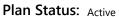
New York Plan Name: MVP Premier Plus Bronze 2 Plan Form: NY-HMO-DB-002-N (2026)





Plan Status: Active		HEALTH CARE
Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$6,400 Person/\$12,800 Family - Embedded	None
Co-insurance	40% Person/40% Family	None
Annual Out-of-Pocket Maximum	\$8,900 Person/\$17,800 Family - Embedded	None
Primary Care Physician Office Visits	40% coinsurance*	3 Combined PCP/MH/SA Visits Covered in Full
Specialist Office Visits	40% coinsurance*	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	Covered in Full. For a full list of covered preventive care services, visit myphealthcare.com.	None
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits	DCD: 400/ in + /C 400/	Nega
Diagnostic Laboratory Services	PCP: 40% coinsurance*/Spec: 40% coinsurance*	None
Diagnostic X-ray	PCP: 40% coinsurance*/Spec: 40% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 40% coinsurance*/Free-Stnd: 40% coinsurance*	None
Rehabilitative Services (PT/OT/ST)	40% coinsurance*	54 visits per condition, per Plan Year combined therapies
Allergy Services	40% coinsurance*	Cost share dependent on location of services
Chemotherapy Visit	40% coinsurance*	None
Inpatient Services - Hospital	1070 comparance	Hone
Medical/Surgical Admissions	40% coinsurance*	Per continuous confinement
Surgical Services	40% coinsurance*	None
Inpatient Physical Rehabilitation	40% coinsurance*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	40% coinsurance*	54 visits per condition/year combined therapies
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
Maternity – Physician Delivery	40% coinsurance*	None
Maternity – Inpatient Hospital Services	40% coinsurance*	None

New York

Plan Name: MVP Premier Plus Bronze 2
Plan Form: NY-HMO-DB-002-N (2026)

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*	First 3 Combined PCP/MH/SA Visits Covered in Full
Substance Use Disorder Inpatient Hospital	40% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	40% coinsurance*	First 3 Combined PCP/MH/SA Visits Covered in Full; 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 vear
Hospice	40% coinsurance*	210 days per plan year, 5 visits for family bereavement 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 Tier 1	Pharm: \$5 copay*/Mail: \$12.50 copay*	30 day retail/90 day mail order
Tier 2	Pharm: \$60 copay*/Mail: \$150 copay*	30 day retail/90 day mail order
Tier 3	Pharm: \$80 copay*/Mail: \$200 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	40% coinsurance*	One exam per 12-month period
Other Plan Features	4070 CONTSULATION	
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	Specialty virtual care providers included in Gia may be subject to the plan's applicable cost-share.	
**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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