**New York**
**Plan Name:** MVP HMO Bronze 2
**Plan Form:** NY-HMO-SB-002 (2024)
**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<br>Adult Annual Physical (One per Contract Year)<br>Mammography<br>Annual Pap Test & Ob/Gyn Exam<br>Immunizations for Adults<br>Colonoscopy /Sigmoidoscopy Screening<br>Bone Density Tests | Covered in Full.<br>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* | Not more than $100 for a 30-day supply of insulin |
| 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* | $100 max out of pocket on 30 day supply of Insulin |
| 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**. | |

Gia virtual care services are available at no member cost-share for medical plans, including qualified high-deductible health plans (QHDHPs), upon enrollment and plan renewal in 2023. Members enrolled in a 2022 QHDHP must meet the plan's annual deductible before Gia services are available at no member cost share.

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**