



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$9,200 Person/\$18,400 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$9,200 Person/\$18,400 Family - Embedded	None
Primary Care Physician Office Visits	0% coinsurance*	First 3 PCP or MH/SA Visits Covered in Full
Specialist Office Visits	0% 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: 0% coinsurance*/Spec: 0% coinsurance*	None
Diagnostic X-ray	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 0% coinsurance*/Free-Stnd: 0% coinsurance*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	0% coinsurance*	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	0% coinsurance*	None
Chemotherapy Visit	0% coinsurance*	None
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	0% coinsurance*	Prior authorization is required for some services
Surgical Services	0% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	0% coinsurance*	None
<b>Outpatient Hospital Services</b>		
Hospital Rehab Services (OT/ST)	0% coinsurance*	30 combined PT/OT/ST visits per year
Hospital Rehab Services (PT)	0% coinsurance*	30 combined PT/OT/ST visits per year
Diagnostic Laboratory Services	0% coinsurance*	None
Diagnostic X-ray	0% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	0% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	0% coinsurance*	Prior authorization is required for some services
<b>Emergency Care</b>		
Emergency Room (ER) Visit	0% coinsurance*	None
Urgent Care Centers	0% coinsurance*	None
Ambulance (Emergency Medical Transportation)	0% coinsurance*	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	0% coinsurance*	None
Maternity – Physician Delivery	0% coinsurance*	None
Maternity – Inpatient Hospital Services	0% coinsurance*	None



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	0% coinsurance*	None
<b>Mental Health Outpatient</b>	0% coinsurance*	First 3 PCP or MH/SA Visits Covered in Full
<b>Substance Use Disorder Inpatient Hospital</b>		
<b>Substance Use Disorder Outpatient</b>	0% coinsurance*	First 3 PCP or MH/SA Visits Covered in Full
<b>Residential Treatment</b>	0% coinsurance*	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	0% coinsurance*	None
<b>Skilled Nursing Facility</b>	0% coinsurance*	None
<b>Home Health Care</b>	0% coinsurance*	None
<b>Hospice</b>	0% coinsurance*	None
<b>Durable Medical Equipment</b>	0% coinsurance*	Prior authorization is required for some items
<b>Diabetic Supplies &amp; Equipment</b>	0% coinsurance*	Prior authorization is required for some items
<b>Chiropractic Benefit</b>	0% coinsurance*	No visit limit for Chiropractic Care
<b>Acupuncture</b>	\$500 allowance	None
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	30 day supply: \$10 copay/90 day supply: \$25 copay	VBID 30 day supply \$1/90 day supply \$2.50. \$0 generics to age 10
<b>Tier 2</b>	0% coinsurance*	VBID 30 day supply \$1/90 day supply \$2.50. Prior authorization is required for some prescriptions
<b>Tier 3</b>	0% coinsurance*	VBID 30 day supply \$1/90 day supply \$2.50. 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>	Integrated with medical	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>	Covered in Full	None
<b>Wellness Benefits</b>	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year
	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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