



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
<b>Annual Deductible per Contract Year</b>	\$2,650 Person/\$5,300 Family - Aggregate	None
<b>Co-insurance</b>	As Noted Below	None
<b>Annual Out-of-Pocket Maximum</b>	\$6,200 Person/\$12,400 Family - Embedded	None
<b>Primary Care Physician Office Visits</b>	\$30 copay*	None
<b>Specialist Office Visits</b>	\$60 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>		
<b>Diagnostic Laboratory Services</b>	PCP: \$30 copay*/Spec: \$60 copay*	None
<b>Diagnostic X-ray</b>	PCP: \$30 copay*/Spec: \$60 copay*	None
<b>Advanced Imaging Services (CT/PET scans, MRIs)</b>	Spec: \$160 copay*/Free-Stnd: \$160 copay*	None
<b>Rehabilitative Services (PT/OT/ST)</b>	\$60 copay*	54 visits per condition, per Plan Year combined therapies
<b>Allergy Services</b>	\$60 copay*	Cost share dependent on location of services
<b>Chemotherapy Visit</b>	\$60 copay*	None
<b>Inpatient Services - Hospital</b>		
<b>Medical/Surgical Admissions</b>	\$500 copay*	Per continuous confinement
<b>Surgical Services</b>	\$100 copay*	None
<b>Inpatient Physical Rehabilitation</b>	\$500 copay*	60 days per Plan Year Combined Therapies
<b>Outpatient Hospital Services</b>		
<b>Hospital Rehab Services (PT/OT/ST)</b>	\$60 copay*	54 visits per condition/year combined therapies
<b>Diagnostic Laboratory Services **</b>	\$60 copay*	None
<b>Diagnostic X-ray **</b>	\$60 copay*	None
<b>Advanced Imaging Services (CT/PET, scans, MRIs) **</b>	\$160 copay*	None
<b>Ambulatory/Outpatient Surgery **</b>	\$200 copay*	None
<b>Emergency Care</b>		
<b>Emergency Room (ER) Visit</b>	\$325 copay*	None
<b>Urgent Care Centers</b>	\$60 copay*	None
<b>Ambulance (Emergency Medical Transportation)</b>	\$300 copay*	None
<b>Maternity Services</b>		
<b>Maternity – Prenatal Care</b>	Covered in Full	None
<b>Maternity – Physician Delivery</b>	\$100 copay*	None
<b>Maternity – Inpatient Hospital Services</b>	\$500 copay*	None

\*Deductible applies to this benefit



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	\$500 copay*	Including residential treatment
<b>Mental Health Outpatient</b>	\$30 copay*	None
<b>Substance Use Disorder Inpatient Hospital</b>	\$500 copay*	Including residential treatment
<b>Substance Use Disorder Outpatient</b>	\$30 copay*	Unlimited; Up to 20 visits per calendar year may be used for family counseling
<b>Residential Treatment</b>	\$500 copay*	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	20% coinsurance*	None
<b>Skilled Nursing Facility</b>	\$500 copay*	200 days per plan year
<b>Home Health Care</b>	\$50 copay*	60 visits per plan year
<b>Hospice</b>	Inpt: \$500 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>	\$30 copay*	Diabetic Insulin Covered in full In Network
<b>Chiropractic Benefit</b>	\$60 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; preventive drugs deductible waived
<b>Tier 2</b>	Pharm: \$45 copay*/Mail: \$112.50 copay*	30 day retail/90 day mail order; preventive drugs deductible waived
<b>Tier 3</b>	Pharm: \$90 copay*/Mail: \$225 copay*	30 day retail/90 day mail order; preventive drugs deductible waived
<b>Prescription Drug Deductible</b>	Subject to annual deductible	None
<b>Vision Care</b>		
<b>Adult Vision Care</b>	Not covered	None
<b>Pediatric Vision Care</b>	\$60 copay*	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**