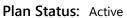
New York

Plan Name: MVP HMO Silver 3 HDHP Plan Form: NY-HMOH-SS-003 (2025)





Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$2,550 Person/\$5,100 Family - Aggregate	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$6,350 Person/\$12,700 Family - Embedded	None
Primary Care Physician Office Visits	\$25 copay*	None
Specialist Office Visits	\$50 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: \$25 copay*/Spec: \$50 copay*	None
Diagnostic X-ray	PCP: \$25 copay*/Spec: \$50 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: \$150 copay*/Free-Stnd: \$150 copay*	None
Rehabilitative Services (PT/OT/ST)	\$50 copay*	54 visits per condition, per Plan Year combined therapies
Allergy Services	\$50 copay*	Cost share dependent on location of services
Chemotherapy Visit	\$50 copay*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	\$500 copay*	Per continuous confinement
Surgical Services	\$150 copay*	None
Inpatient Physical Rehabilitation	\$500 copay*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	\$50 copay*	54 visits per condition/year combined therapie
Diagnostic Laboratory Services **	\$50 copay*	None
Diagnostic X-ray **	\$50 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	\$150 copay*	None
Ambulatory/Outpatient Surgery ++	\$250 copay*	None
Emergency Care		
	\$300 copay*	None
Emergency Room (ER) Visit		
Urgent Care Centers	\$50 copay*	None
		None None
Urgent Care Centers	\$50 copay*	
Urgent Care Centers Ambulance (Emergency Medical Transportation)	\$50 copay*	
Urgent Care Centers Ambulance (Emergency Medical Transportation) Maternity Services	\$50 copay* \$300 copay*	None

New York

Plan Name: MVP HMO Silver 3 HDHP Plan Form: NY-HMOH-SS-003 (2025)

Plan Status: Active



	Coverage Information	Limits and Exclusions	
Behavioral Health Services			
Mental Health Inpatient Hospital	\$500 copay*	Including residential treatment	
Mental Health Outpatient	\$25 copay*	None	
Substance Use Disorder Inpatient Hospital	\$500 copay*	Including residential treatment	
Substance Use Disorder Outpatient	\$25 copay*	Unlimited; Up to 20 visits per plan year may be used for family counseling	
Residential Treatment	\$500 copay*	None	
Other Services			
Physician Administered Drugs	20% coinsurance*	None	
Skilled Nursing Facility	\$500 copay*	200 days per plan year	
Home Health Care	\$50 copay*	60 visits per year	
Hamisa	Inpt: \$500 copay* / Outpt: \$50 copay*	210 days per plan year, 5 visits for family bereavement	
Hospice		counseling	
Durable Medical Equipment	50% coinsurance*	Standard equipment covered	
Diabetic Supplies & Equipment	\$25 copay*	Diabetic Insulin Covered in full In Network	
Chiropractic Benefit	\$50 copay*	None	
Acupuncture	50% coinsurance*	12 visits per plan year	
Prescription Drug Coverage			
Tier 1	Pharm: \$15 copay*/Mail: \$37.50 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	
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	\$50 copay*	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 myphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to		
Pediatric Dental	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 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.