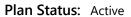
New York Plan Name: MVP Premier Bronze 2 Plan Form: NY-HMO-DB-002-S (2024)





		THE TETT CARE
Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$4,600 Person/\$9,200 Family - Embedded	None
•	As Noted Below	None
Co-insurance	\$9,450 Person/\$18,900 Family - Embedded	None None
Annual Out-of-Pocket Maximum	\$3,430 Person, \$10,300 Parmy - Embedded	Notice
Primary Care Physician Office Visits	\$50 copay*	First 3 Combined PCP/MH/SA or SP visits before
Specialist Office Visits	\$75 copay*	First 3 Combined PCP/MH/SA or SP visits before
Preventive & Well Care Services		
Well Child Care & Immunizations		
Adult Annual Physical (One per Contract Year)	Covered in Full.	
Mammography	For a full list of covered preventive care	
Annual Pap Test & Ob/Gyn Exam	services, visit	None
Immunizations for Adults	mvphealthcare.com.	
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests Physician Office Vicits		
Physician Office Visits	DCD: \$50 conqué/Spac: \$50 conqué	None
Diagnostic Laboratory Services	PCP: \$50 copay*/Spec: \$50 copay*	None
	PCP: \$75 copay*/Spec: \$75 copay*	None
Diagnostic X-ray		
Advanced language Complete (CT/DFT comp. MDIs)	Spec: \$175 copay*/Free-Stnd: \$175 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)		
	\$50 copay*	60 visits per condition, per Plan Year combined
		therapies
Rehabilitative Services (PT/OT/ST)		
	\$75 copay*	None
Allergy Services		
Chemotherapy Visit	\$50 copay*	None
Inpatient Services - Hospital		
	\$1,500 copay*	Per continuous confinement
Medical/Surgical Admissions		
	\$150 copay*	None
Surgical Services	\$130 сорау	None
	\$1,500 copay*	60 days per Plan Year Combined Therapies
Inpatient Physical Rehabilitation	+ .,500 copuj	adjo per rian real combined merupies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	\$50 copay*	60 visits per condition/year combined therapies
Diagnostic Laboratory Services	\$50 copay*	None
Diagnostic X-ray	\$75 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	\$175 copay*	None
Ambulatory/Outpatient Surgery		
Emergency Care	\$150 copay*	None
	\$150 copay*	None
Emergency Room (ER) Visit	\$150 copay* \$500 copay*	None None
Emergency Room (ER) Visit	\$500 copay*	None
Emergency Room (ER) Visit Urgent Care Centers	\$500 copay* \$75 copay*	None None
Emergency Room (ER) Visit Urgent Care Centers Ambulance (Emergency Medical Transportation)	\$500 copay* \$75 copay*	None None
Emergency Room (ER) Visit Urgent Care Centers Ambulance (Emergency Medical Transportation) Maternity Services Maternity – Prenatal Care	\$500 copay* \$75 copay* \$300 copay* Covered in Full	None None None
Emergency Room (ER) Visit Urgent Care Centers Ambulance (Emergency Medical Transportation) Maternity Services	\$500 copay* \$75 copay* \$300 copay*	None None None

New York

Plan Name: MVP Premier Bronze 2
Plan Form: NY-HMO-DB-002-S (2024)

Plan Status: Active



	Coverage Information	Limits and Exclusions	
Behavioral Health Services			
Mental Health Inpatient Hospital	\$1,500 copay*	Including residential treatment	
Mental Health Outpatient	\$50 copay*	First 3 Combined PCP/MH/SA or SP visits before DD	
Substance Use Disorder Inpatient Hospital	\$1,500 copay*	Including residential treatment	
Substance Use Disorder Outpatient	\$50 copay*	First 3 combined PCP/MH/SA or SP visits before DD; 20 visits per plan year may be used for family counseling	
Residential Treatment	\$1,500 copay*	None	
Other Services			
Physician Administered Drugs	\$50 copay*	None	
Skilled Nursing Facility	\$1,500 copay*	200 days per plan year	
Home Health Care	\$50 copay*	40 visits per year	
Hospice	Inpt: \$1,500 copay* / Outpt: \$50 copay*	210 days per plan year, 5 visits for family bereavement	
Durable Medical Equipment	50% coinsurance*	counseling Standard equipment covered	
Diabetic Supplies & Equipment	\$50 copay*	Not more than \$100 for a 30-day supply of insulin	
Chiropractic Benefit	\$75 copay*	None	
Acupuncture	Not covered	None	
Prescription Drug Coverage			
Tier 1	Pharm: \$10 copay*/Mail: \$25 copay*	30 day retail/90 day mail order	
Tier 2	Pharm: \$35 copay*/Mail: \$87.50 copay*	\$100 max out of pocket on 30 day supply of Insulin	
Tier 3	Pharm: \$70 copay*/Mail: \$175 copay*	30 day retail/90 day mail order	
Prescription Drug Deductible	Subject to annual deductible	None	
Vision Care			
Adult Vision Care	Not covered	None	
Pediatric Vision Care	\$50 copay*	One exam per 12-month period	
Other Plan Features			
Gia® Virtual Care	Covered in Full	None	
Wellness Benefits	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement	
Plan Highlights	Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.		

Gia virtual care services are available at no member cost-share for medical plans, including qualified high-deductible health plans (QHDHPs), upon enrollment and plan renewal in 2023. Members enrolled in a 2022 QHDHP must meet the plan's annual deductible before Gia services are available at no member cost share.

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 myphealthcare.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.