New York
Plan Name: MVP HMO Bronze 2
Plan Form: NY-HMO-SB-002 (2025)
Plan Status: Active

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$6,150 Person/$12,300 Family - Embedded	None
Co-insurance	30% Person/30% Family	None
Annual Out-of-Pocket Maximum	$8,900 Person/$17,800 Family - Embedded	None
Primary Care Physician Office Visits	$35 copay*	First 3 Combined PCP/MH/SA Visits Covered in
Specialist Office Visits	$60 copay*	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: $35 copay*/Spec: $60 copay*	None
Diagnostic X-ray	PCP: $35 copay*/Spec: $60 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $60 copay*/Free-Stnd: $60 copay*	None
Rehabilitative Services (PT/OT/ST)	$60 copay*	54 visits per condition, per Plan Year combined therapies
Allergy Services	$60 copay*	Cost share dependent on location of services
Chemotherapy Visit	$60 copay*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	30% coinsurance*	Per continuous confinement
Surgical Services	30% coinsurance*	None
Inpatient Physical Rehabilitation	30% coinsurance*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	$60 copay*	54 visits per condition/year combined therapies
Diagnostic Laboratory Services ++	$60 copay*	None
Diagnostic X-ray ++	$60 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	$60 copay*	None
Ambulatory/Outpatient Surgery ++	$300 copay*	None
Emergency Care		
Emergency Room (ER) Visit	$350 copay*	None
Urgent Care Centers	$60 copay*	None
Ambulance (Emergency Medical Transportation)	$350 copay*	None
Maternity Services		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	30% coinsurance*	None
Maternity – Inpatient Hospital Services	30% coinsurance*	None

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	30% coinsurance*	Including residential treatment
Mental Health Outpatient	$35 copay*	First 3 Combined PCP/MH/SA Visits Covered in Full
Substance Use Disorder Inpatient Hospital	30% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	$35 copay*	First 3 Combined PCP/MH/SA Visits Covered in Full; 20 visits per plan year may be used for family counseling
Residential Treatment	30% coinsurance*	None
Other Services		
Physician Administered Drugs	20% coinsurance*	None
Skilled Nursing Facility	30% coinsurance*	200 days per plan year
Home Health Care	$50 copay*	60 visits per year
Hospice	Inpt: 30% coinsurance* / Outpt: $50 copay*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance*	Standard equipment covered
Diabetic Supplies & Equipment	$35 copay*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	$60 copay*	None
Acupuncture	50% coinsurance*	12 visits per plan year
Prescription Drug Coverage		
Tier 1	Pharm: $10 copay*/Mail: $25 copay*	30 day retail/90 day mail order
Tier 2	Pharm: $40 copay*/Mail: $100 copay*	30 day retail/90 day mail order
Tier 3	Pharm: $60 copay*/Mail: $150 copay*	30 day retail/90 day mail order
Prescription Drug Deductible	Subject to annual deductible	None
Vision Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	$60 copay*	One exam per 12-month period
Other Plan Features		
Gia® Virtual Care	Covered in Full	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**