

**New York**  
**Plan Name:** MVP HMO Bronze 9 HDHP  
**Plan Form:** NY-HMOH-SB-009 (2026)  
**Plan Status:** Active



| Plan Cost-Sharing Highlights                                                                                                                                                                                               | Coverage Information                                                                                                                      | Limits and Exclusions                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| Annual Deductible per Contract Year                                                                                                                                                                                        | \$6,250 Person/\$12,500 Family - Embedded                                                                                                 | None                                                      |
| Co-insurance                                                                                                                                                                                                               | 50% Person/50% Family                                                                                                                     | None                                                      |
| Annual Out-of-Pocket Maximum                                                                                                                                                                                               | \$7,250 Person/\$14,500 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<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 <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% coinsurance*                                                                                        | None                                                      |
| Rehabilitative Services (PT/OT/ST)                                                                                                                                                                                         | 50% coinsurance*                                                                                                                          | 54 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*                                                                                                                          | 54 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*                                                                                                                          | None                                                      |
| Maternity – Inpatient Hospital Services                                                                                                                                                                                    | 50% coinsurance*                                                                                                                          | None                                                      |

\*Deductible applies to this benefit

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|                                           | Coverage Information                                                                                                                                                                                                                                     | Limits and Exclusions                                                                          |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <b>Behavioral Health Services</b>         |                                                                                                                                                                                                                                                          |                                                                                                |
| Mental Health Inpatient Hospital          | 50% coinsurance*                                                                                                                                                                                                                                         | Including residential treatment                                                                |
| Mental Health Outpatient                  | 50% coinsurance*                                                                                                                                                                                                                                         | None                                                                                           |
| Substance Use Disorder Inpatient Hospital | 50% coinsurance*                                                                                                                                                                                                                                         | Including residential treatment                                                                |
| Substance Use Disorder Outpatient         | 50% coinsurance*                                                                                                                                                                                                                                         | Unlimited; Up to 20 visits per plan year may be used for family counseling                     |
| Residential Treatment                     | 50% coinsurance*                                                                                                                                                                                                                                         | None                                                                                           |
| <b>Other Services</b>                     |                                                                                                                                                                                                                                                          |                                                                                                |
| Physician Administered Drugs              | 50% coinsurance*                                                                                                                                                                                                                                         | None                                                                                           |
| Skilled Nursing Facility                  | 50% coinsurance*                                                                                                                                                                                                                                         | 200 days per plan year                                                                         |
| Home Health Care                          | 50% coinsurance*                                                                                                                                                                                                                                         | 60 visits per plan year                                                                        |
| Hospice                                   | 50% coinsurance*                                                                                                                                                                                                                                         | 210 days per plan year, 5 visits for family bereavement counseling                             |
| Durable Medical Equipment                 | 50% coinsurance*                                                                                                                                                                                                                                         | Standard equipment covered                                                                     |
| Diabetic Supplies & Equipment             | 50% coinsurance*                                                                                                                                                                                                                                         | Diabetic Insulin Covered in full In Network                                                    |
| Chiropractic Benefit                      | 50% coinsurance*                                                                                                                                                                                                                                         | None                                                                                           |
| Acupuncture                               | 50% coinsurance*                                                                                                                                                                                                                                         | 12 visits per Plan Year                                                                        |
| <b>Prescription Drug Coverage</b>         |                                                                                                                                                                                                                                                          |                                                                                                |
| Tier 1                                    | Pharm: \$10 copay*/Mail: \$25 copay*                                                                                                                                                                                                                     | 30 day retail/90 day mail order; preventive drugs deductible waived                            |
| Tier 2                                    | Pharm: \$35 copay*/Mail: \$87.50 copay*                                                                                                                                                                                                                  | 30 day retail/90 day mail order; preventive drugs deductible waived                            |
| Tier 3                                    | Pharm: \$70 copay*/Mail: \$175 copay*                                                                                                                                                                                                                    | 30 day retail/90 day mail order; preventive drugs deductible waived                            |
| Prescription Drug Deductible              | Subject to annual deductible                                                                                                                                                                                                                             | None                                                                                           |
| <b>Vision Care</b>                        |                                                                                                                                                                                                                                                          |                                                                                                |
| Adult Vision Care                         | Not covered                                                                                                                                                                                                                                              | None                                                                                           |
| Pediatric Vision Care                     | 50% coinsurance*                                                                                                                                                                                                                                         | One exam per 12-month period                                                                   |
| <b>Other Plan Features</b>                |                                                                                                                                                                                                                                                          |                                                                                                |
| 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                           | Specialty virtual care providers included in Gia may be subject to the plan's applicable cost-share.                                                                                                                                                     |                                                                                                |
| Pediatric Dental                          | Preventive, Routine, and Major (including medically-necessary orthodontia) – See Schedule of Benefits for Cost Share Details. <i>Services can be obtained from any licensed provider.</i>                                                                |                                                                                                |
| **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 <a href="http://mvphealthcare.com">mvphealthcare.com</a> . |                                                                                                |

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).

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.

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