

	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	In Network	Out of Network	
Annual Deductible per Contract Year	\$1,000 Person/\$2,000 Family - Embedded	\$2,000 Person/\$4,000 Family - Embedded	None
Co-insurance	10% coinsurance*	40% Coinsurance*	None
Annual Out-of-Pocket Maximum	\$2,500 Person/\$5,000 Family - Embedded	\$5,000 Person/\$10,000 Family	None
Primary Care Physician Office Visits	\$20 copay not subject to Deductible	40% coinsurance*	\$0 Copay for members to age 19 not subject to Deductible
Specialist Office Visits	\$50 copay not subject to Deductible	40% coinsurance*	None
Preventive & Well Care Services			
Well Child Care & Immunizations	Covered in Full not subject to Deductible For a full list of covered preventive care services, visit mvphealthcare.com .	Well Child Care & Immunizations Covered in Full; Subject to out-of-network cost share for all other services.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
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: 10% coinsurance*/Spec: 10% coinsurance*	PCP: 40% coinsurance*/Spec: 40% coinsurance*	\$0 Copay for members to age 19 not subject to Deductible
Diagnostic X-ray	PCP: 10% coinsurance*/Spec: 10% coinsurance*	PCP: 40% coinsurance*/Spec: 40% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 10% coinsurance*/Free-Stnd: 10% coinsurance*	Spec: 40% coinsurance*/Free-Stnd: 40% coinsurance*	Prior authorization required for non-participating provider
Rehabilitative Services (PT/OT/ST)	10% coinsurance*	40% coinsurance*	60 combined PT/OT/ST visits per year
Allergy Services	10% coinsurance*	40% coinsurance*	None
Chemotherapy Visit	10% coinsurance*	40% coinsurance*	None
Inpatient Services - Hospital			
Medical/Surgical Admissions	10% coinsurance*	40% coinsurance*	Prior Authorization required for non-participating provider
Surgical Services	10% coinsurance*	40% coinsurance*	Prior auth required for non-par
Inpatient Physical Rehabilitation	10% coinsurance*	40% coinsurance*	30 days per Plan Year combined therapies. Prior Auth required for non-participating provider
Outpatient Hospital Services			
Hospital Rehab Services (PT/OT/ST)	10% coinsurance*	40% coinsurance*	60 combined PT/OT/ST visits per year
Diagnostic Laboratory Services **	10% coinsurance*	40% coinsurance*	None
Diagnostic X-ray **	10% coinsurance*	40% coinsurance*	None

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Advanced Imaging Services (CT/PET, scans, MRIs) **	10% coinsurance*	40% coinsurance*	Prior authorization required for non-participating provider
Ambulatory/Outpatient Surgery **	10% coinsurance*	40% coinsurance*	Prior authorization required for non-participating provider
Infusion Therapy	10% coinsurance*	40% coinsurance*	None
Emergency Care			
Emergency Room (ER) Visit	\$200 copay not subject to Deductible	\$200 copay not subject to Deductible	None
Urgent Care Centers	\$50 copay not subject to Deductible	40% coinsurance*	None
Ambulance (Emergency Medical Transportation)	\$200 copay not subject to Deductible	\$200 copay not subject to Deductible	None
Maternity Services			
Maternity – Prenatal Care Office Visit	Covered in Full not subject to Deductible	40% coinsurance*	None
Maternity – Physician Delivery	10% coinsurance*	40% coinsurance*	None
Maternity – Inpatient Hospital Services	10% coinsurance*	40% coinsurance*	None
Behavioral Health Services			
Mental Health Inpatient Hospital	10% coinsurance*	40% coinsurance*	Prior authorization required for non-participating provider
Mental Health Outpatient	\$20 copay not subject to Deductible	40% coinsurance*	\$0 Copay for members to age 19 not subject to Deductible
Substance Use Disorder Inpatient Hospital	10% coinsurance*	40% coinsurance*	Including residential treatment. Prior Authorization required for non-participating provider
Substance Use Disorder Outpatient	\$20 copay not subject to Deductible	40% coinsurance*	Up to 20 visits per Plan Year may be used for family counseling. Prior Auth required for non-participating provider
Autism Treatment	\$20 copay not subject to Deductible	40% coinsurance*	\$0 Copay for members to age 19 not subject to Deductible
Assistive Communication Devices for Autism Spectrum Disorder	\$20 copay not subject to Deductible	40% coinsurance*	\$0 Copay for members to age 19 not subject to Deductible
Other Services			Other Services
Physician Administered Drugs Outpatient	10% coinsurance*	40% coinsurance*	None
Skilled Nursing Facility	10% coinsurance*	40% coinsurance*	120 days per Plan Year. Prior Authorization required for non-participating provider
Home Health Care	10% coinsurance*	40% coinsurance*	100 visits per Plan Year. Prior auth required for non-par
Hospice	Inpt: 10% coinsurance*/Outpt: 10% coinsurance*	Inpt: 40% coinsurance*/Outpt: 40% coinsurance*	Five (5) visits for family bereavement counseling
Durable Medical Equipment	10% coinsurance*	40% coinsurance*	None
Diabetic Supplies & Equipment	\$20 copay not subject to Deductible	40% coinsurance*	Diabetic Insulin Covered in full In Network

*Deductible applies to this benefit

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Chiropractic Benefit	\$50 copay not subject to Deductible	40% coinsurance*	None
Acupuncture	\$50 copay not subject to Deductible	Not Covered	None
Home Infusion	10% coinsurance*	40% coinsurance*	Home Infusion counts towards Home Health Care Visit Limits
Prescription Drug Coverage			
Tier 1	Pharm: Not covered/Mail: Not covered	Pharm: Not covered/Mail: Not covered	SUD and Fertility Drugs only - 30-day supply retail takes PCP Copay; Mail Order, takes 3 x PCP Copay, Up to a 90-day supply
Tier 2	Pharm: Not covered/Mail: Not covered	See Available Riders	None
Tier 3	Pharm: Not covered/Mail: Not covered	See Available Riders	None
Ancillary Care		Ancillary Care	
Adult Vision Care	Not covered	Not covered	None
Pediatric Vision Care	Not covered	Not covered	None
Pediatric Dental	Not covered	Not covered	None
Other Plan Features		Other Plan Features	
Gia® Virtual Care	Covered in Full not subject to Deductible	Not covered	None
Wellness Benefits	Get reimbursed up to \$800 per contract, per calendar year for expenses associated with activities, tools, and apps that enhance your overall well-being with MVP's Well-Being Reimbursement		
Doula	Get reimbursed up to \$1,500 per plan year for expenses with MVP's Doula Reimbursement Program.		
Plan Highlights	Visit mvphealthcare.com for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.		
**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 .		

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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