

**New York**  
**Plan Name:** MVP HMO Silver 3 HDHP  
**Plan Form:** NY-HMOH-SS-003 (2025)  
**Plan Status:** Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
<b>Annual Deductible per Contract Year</b>	\$2,550 Person/\$5,100 Family - Aggregate	None
<b>Co-insurance</b>	As Noted Below	None
<b>Annual Out-of-Pocket Maximum</b>	\$6,350 Person/\$12,700 Family - Embedded	None
<b>Primary Care Physician Office Visits</b>	\$25 copay*	None
<b>Specialist Office Visits</b>	\$50 copay*	None
<b>Preventive &amp; Well Care Services</b>		
Well Child Care & Immunizations Adult Annual Physical (One per Contract Year) Mammography Annual Pap Test & Ob/Gyn Exam Immunizations for Adults Colonoscopy /Sigmoidoscopy Screening Bone Density Tests	Covered in Full. For a full list of covered preventive care services, visit <a href="http://mvphealthcare.com">mvphealthcare.com</a> .	None
<b>Physician Office Visits</b>		
<b>Diagnostic Laboratory Services</b>	PCP: \$25 copay*/Spec: \$50 copay*	None
<b>Diagnostic X-ray</b>	PCP: \$25 copay*/Spec: \$50 copay*	None
<b>Advanced Imaging Services (CT/PET scans, MRIs)</b>	Spec: \$150 copay*/Free-Stnd: \$150 copay*	None
<b>Rehabilitative Services (PT/OT/ST)</b>	\$50 copay*	54 visits per condition, per Plan Year combined therapies
<b>Allergy Services</b>	\$50 copay*	Cost share dependent on location of services
<b>Chemotherapy Visit</b>	\$50 copay*	None
<b>Inpatient Services - Hospital</b>		
<b>Medical/Surgical Admissions</b>	\$500 copay*	Per continuous confinement
<b>Surgical Services</b>	\$150 copay*	None
<b>Inpatient Physical Rehabilitation</b>	\$500 copay*	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
<b>Hospital Rehab Services (PT/OT/ST)</b>	\$50 copay*	54 visits per condition/year combined therapies
<b>Diagnostic Laboratory Services **</b>	\$50 copay*	None
<b>Diagnostic X-ray **</b>	\$50 copay*	None
<b>Advanced Imaging Services (CT/PET, scans, MRIs) **</b>	\$150 copay*	None
<b>Ambulatory/Outpatient Surgery **</b>	\$250 copay*	None
<b>Emergency Care</b>		
<b>Emergency Room (ER) Visit</b>	\$300 copay*	None
<b>Urgent Care Centers</b>	\$50 copay*	None
<b>Ambulance (Emergency Medical Transportation)</b>	\$300 copay*	None
<b>Maternity Services</b>		
<b>Maternity – Prenatal Care</b>	Covered in Full	None
<b>Maternity – Physician Delivery</b>	\$150 copay*	None
<b>Maternity – Inpatient Hospital Services</b>	\$500 copay*	None

\*Deductible applies to this benefit

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<b>Behavioral Health Services</b>		
Mental Health Inpatient Hospital	\$500 copay*	Including residential treatment
Mental Health Outpatient	\$25 copay*	None
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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	Visit <a href="http://mvphealthcare.com">mvphealthcare.com</a> for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.	
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).

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