



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$0 Person/\$0 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$6,950 Person/\$13,900 Family - Embedded	None
Primary Care Physician Office Visits	\$40 copay	None
Specialist Office Visits	\$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>		
Diagnostic Laboratory Services	PCP: \$40 copay/Spec: \$50 copay	None
Diagnostic X-ray	PCP: \$40 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
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	\$1,000 copay	Per continuous confinement
Surgical Services	Covered in Full	None
Inpatient Physical Rehabilitation	\$1,000 copay	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
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 **	\$300 copay	None
<b>Emergency Care</b>		
Emergency Room (ER) Visit	\$500 copay	None
Urgent Care Centers	\$50 copay	None
Ambulance (Emergency Medical Transportation)	\$500 copay	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	Covered in Full	None
Maternity – Inpatient Hospital Services	\$1,000 copay	None

	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	\$1,000 copay	Including residential treatment
<b>Mental Health Outpatient</b>	\$40 copay	None
<b>Substance Use Disorder Inpatient Hospital</b>	\$1,000 copay	Including residential treatment
<b>Substance Use Disorder Outpatient</b>	\$40 copay	Unlimited; Up to 20 visits per calendar year may be used for family counseling
<b>Residential Treatment</b>	\$1,000 copay	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	20% coinsurance	None
<b>Skilled Nursing Facility</b>	\$1,000 copay	200 days per plan year
<b>Home Health Care</b>	\$50 copay	60 visits per plan year
<b>Hospice</b>	Inpt: \$1,000 copay / Outpt: \$50 copay	210 days per plan year, 5 visits for family bereavement counseling
<b>Durable Medical Equipment</b>	50% coinsurance	Standard equipment covered
<b>Diabetic Supplies &amp; Equipment</b>	\$40 copay	Not more than \$100 for a 30-day supply of insulin
<b>Chiropractic Benefit</b>	\$50 copay	None
<b>Acupuncture</b>	50% coinsurance	12 visits per plan year
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	Pharm: \$10 copay/Mail: \$25 copay	30 day retail/90 day mail order
<b>Tier 2</b>	Pharm: \$40 copay/Mail: \$100 copay	\$100 max out of pocket on 30 day supply of Insulin
<b>Tier 3</b>	Pharm: \$60 copay/Mail: \$150 copay	30 day retail/90 day mail order
<b>Prescription Drug Deductible</b>	None	None
<b>Vision Care</b>		
<b>Adult Vision Care</b>	Not covered	None
<b>Pediatric Vision Care</b>	\$50 copay	One exam per 12-month period
<b>Other Plan Features</b>		
<b>Gia® Virtual Care</b>	Covered in Full	None
<b>Wellness Benefits</b>	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year with MVP's Well-Being Reimbursement
<b>Plan Highlights</b>	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.	
<b>**Preferred Provider Facilities</b>	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> .	

MVP virtual care services through Gia are available at no cost-share for most members, except those enrolled in a qualified high-deductible health plan (QHDHP). QHDHP members must meet the annual deductible before Gia services are covered in full. In-person visits and referrals are subject to cost-share per plan. Members enrolled in a Medicare Rx plan without additional MVP medical coverage do not have access to MVP virtual care services through Gia.

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).

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.