

<p style="text-align: center;">Form 5500</p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: small;">This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold; text-align: center;">2023</p> <hr/> <p style="text-align: center; font-weight: bold;">This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here.

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>LAWMANHEATINGANDCOOLINGEMPLOYEEBENEFITSPLAN</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>LAWMAN HEATING AND COOLING</u></p> <p><u>PO BOX 599</u> <u>SACKETS HARBOR, NY 13685-0599</u></p>	<p>1c Effective date of plan <u>01/01/2023</u></p> <p>2b Employer Identification Number (EIN) <u>16-1100145</u></p> <p>2c Plan Sponsor's telephone number <u>315-646-2919</u></p> <p>2d Business code (see instructions) <u>238220</u></p>

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/11/2024	ROBERT KILLMER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning **01/01/2023** and ending **12/31/2023**

A Name of plan LAWMANHEATINGANDCOOLINGEMPLOYEEBENEFITPLAN		B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 LAWMAN HEATING AND COOLING		D Employer Identification Number (EIN) 16-1100145	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier

MVP HEALTH CARE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
14-1640868	95521	700900	38	01/01/2023	12/31/2023

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid 13619	(b) Total amount of fees paid
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

MVP HEALTH CARE

**625 STATE ST
SCHENECTADY, NY 12305**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
13619			

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year..... **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits **7c(2)**
 (3) Interest credited during the year **7c(3)**
 (4) Transferred from separate account..... **7c(4)**
 (5) Other (specify below) **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:
 (1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier **7e(2)**
 (3) Transferred to separate account..... **7e(3)**
 (4) Other (specify below) **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**) **7f**

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	340497	
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)	5925	
	(3) Increase (decrease) in unearned premium reserve	9a(3)		
	(4) Earned ((1) + (2) - (3)).....	9a(4)		346422
b	Benefit charges (1) Claims paid.....	9b(1)		
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2)).....	9b(3)		
	(4) Claims charged	9b(4)		
c	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions	9c(1)(A)		
	(B) Administrative service or other fees	9c(1)(B)		
	(C) Other specific acquisition costs	9c(1)(C)		
	(D) Other expenses	9c(1)(D)		
	(E) Taxes	9c(1)(E)		
	(F) Charges for risks or other contingencies.....	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)		
	(H) Total retention	9c(1)(H)		
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)	9c(2)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		
	(2) Claim reserves	9d(2)		
	(3) Other reserves.....	9d(3)		
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e		

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

New York
Plan Name: MVP EPO Silver 3 HDHP
Plan Form: NY-EPOH-SS-003 (2024)
Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$2,550 Person/\$5,100 Family - Aggregate	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$6,350 Person/\$12,700 Family - Embedded	None
Primary Care Physician Office Visits	\$25 copay*	None
Specialist Office Visits	\$50 copay*	None
Preventive & Well Care Services		
Well Child Care & Immunizations		
Adult Annual Physical (One per Contract Year)		
Mammography	Covered in Full.	
Annual Pap Test & Ob/Gyn Exam	For a full list of covered preventive care services, visit	None
Immunizations for Adults	mvphealthcare.com .	
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits		
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
Inpatient Services - Hospital		
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
Outpatient Hospital Services		
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
Emergency Care		
Emergency Room (ER) Visit	\$300 copay*	None
Urgent Care Centers	\$50 copay*	None
Ambulance (Emergency Medical Transportation)	\$300 copay*	None
Maternity Services		
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

New York
Plan Name: MVP EPO Silver 3 HDHP
Plan Form: NY-EPOH-SS-003 (2024)
Plan Status: Active



	Coverage Information	Limits and Exclusions
Behavioral Health Services		
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
Other Services		
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*	Not more than \$100 for a 30-day supply of insulin
Chiropractic Benefit	\$50 copay*	None
Acupuncture	50% coinsurance*	12 visits per plan year
Prescription Drug Coverage		
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*	\$100 max out of pocket on 30 day supply of Insulin; 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
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	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 mvphealthcare.com 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 mvphealthcare.com .	

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 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.

New York
Plan Name: MVP HMO Silver 3 HDHP
Plan Form: NY-HMOH-SS-003 (2024)
Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$2,550 Person/\$5,100 Family - Aggregate	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$6,350 Person/\$12,700 Family - Embedded	None
Primary Care Physician Office Visits	\$25 copay*	None
Specialist Office Visits	\$50 copay*	None
Preventive & Well Care Services		
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 mvphealthcare.com .	None
Physician Office Visits		
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
Inpatient Services - Hospital		
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
Outpatient Hospital Services		
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
Emergency Care		
Emergency Room (ER) Visit	\$300 copay*	None
Urgent Care Centers	\$50 copay*	None
Ambulance (Emergency Medical Transportation)	\$300 copay*	None
Maternity Services		
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

New York
Plan Name: MVP HMO Silver 3 HDHP
Plan Form: NY-HMOH-SS-003 (2024)
Plan Status: Active



	Coverage Information	Limits and Exclusions
Behavioral Health Services		
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
Other Services		
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*	Not more than \$100 for a 30-day supply of insulin
Chiropractic Benefit	\$50 copay*	None
Acupuncture	50% coinsurance*	12 visits per plan year
Prescription Drug Coverage		
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*	\$100 max out of pocket on 30 day supply of Insulin; 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
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	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 mvphealthcare.com 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 mvphealthcare.com .	

