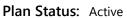
New York Plan Name: MVP EPO Bronze 7 HDHP Plan Form: NY-EPOH-SB-007 (2025)





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
Co-insurance	\$7,100 Person/\$14,200 Family - Embedded	None
Annual Out-of-Pocket Maximum	\$7,100 Fe13011, \$14,200 Fullilly Ellipedaca	TVOTE
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)	C 1: 5 II	
Mammography	Covered in Full.  For a full list of covered preventive care	
Annual Pap Test & Ob/Gyn Exam	services, visit	None
Immunizations for Adults	mvphealthcare.com.	
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits		
Diagnostic Laboratory Services	PCP: 40% coinsurance*/Spec: 40%	None
Diagnostic Laboratory Services	coinsurance*	
Diagnostic Y-ray	PCP: 40% coinsurance*/Spec: 40%	None
Diagnostic X-ray	coinsurance*	
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 40% coinsurance*/Free-Stnd: 40%	None
Advanced imaging Services (CT/FET Scalls, WKIS)	coinsurance*	
	40% coinsurance*	54 visits per condition, per Plan Year combined
		therapies
Rehabilitative Services (PT/OT/ST)		
	40% coinsurance*	Cost share dependent on location of services
Allergy Services		
Chemotherapy Visit	40% coinsurance*	None
Inpatient Services - Hospital		
Madical/Countries Admirations	40% coinsurance*	Per continuous confinement
Medical/Surgical Admissions		
	40% coinsurance*	None
Surgical Services		
Inpatient Physical Rehabilitation	40% coinsurance*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services	1004	
Hospital Rehab Services (PT/OT/ST)	40% coinsurance*	54 visits per condition/year combined therapie
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
	400/ soingurans-*	None
Maternity – Physician Delivery	40% coinsurance*	None
	40% coinsurance*	None

**New York** 

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

Plan Status: Active



	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	
Hamisa	40% coinsurance*	210 days per plan year, 5 visits for family bereavement	
Hospice		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			
. 3	Pharm: \$10 copay*/Mail: \$25 copay*	30 day retail/90 day mail order; preventive drugs	
Tier 1		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	
Tion 2	Pharm: \$60 copay/Mail: \$150 copay*	30 day retail/90 day mail order; preventive drugs	
Tier 3		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	
	Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to		
Plan Highlights	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.

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