New York
Plan Name: MVP EPO Bronze 7 HDHP
Plan Form: NY-EPOH-SB-007 – (2027)
Plan Status: Active

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
Annual Deductible per Contract Year	$6,500 Person/$13,000 Family - Embedded	None
Co-insurance	40% coinsurance*	None
Annual Out-of-Pocket Maximum	$8,050 Person/$16,100 Family - Embedded	None
Primary Care Physician Office Visits	40% coinsurance*	None
Specialist Office Visits	40% coinsurance*	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: 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		
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 Rehabilitation Services (PT/OT/ST)	40% coinsurance*	54 visits per condition, per Plan 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
Infusion Therapy	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 Office Visit	Covered in Full not subject to Deductible	None
Maternity – Physician Delivery	40% coinsurance*	None
Maternity – Inpatient Hospital Services	40% coinsurance*	None
Behavioral Health Services		
Mental Health Inpatient Hospital	40% coinsurance*	Including residential treatment
Mental Health Outpatient	40% coinsurance*	None
Substance Use Disorder Inpatient Hospital	40% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	40% coinsurance*	Unlimited; Up to 20 visits per Plan Year may be used for family counseling

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Autism Treatment	40% coinsurance*	None
Assistive Communication Devices for Autism Spectrum Disorder	40% coinsurance*	None
Other Services		
Physician Administered Drugs Outpatient	40% coinsurance*	None
Skilled Nursing Facility	40% coinsurance*	200 days per Plan Year
Home Health Care	40% coinsurance*	60 visits per Plan Year
Hospice	Inpt: 40% coinsurance*/Outpt: 40% coinsurance*	210 days per Plan Year, Five (5) visits for family bereavement counseling
Durable Medical Equipment	40% coinsurance*	None
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.
Home Infusion	40% coinsurance*	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: $0 copay* /Mail: $0 copay*	30 day retail/90 day mail order; Preventive drugs deductible waived
Tier 2 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: $40 copay* /Mail: $100 copay*	30 day retail/90 day mail order; Preventive drugs deductible waived
Tier 3 Diabetic medication and supplies are subject to the Primary Care Provider (PCP) cost sharing	Pharm: $60 copay* /Mail: $150 copay*	30 day retail/90 day mail order; Preventive drugs deductible waived
Ancillary Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	40% coinsurance*	One (1) exam per 12-month periodNone
Pediatric Dental	$25 copay*	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**.

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 are available in all states and counties.

***Deductible applies to this benefit**