

**New York**  
**Plan Name:** MVP HMO Silver 3 HDHP  
**Plan Form:** NY-HMOH-SS-003 (2026)  
**Plan Status:** Active



| Plan Cost-Sharing Highlights                                                                                                                                                                                               | Coverage Information                                                                                                                      | Limits and Exclusions                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| Annual Deductible per Contract Year                                                                                                                                                                                        | \$2,700 Person/\$5,400 Family - Aggregate                                                                                                 | None                                                      |
| Co-insurance                                                                                                                                                                                                               | As Noted Below                                                                                                                            | None                                                      |
| Annual Out-of-Pocket Maximum                                                                                                                                                                                               | \$7,000 Person/\$14,000 Family - Embedded                                                                                                 | None                                                      |
| Primary Care Physician Office Visits                                                                                                                                                                                       | \$25 copay*                                                                                                                               | None                                                      |
| Specialist Office Visits                                                                                                                                                                                                   | \$50 copay*                                                                                                                               | 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: \$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                                                      |
| <b>Inpatient Services - Hospital</b>                                                                                                                                                                                       |                                                                                                                                           |                                                           |
| 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                  |
| <b>Outpatient Hospital Services</b>                                                                                                                                                                                        |                                                                                                                                           |                                                           |
| Hospital Rehab Services (PT/OT/ST)                                                                                                                                                                                         | \$50 copay*                                                                                                                               | 54 visits per condition/year combined therapies           |
| 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                                                      |
| <b>Emergency Care</b>                                                                                                                                                                                                      |                                                                                                                                           |                                                           |
| Emergency Room (ER) Visit                                                                                                                                                                                                  | \$300 copay*                                                                                                                              | None                                                      |
| Urgent Care Centers                                                                                                                                                                                                        | \$50 copay*                                                                                                                               | None                                                      |
| Ambulance (Emergency Medical Transportation)                                                                                                                                                                               | \$300 copay*                                                                                                                              | None                                                      |
| <b>Maternity Services</b>                                                                                                                                                                                                  |                                                                                                                                           |                                                           |
| Maternity – Prenatal Care                                                                                                                                                                                                  | Covered in Full                                                                                                                           | None                                                      |
| Maternity – Physician Delivery                                                                                                                                                                                             | \$150 copay*                                                                                                                              | None                                                      |
| Maternity – Inpatient Hospital Services                                                                                                                                                                                    | \$500 copay*                                                                                                                              | None                                                      |

\*Deductible applies to this benefit

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|                                           | Coverage Information                                                                                                                                                                                                                                     | Limits and Exclusions                                                                          |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <b>Behavioral Health Services</b>         |                                                                                                                                                                                                                                                          |                                                                                                |
| 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                                                                                           |
| <b>Other Services</b>                     |                                                                                                                                                                                                                                                          |                                                                                                |
| 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                                                                             |
| Hospice                                   | Inpt: \$500 copay* / 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             | \$25 copay*                                                                                                                                                                                                                                              | Diabetic Insulin Covered in full In Network                                                    |
| Chiropractic Benefit                      | \$50 copay*                                                                                                                                                                                                                                              | None                                                                                           |
| Acupuncture                               | 50% coinsurance*                                                                                                                                                                                                                                         | 12 visits per plan year                                                                        |
| <b>Prescription Drug Coverage</b>         |                                                                                                                                                                                                                                                          |                                                                                                |
| 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                                                                                           |
| <b>Vision Care</b>                        |                                                                                                                                                                                                                                                          |                                                                                                |
| Adult Vision Care                         | Not covered                                                                                                                                                                                                                                              | None                                                                                           |
| Pediatric Vision Care                     | \$50 copay*                                                                                                                                                                                                                                              | 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.

**\*Deductible applies to this benefit**