



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$5,800 Person/\$11,600 Family - Aggregate	None
Co-insurance	50% Person/50% Family	None
Annual Out-of-Pocket Maximum	\$7,100 Person/\$14,200 Family (Max \$9,100 per family member) - Aggregate	None
Primary Care Physician Office Visits	50% coinsurance*	None
Specialist Office Visits	50% coinsurance*	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: 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*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	50% coinsurance*	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	50% coinsurance*	None
Chemotherapy Visit	50% coinsurance*	None
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	50% coinsurance*	Prior authorization is required for some services
Surgical Services	50% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	50% coinsurance*	None
<b>Outpatient Hospital Services</b>		
Hospital Rehab Services (OT/ST)	50% coinsurance*	30 combined PT/OT/ST visits per year
Hospital Rehab Services (PT)	50% coinsurance*	30 combined PT/OT/ST visits per year
Diagnostic Laboratory Services	50% coinsurance*	None
Diagnostic X-ray	50% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	50% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	50% coinsurance*	Prior authorization is required for some services
<b>Emergency Care</b>		
Emergency Room (ER) Visit	50% coinsurance*	None
Urgent Care Centers	50% coinsurance*	None
Ambulance (Emergency Medical Transportation)	50% coinsurance*	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	50% coinsurance*	None
Maternity – Physician Delivery	50% coinsurance*	None
Maternity – Inpatient Hospital Services	50% coinsurance*	None



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	50% coinsurance*	None
<b>Mental Health Outpatient</b>	50% coinsurance*	None
<b>Substance Use Disorder Inpatient Hospital</b>	50% coinsurance*	None
<b>Substance Use Disorder Outpatient</b>	50% coinsurance*	None
<b>Residential Treatment</b>	50% coinsurance*	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	50% coinsurance*	None
<b>Skilled Nursing Facility</b>	50% coinsurance*	None
<b>Home Health Care</b>	50% coinsurance*	None
<b>Hospice</b>	50% coinsurance*	None
<b>Durable Medical Equipment</b>	50% coinsurance*	Prior authorization is required for some items
<b>Diabetic Supplies &amp; Equipment</b>	60% coinsurance*	Prior authorization is required for some items
<b>Chiropractic Benefit</b>	50% coinsurance*	No visit limit for Chiropractic Care
<b>Acupuncture</b>	Not covered	None
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	30 day supply: \$12 copay*/90 day supply: \$30 copay*	Preventive drugs deductible waived
<b>Tier 2</b>	40% coinsurance*	Preventive drugs deductible waived. Prior authorization is required for some prescriptions
<b>Tier 3</b>	60% coinsurance*	Preventive drugs deductible waived. Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment
<b>Prescription Drug Deductible</b>	Subject to annual deductible	None
<b>Prescription Out-of-Pocket Maximum</b>	\$1,500 Person/\$3,000 Family - Aggregate	None
<b>Vision Care</b>		
<b>Adult Vision Care</b>	Not covered	None
<b>Pediatric Vision Care</b>	\$20 copay*	One eye exam per year to age 21
<b>Other Plan Features</b>		
<b>Gia® Virtual Care</b>	0% coinsurance	None
<b>Wellness Benefits</b>	Not covered	None
	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.	

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](http://mvphealthcare.com).

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