



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$5,500 Person/\$11,000 Family - Embedded	None
Co-insurance	50% Person/50% Family	None
Annual Out-of-Pocket Maximum	\$8,050 Person/\$16,100 Family - Embedded	None
Primary Care Physician Office Visits	50% coinsurance*	None
Specialist Office Visits	50% coinsurance*	None
<b>Preventive &amp; Well Care Services</b>		
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 <a href="http://mvphealthcare.com">mvphealthcare.com</a> .	None
<b>Physician Office Visits</b>		
Diagnostic Laboratory Services	PCP: 50% coinsurance*/Spec: 50% coinsurance	None
Diagnostic X-ray	PCP: 50% coinsurance*/Spec: 50% coinsurance	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 50% coinsurance*/Free-Stnd: 50% coinsu	None
Rehabilitative Services (PT/OT/ST)	50% coinsurance*	60 visits per condition, per Plan Year combined therapies
Allergy Services	50% coinsurance*	Cost share dependent on location of services
Chemotherapy Visit	50% coinsurance*	None
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	50% coinsurance*	Per continuous confinement
Surgical Services	50% coinsurance*	None
Inpatient Physical Rehabilitation	50% coinsurance*	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
Hospital Rehab Services (PT/OT/ST)	50% coinsurance*	60 visits per condition/year combined therapies
Diagnostic Laboratory Services	50% coinsurance*	None
Diagnostic X-ray	50% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	50% coinsurance*	None
Ambulatory/Outpatient Surgery	50% coinsurance*	None
<b>Emergency Care</b>		
Emergency Room (ER) Visit	50% coinsurance*	None
Urgent Care Centers	50% coinsurance*	None
Ambulance (Emergency Medical Transportation)	50% coinsurance*	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	50% coinsurance*	50% coinsurance*
Maternity – Inpatient Hospital Services	50% coinsurance*	None

\*Deductible applies to this benefit

**New York**  
**Plan Name:** MVP Premier Bronze 1 HDHP Child Only  
**Plan Form:** NY-HMOH-DB-001-S-CO (2025)  
**Plan Status:** Active



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	50% coinsurance*	Including residential treatment
<b>Mental Health Outpatient</b>	50% coinsurance*	None
<b>Substance Use Disorder Inpatient Hospital</b>	50% coinsurance*	Including residential treatment
<b>Substance Use Disorder Outpatient</b>	50% coinsurance*	Unlimited; Up to 20 visits per calendar year may be used for family counseling
<b>Residential Treatment</b>	50% coinsurance*	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	50% coinsurance*	None
<b>Skilled Nursing Facility</b>	50% coinsurance*	200 days per plan year
<b>Home Health Care</b>	50% coinsurance*	40 visits per year
<b>Hospice</b>	50% coinsurance*	210 days per plan year, 5 visits for family bereavement counseling
<b>Durable Medical Equipment</b>	50% coinsurance*	Standard equipment covered
<b>Diabetic Supplies &amp; Equipment</b>	50% coinsurance*	Diabetic Insulin Covered in full In Network
<b>Chiropractic Benefit</b>	50% coinsurance*	None
<b>Acupuncture</b>	Not covered	None
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	Pharm: \$10 copay*/Mail: \$25 copay*	30 day retail/90 day mail order
<b>Tier 2</b>	Pharm: \$35 copay*/Mail: \$87.50 copay*	30 day retail/90 day mail order
<b>Tier 3</b>	Pharm: \$70 copay*/Mail: \$175 copay*	30 day retail/90 day mail order
<b>Prescription Drug Deductible</b>	Subject to annual deductible	None
<b>Vision Care</b>		
<b>Adult Vision Care</b>	Not covered	None
<b>Pediatric Vision Care</b>	50% coinsurance*	One exam per 12-month period
<b>Other Plan Features</b>		
<b>Gia® Virtual Care</b>	0% coinsurance*	None
<b>Wellness Benefits</b>	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement
<b>Plan Highlights</b>	Visit <a href="http://mvphealthcare.com">mvphealthcare.com</a> for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.	

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](http://mvphealthcare.com).

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