New York
Plan Name: MVP EPO Bronze 11
Plan Form: NY-EPO-SB-011 – (2027)
Plan Status: Active

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
Annual Deductible per Contract Year	$10,500 Person/$21,000 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	$10,500 Person/$21,000 Family - Embedded	None
Primary Care Physician Office Visits	Covered in Full*	First Three (3) visits Covered in full
Specialist Office Visits	Covered in Full*	None
Preventive & Well Care Services		
Well Child Care & Immunizations	Covered in Full not subject to Deductible For a full list of covered preventive care services, visit mvphealthcare.com.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
Adult Annual Physical (One per Contract Year)		
Mammography		
Annual Pap Test & Ob/Gyn Exam		
Immunizations for Adults		
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits		
Diagnostic Laboratory Services	PCP: Covered in Full*/Spec: Covered in Full*	None
Diagnostic X-ray	PCP: Covered in Full*/Spec: Covered in Full*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: Covered in Full*/Free-Stnd: Covered in Full*	None
Rehabilitative Services (PT/OT/ST)	Covered in Full*	54 visits per condition, per Plan Year combined therapies
Allergy Services	Covered in Full*	
Chemotherapy Visit	Covered in Full*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	Covered in Full*	Per continuous confinement
Surgical Services	Covered in Full*	None
Inpatient Physical Rehabilitation	Covered in Full*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehabilitation Services (PT/OT/ST)	Covered in Full*	54 visits per condition, per Plan Year combined therapies
Diagnostic Laboratory Services ++	Covered in Full*	None
Diagnostic X-ray ++	Covered in Full*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	Covered in Full*	None
Ambulatory/Outpatient Surgery ++	Covered in Full*	None
Infusion Therapy	Covered in Full*	None
Emergency Care		
Emergency Room (ER) Visit	Covered in Full*	None
Urgent Care Centers	Covered in Full*	None
Ambulance (Emergency Medical Transportation)	Covered in Full*	None
Maternity Services		
Maternity – Prenatal Care Office Visit	Covered in Full not subject to Deductible	None
Maternity – Physician Delivery	Covered in Full*	None
Maternity – Inpatient Hospital Services	Covered in Full*	None
Behavioral Health Services		
Mental Health Inpatient Hospital	Covered in Full*	Including residential treatment
Mental Health Outpatient	Covered in Full*	First Three (3) visits Covered in full
Substance Use Disorder Inpatient Hospital	Covered in Full*	Including residential treatment
Substance Use Disorder Outpatient	Covered in Full*	First Three (3) visits Covered in full Unlimited; Up to 20 visits per Plan Year may be used for family counseling
Autism Treatment	Covered in Full*	First Three (3) visits Covered in full

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Assistive Communication Devices for Autism Spectrum Disorder	Covered in Full*	None
Other Services		
Physician Administered Drugs Outpatient	Covered in Full*	None
Skilled Nursing Facility	Covered in Full*	200 days per Plan Year
Home Health Care	Covered in Full*	60 visits per Plan Year
Hospice	Inpt: Covered in Full*/Outpt: Covered in Full*	210 days per Plan Year, Five (5) visits for family bereavement counseling
Durable Medical Equipment	Covered in Full*	None
Diabetic Supplies & Equipment	Covered in Full*	Diabetic Insulin Covered in full In Network
Chiropractic Benefit	Covered in Full*	None
Acupuncture	Covered in Full*	12 visits per Plan Year.
Home Infusion	Covered in Full*	Home infusion counts toward home health care visit limits
Prescription Drug Coverage		
Tier 1 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: Covered in Full not subject to Deductible /Mail: Covered in Full not subject to Deductible	30 day retail/90 day mail order
Tier 2 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: Covered in Full* /Mail: Covered in Full*	30 day retail/90 day mail order
Tier 3 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: Covered in Full* /Mail: Covered in Full*	30 day retail/90 day mail order
Ancillary Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	Covered in Full*	One (1) exam per 12-month periodNone
Pediatric Dental	Covered in Full not subject to Deductible	One (1) dental exam and cleaning per six (6) month period
Other Plan Features		
Gia® Virtual Care	Covered in Full not subject to Deductible	None
Wellness Benefits	Get reimbursed up to $600 per contract, per calendar year for expenses associated with activities, tools, and apps that enhance your overall well-being with MVP's Well-Being Reimbursement	
Doula Program	Get reimbursed up to $1,500 per plan year for doula expenses with MVP's Doula Reimbursement Program.	
Plan Highlights	Visit **mvphealthcare.com** for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.	
++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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***Deductible applies to this benefit**