New York
Plan Name: MVP EPO Bronze 7 HDHP
Plan Form: NY-EPOH-SB-007 (2025)
Plan Status: Active

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$6,350 Person/$12,700 Family - Embedded	None
Co-insurance	40% Person/40% Family	None
Annual Out-of-Pocket Maximum	$7,100 Person/$14,200 Family - Embedded	None
Primary Care Physician Office Visits	40% coinsurance*	None
Specialist Office Visits	40% coinsurance*	None
Preventive & Well Care Services		
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 mvphealthcare.com.	None
Physician Office Visits		
Diagnostic Laboratory Services	PCP: 40% coinsurance*/Spec: 40% coinsurance*	None
Diagnostic X-ray	PCP: 40% coinsurance*/Spec: 40% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 40% coinsurance*/Free-Stnd: 40% coinsurance*	None
Rehabilitative Services (PT/OT/ST)	40% coinsurance*	54 visits per condition, per Plan Year combined therapies
Allergy Services	40% coinsurance*	Cost share dependent on location of services
Chemotherapy Visit	40% coinsurance*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	40% coinsurance*	Per continuous confinement
Surgical Services	40% coinsurance*	None
Inpatient Physical Rehabilitation	40% coinsurance*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	40% coinsurance*	54 visits per condition/year combined therapies
Diagnostic Laboratory Services ++	40% coinsurance*	None
Diagnostic X-ray ++	40% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	40% coinsurance*	None
Ambulatory/Outpatient Surgery ++	40% coinsurance*	None
Emergency Care		
Emergency Room (ER) Visit	40% coinsurance*	None
Urgent Care Centers	40% coinsurance*	None
Ambulance (Emergency Medical Transportation)	40% coinsurance*	None
Maternity Services		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	40% coinsurance*	None
Maternity – Inpatient Hospital Services	40% coinsurance*	None

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	40% coinsurance*	Including residential treatment
Mental Health Outpatient	40% coinsurance*	None
Substance Use Disorder Inpatient Hospital	40% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	40% coinsurance*	Unlimited; Up to 20 visits per plan year may be used for family counseling
Residential Treatment	40% coinsurance*	None
Other Services		
Physician Administered Drugs	40% coinsurance*	None
Skilled Nursing Facility	40% coinsurance*	200 days per plan year
Home Health Care	40% coinsurance*	60 visits per plan year
Hospice	40% coinsurance*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	40% coinsurance*	Standard equipment covered
Diabetic Supplies & Equipment	40% coinsurance*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	40% coinsurance*	None
Acupuncture	40% coinsurance*	12 visits per plan year
Prescription Drug Coverage		
Tier 1	Pharm: $10 copay*/Mail: $25 copay*	30 day retail/90 day mail order; preventive drugs deductible waived
Tier 2	Pharm: $40 copay*/Mail: $100 copay*	30 day retail/90 day mail order; preventive drugs deductible waived. Prior authorization is required for some prescriptions
Tier 3	Pharm: $60 copay/Mail: $150 copay*	30 day retail/90 day mail order; preventive drugs deductible waived
Prescription Drug Deductible	Subject to annual deductible	None
Vision Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	40% coinsurance*	One exam per 12-month period
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 deductible (if applicable). Find a preferred provider facility in your area at **mvphealthcare.com**.	

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**