs		
Tier 2       deductible waived         Tier 3       50% coinsurance*       30 day retail/90 day mail order; preventive drugs deductible waived         Prescription Drug Deductible       Subject to annual deductible       None         Vision Care       Subject to annual deductible       None         Adult Vision Care       Not covered       None         Pediatric Vision Care       50% coinsurance*       One exam per 12-month period         Other Plan Features       0% coinsurance*       None         Gia® Virtual Care       0% coinsurance*       None         Wellness Benefits       0% coinsurance*       None         Plan Highlights       Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         ***Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Tier 1				
Tier 3       deductible waived         Prescription Drug Deductible       Subject to annual deductible       None         Vision Care       Adult Vision Care       None         Adult Vision Care       Not covered       None         Pediatric Vision Care       So% coinsurance*       One exam per 12-month period         Other Plan Features       0% coinsurance*       None         Gia ® Virtual Care       0% coinsurance*       None         Wellness Benefits       \$600 allowance       Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Tier 2	Pharm: \$30 copay*/Mail: \$75 copay*			
Prescription Drug Deductible       Subject to annual deductible       None         Vision Care       Mot covered       None         Adult Vision Care       Not covered       None         Pediatric Vision Care       50% coinsurance*       One exam per 12-month period         Other Plan Features       0% coinsurance*       None         Gia® Virtual Care       0% coinsurance*       None         Wellness Benefits       \$600 allowance       Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Pediatric Dental       Preventive, Routine, and Major (including metically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         taboratory, radiology, and ambulatory services t a preferred provider facility will be covered in full, after	Tier 3	50% coinsurance*			
Adult Vision Care       Not covered       None         Pediatric Vision Care       50% coinsurance*       One exam per 12-month period         Other Plan Features       6       0% coinsurance*       None         Gia® Virtual Care       0% coinsurance*       None         Wellness Benefits       \$600 allowance       Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         +**Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Prescription Drug Deductible	Subject to annual deductible	None		
Pediatric Vision Care       50% coinsurance*       One exam per 12-month period         Other Plan Features       Gia® Virtual Care       0% coinsurance*       None         Gia® Virtual Care       0% coinsurance*       None         Wellness Benefits       \$600 allowance       Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         t**Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Vision Care				
Other Plan Features         Gia ® Virtual Care       0% coinsurance*       None         Wellness Benefits       \$600 allowance       Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         +**Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Adult Vision Care	Not covered	None		
Gia ® Virtual Care       0% coinsurance*       None         Wellness Benefits       \$600 allowance       Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         ***Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Pediatric Vision Care	50% coinsurance*	One exam per 12-month period		
Wellness Benefits       \$600 allowance       Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement         Plan Highlights       Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         **Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Other Plan Features				
Wellness Benefits       with MVP's Well-Being Reimbursement         Plan Highlights       Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         **Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Gia® Virtual Care	0% coinsurance*	None		
Plan Highlights       Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.         Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         ***Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Wellness Benefits	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement		
Pediatric Dental       Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. Services can be obtained from any licensed provider.         **Preferred Provider Facilities       Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after	Plan Highlights	Visit myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to			
**Preferred Provider Facilities       Cost Share Details. Services can be obtained from any licensed provider.         Laboratory, radiology, and ambulatory services at a preferred provider facility will be covered in full, after					
Preterred Provider Facilities	Pediatric Dental				
	**Preferred Provider Facilities				

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