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 mvphealthcare.com.

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*Deductible applies to this benefit

New York
Plan Name: MVP HMO Bronze 9 HDHP
Plan Form: NY-HMOH-SB-009 (2024)
Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$6,250 Person/\$12,500 Family - Embedded	None
Co-insurance	50% Person/50% Family	None
Annual Out-of-Pocket Maximum	\$7,100 Person/\$14,200 Family - Embedded	None
Primary Care Physician Office Visits	50% coinsurance*	None
Specialist Office Visits	50% coinsurance*	None
Preventive & Well Care Services		
Well Child Care & Immunizations		
Adult Annual Physical (One per Contract Year)		
Mammography	Covered in Full.	
Annual Pap Test & Ob/Gyn Exam	For a full list of covered preventive care services, visit	None
Immunizations for Adults	mvphealthcare.com	
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits		
Diagnostic Laboratory Services	PCP: 50% coinsurance*/Spec: 50% coinsurance*	None
Diagnostic X-ray	PCP: 50% coinsurance*/Spec: 50% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 50% coinsurance*/Free-Stnd: 50% coinsurance*	None
Rehabilitative Services (PT/OT/ST)	50% coinsurance*	54 visits per condition, per Plan Year combined therapies
Allergy Services	50% coinsurance*	Cost share dependent on location of services
Chemotherapy Visit	50% coinsurance*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	50% coinsurance*	Per continuous confinement
Surgical Services	50% coinsurance*	None
Inpatient Physical Rehabilitation	50% coinsurance*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	50% coinsurance*	54 visits per condition/year combined therapies
Diagnostic Laboratory Services **	50% coinsurance*	None
Diagnostic X-ray **	50% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs) **	50% coinsurance*	None
Ambulatory/Outpatient Surgery **	50% coinsurance*	None
Emergency Care		
Emergency Room (ER) Visit	50% coinsurance*	None
Urgent Care Centers	50% coinsurance*	None
Ambulance (Emergency Medical Transportation)	50% coinsurance*	None
Maternity Services		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	50% coinsurance*	None
Maternity – Inpatient Hospital Services	50% coinsurance*	None

*Deductible applies to this benefit

New York
Plan Name: MVP HMO Bronze 9 HDHP
Plan Form: NY-HMOH-SB-009 (2024)
Plan Status: Active



	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	50% coinsurance*	Including residential treatment
Mental Health Outpatient	50% coinsurance*	None
Substance Use Disorder Inpatient Hospital	50% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	50% coinsurance*	Unlimited; Up to 20 visits per plan year may be used for family counseling
Residential Treatment	50% coinsurance*	None
Other Services		
Physician Administered Drugs	50% coinsurance*	None
Skilled Nursing Facility	50% coinsurance*	200 days per plan year
Home Health Care	50% coinsurance*	60 visits per plan year
Hospice	50% coinsurance*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance*	Standard equipment covered
Diabetic Supplies & Equipment	50% coinsurance*	Not more than \$100 for a 30-day supply of insulin
Chiropractic Benefit	50% coinsurance*	None
Acupuncture	50% coinsurance*	12 visits per Plan Year
Prescription Drug Coverage		
Tier 1	Pharm: \$10 copay*/Mail: \$25 copay*	30 day retail/90 day mail order; preventive drugs deductible waived
Tier 2	Pharm: \$35 copay*/Mail: \$87.50 copay*	\$100 max out of pocket on 30 day supply of insulin; preventive drugs deductible waived
Tier 3	Pharm: \$70 copay*/Mail: \$175 copay*	30 day retail/90 day mail order; preventive drugs deductible waived
Prescription Drug Deductible	Subject to annual deductible	None
Vision Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	50% coinsurance*	One exam per 12-month period
Other Plan Features		
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 mvphealthcare.com 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 mvphealthcare.com .	

