



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
<b>Annual Deductible per Contract Year</b>	\$0 Person/\$0 Family - Embedded	None
<b>Co-insurance</b>	As Noted Below	None
<b>Annual Out-of-Pocket Maximum</b>	\$5,800 Person/\$11,600 Family - Embedded	None
<b>Primary Care Physician Office Visits</b>	0% coinsurance	None
<b>Specialist Office Visits</b>	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>		
<b>Diagnostic Laboratory Services</b>	PCP: 50% coinsurance/Spec: 50% coinsurance	None
<b>Diagnostic X-ray</b>	PCP: 50% coinsurance/Spec: 50% coinsurance	None
<b>Advanced Imaging Services (CT/PET scans, MRIs)</b>	Spec: 50% coinsurance/Free-Stnd: 50% coinsurance	None
<b>Rehabilitative Services (PT/OT/ST)</b>	50% coinsurance	54 combined PT/OT/ST visits per year
<b>Allergy Services</b>	50% coinsurance	None
<b>Chemotherapy Visit</b>	50% coinsurance	None
<b>Inpatient Services - Hospital</b>		
<b>Medical/Surgical Admissions</b>	50% coinsurance	Per continuous confinement
<b>Surgical Services</b>	50% coinsurance	None
<b>Inpatient Physical Rehabilitation</b>	50% coinsurance	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
<b>Hospital Rehab Services (PT/OT/ST)</b>	50% coinsurance	54 visits per condition/year combined therapies
<b>Diagnostic Laboratory Services **</b>	50% coinsurance	None
<b>Diagnostic X-ray **</b>	50% coinsurance	None
<b>Advanced Imaging Services (CT/PET, scans, MRIs) **</b>	50% coinsurance	None
<b>Ambulatory/Outpatient Surgery **</b>	50% coinsurance	None
<b>Emergency Care</b>		
<b>Emergency Room (ER) Visit</b>	50% coinsurance	None
<b>Urgent Care Centers</b>	50% coinsurance	None
<b>Ambulance (Emergency Medical Transportation)</b>	50% coinsurance	None
<b>Maternity Services</b>		
<b>Maternity – Prenatal Care</b>	Covered in Full	None
<b>Maternity – Physician Delivery</b>	50% coinsurance	None
<b>Maternity – Inpatient Hospital Services</b>	50% coinsurance	None

\*Deductible applies to this benefit



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	50% coinsurance	Including residential treatment
<b>Mental Health Outpatient</b>	0% coinsurance	None
<b>Substance Use Disorder Inpatient Hospital</b>	50% coinsurance	Including residential treatment
<b>Substance Use Disorder Outpatient</b>	0% coinsurance	Unlimited; Up to 20 visits per calendar year may be used for family counseling
<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	200 days per plan year
<b>Home Health Care</b>	50% coinsurance	60 visits per plan year
<b>Hospice</b>	50% coinsurance	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>	0% coinsurance	Diabetic Insulin Covered in full In Network
<b>Chiropractic Benefit</b>	50% coinsurance	None
<b>Acupuncture</b>	50% coinsurance	12 visits per plan year
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	Pharm: 50% coinsurance/Mail: \$0.50 copay	30 day retail/90 day mail order
<b>Tier 2</b>	50% coinsurance	30 day retail/90 day mail order
<b>Tier 3</b>	50% coinsurance	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% coinsurance	One exam per 12-month period
<b>Other Plan Features</b>		
<b>Gia® Virtual Care</b>	0% coinsurance	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> .	

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.

**\*Deductible applies to this benefit**