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 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

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110
1210-0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

- A This return/report is for: [] a multiemployer plan [] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) [X] a single-employer plan [] a DFE (specify) ____
B This return/report is: [X] the first return/report [] the final return/report [] an amended return/report [] a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here []
D Check box if filing under: [X] Form 5558 [] automatic extension [] the DFVC program [] special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here []

Part II Basic Plan Information—enter all requested information

1a Name of plan: LAWMANHEATINGANDCOOLINGEMPLOYEEBENEFITSPLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan: 01/01/2023
2a Plan sponsor's name (employer, if for a single-employer plan): LAWMAN HEATING AND COOLING
2b Employer Identification Number (EIN): 16-1100145
2c Plan Sponsor's telephone number: 315-646-2919
2d Business code (see instructions): 238220

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2023) v. 230728

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 29
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6a(1) 29 6a(2) 34 6b 0 6c 6d 34 6e 6f 34 6g(1) 6g(2) 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
---	---

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u> 1 </u> (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
---	---

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A Name of plan
LAWMANHEATINGANDCOOLINGEMPLOYEEBENEFITSPLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
LAWMAN HEATING AND COOLING

D Employer Identification Number (EIN)
16-1100145

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
MVP HEALTH CARE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
14-1640868	95521	700900	38	01/01/2023	12/31/2023

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid 13619	(b) Total amount of fees paid
--	--------------------------------------

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MVP HEALTH CARE 625 STATE ST
SCHENECTADY, NY 12305

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
13619			

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount

Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

6b	
6c	
6d	

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

- a** Type of contract: (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other ▶

b Balance at the end of the **previous year**

c Additions: (1) Contributions deposited during the year

(2) Dividends and credits

(3) Interest credited during the year

(4) Transferred from separate account

(5) Other (specify below)

▶

(6) Total additions

d Total of balance and additions (add lines **7b** and **7c(6)**)

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

(2) Administration charge made by carrier

(3) Transferred to separate account

(4) Other (specify below)

▶

(5) Total deductions

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)

7b	
7c(1)	
7c(2)	
7c(3)	
7c(4)	
7c(5)	
7c(6)	
7d	
7e(1)	
7e(2)	
7e(3)	
7e(4)	
7e(5)	
7f	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	340497
(2) Increase (decrease) in amount due but unpaid	9a(2)	5925
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3))	9a(4)	346422
b Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))	9b(3)	
(4) Claims charged	9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees	9c(1)(B)	
(C) Other specific acquisition costs	9c(1)(C)	
(D) Other expenses	9c(1)(D)	
(E) Taxes	9c(1)(E)	
(F) Charges for risks or other contingencies	9c(1)(F)	
(G) Other retention charges	9c(1)(G)	
(H) Total retention	9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)	9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)	
(2) Claim reserves	9d(2)	
(3) Other reserves	9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

New York

Plan Name: MVP EPO Silver 3 HDHP

Plan Form: NY-EPOH-SS-003 (2024)

Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$2,550 Person/\$5,100 Family - Aggregate	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$6,350 Person/\$12,700 Family - Embedded	None
Primary Care Physician Office Visits	\$25 copay*	None
Specialist Office Visits	\$50 copay*	None
Preventive & Well Care Services		
Well Child Care & Immunizations	Covered in Full. For a full list of covered preventive care services, visit mvphealthcare.com .	None
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: \$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
Inpatient Services - Hospital		
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
Outpatient Hospital Services		
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
Emergency Care		
Emergency Room (ER) Visit	\$300 copay*	None
Urgent Care Centers	\$50 copay*	None
Ambulance (Emergency Medical Transportation)	\$300 copay*	None
Maternity Services		
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

New York

Plan Name: MVP EPO Silver 3 HDHP

Plan Form: NY-EPOH-SS-003 (2024)

Plan Status: Active



	Coverage Information	Limits and Exclusions
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Behavioral Health Services

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

Other Services

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*	Not more than \$100 for a 30-day supply of insulin
Chiropractic Benefit	\$50 copay*	None
Acupuncture	50% coinsurance*	12 visits per plan year

Prescription Drug Coverage

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*	\$100 max out of pocket on 30 day supply of Insulin; 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

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	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 mvphealthcare.com 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 mvphealthcare.com .	

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 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

New York

Plan Name: MVP HMO Silver 3 HDHP

Plan Form: NY-HMOH-SS-003 (2024)

Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$2,550 Person/\$5,100 Family - Aggregate	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$6,350 Person/\$12,700 Family - Embedded	None
Primary Care Physician Office Visits	\$25 copay*	None
Specialist Office Visits	\$50 copay*	None
Preventive & Well Care Services		
Well Child Care & Immunizations	Covered in Full. For a full list of covered preventive care services, visit mvphealthcare.com .	None
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: \$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
Inpatient Services - Hospital		
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
Outpatient Hospital Services		
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
Emergency Care		
Emergency Room (ER) Visit	\$300 copay*	None
Urgent Care Centers	\$50 copay*	None
Ambulance (Emergency Medical Transportation)	\$300 copay*	None
Maternity Services		
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

New York

Plan Name: MVP HMO Silver 3 HDHP

Plan Form: NY-HMOH-SS-003 (2024)

Plan Status: Active



	Coverage Information	Limits and Exclusions
--	----------------------	-----------------------

Behavioral Health Services		
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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

Other Services		
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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*	Not more than \$100 for a 30-day supply of insulin
Chiropractic Benefit	\$50 copay*	None
Acupuncture	50% coinsurance*	12 visits per plan year

Prescription Drug Coverage		
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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*	\$100 max out of pocket on 30 day supply of Insulin; 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

Vision Care		
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Adult Vision Care	Not covered	None
Pediatric Vision Care	\$50 copay*	One exam per 12-month period

Other Plan Features		
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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 mvphealthcare.com 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. Services can be obtained from any licensed provider.	
** 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 .	

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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

New York

Plan Name: MVP HMO Bronze 9 HDHP

Plan Form: NY-HMOH-SB-009 (2024)

Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$6,250 Person/\$12,500 Family - Embedded	None
Co-insurance		
Annual Out-of-Pocket Maximum	50% Person/50% Family \$7,100 Person/\$14,200 Family - Embedded	None
Primary Care Physician Office Visits	50% coinsurance*	None
Specialist Office Visits	50% coinsurance*	None
Preventive & Well Care Services		
Well Child Care & Immunizations	Covered in Full. For a full list of covered preventive care services, visit mvphealthcare.com	None
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: 50% coinsurance*/Spec: 50% coinsurance*	None
Diagnostic X-ray	PCP: 50% coinsurance*/Spec: 50% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 50% coinsurance*/Free-Stnd: 50% coinsurance* 50% coinsurance*	None
Rehabilitative Services (PT/OT/ST)		54 visits per condition, per Plan Year combined therapies
Allergy Services	50% coinsurance*	Cost share dependent on location of services
Chemotherapy Visit	50% coinsurance*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	50% coinsurance*	Per continuous confinement
Surgical Services	50% coinsurance*	None
Inpatient Physical Rehabilitation	50% coinsurance*	60 days per Plan Year Combined Therapies
Outpatient Hospital Services		
Hospital Rehab Services (PT/OT/ST)	50% coinsurance*	54 visits per condition/year combined therapies
Diagnostic Laboratory Services **	50% coinsurance*	None
Diagnostic X-ray **	50% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs) **	50% coinsurance*	None
Ambulatory/Outpatient Surgery **	50% coinsurance*	None
Emergency Care		
Emergency Room (ER) Visit	50% coinsurance*	None
Urgent Care Centers	50% coinsurance*	None
Ambulance (Emergency Medical Transportation)	50% coinsurance*	None
Maternity Services		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	50% coinsurance*	None
Maternity – Inpatient Hospital Services	50% coinsurance*	None

*Deductible applies to this benefit

New York

Plan Name: MVP HMO Bronze 9 HDHP

Plan Form: NY-HMOH-SB-009 (2024)

Plan Status: Active



	Coverage Information	Limits and Exclusions
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Behavioral Health Services

Mental Health Inpatient Hospital	50% coinsurance*	Including residential treatment
Mental Health Outpatient	50% coinsurance*	None
Substance Use Disorder Inpatient Hospital	50% coinsurance*	Including residential treatment
Substance Use Disorder Outpatient	50% coinsurance*	Unlimited; Up to 20 visits per plan year may be used for family counseling
Residential Treatment	50% coinsurance*	None

Other Services

Physician Administered Drugs	50% coinsurance*	None
Skilled Nursing Facility	50% coinsurance*	200 days per plan year
Home Health Care	50% coinsurance*	60 visits per plan year
Hospice	50% coinsurance*	210 days per plan year, 5 visits for family bereavement counseling
Durable Medical Equipment	50% coinsurance*	Standard equipment covered
Diabetic Supplies & Equipment	50% coinsurance*	Not more than \$100 for a 30-day supply of insulin
Chiropractic Benefit	50% coinsurance*	None
Acupuncture	50% coinsurance*	12 visits per Plan Year

Prescription Drug Coverage

Tier 1	Pharm: \$10 copay*/Mail: \$25 copay*	30 day retail/90 day mail order; preventive drugs deductible waived
Tier 2	Pharm: \$35 copay*/Mail: \$87.50 copay*	\$100 max out of pocket on 30 day supply of Insulin; preventive drugs deductible waived
Tier 3	Pharm: \$70 copay*/Mail: \$175 copay*	30 day retail/90 day mail order; preventive drugs deductible waived
Prescription Drug Deductible	Subject to annual deductible	None

Vision Care

Adult Vision Care	Not covered	None
Pediatric Vision Care	50% coinsurance*	One exam per 12-month period

Other Plan Features

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 mvphealthcare.com 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. Services can be obtained from any licensed provider.	
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 .	

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 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






Lawman 5500

Final Audit Report

2024-07-10

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