



	Coverage Information		Limits and Exclusions
Plan Cost-Sharing Highlights	In-Network	Out-of-Network	
Annual Deductible per Contract Year	\$2,500 Person/\$5,000 Family - Aggregate	\$4,000 Person/\$8,000 Family	None
Co-insurance	As Noted Below	40% Person/40% Family	None
Annual Out-of-Pocket Maximum	\$2,500 Person/\$5,000 Family - Embedded	\$8,000 Person/\$16,000 Family	None
Primary Care Physician Office Visits	0% coinsurance*	40% coinsurance*	None
Specialist Office Visits	0% coinsurance*	40% coinsurance*	None
Preventive & Well Care Services	In-Network	Out-of-Network	
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> .	Well Child Care & Immunizations Covered in Full; Subject to out-of-network cost share for all other services.	None
Physician Office Visits	In-Network	Out-of-Network	
Diagnostic Laboratory Services	PCP: 0% coinsurance*/Spec: 0% coinsurance*	PCP: 40% coinsurance*/Spec: 40% coinsurance*	None
Diagnostic X-ray	PCP: 0% coinsurance*/Spec: 0% coinsurance*	PCP: 40% coinsurance*/Spec: 40% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 0% coinsurance*/Free-Stnd: 0% coinsurance*	Spec: 40% coinsurance*/Free-Stnd: 40% coinsurance*	None
Rehabilitative Services (PT/OT/ST)	0% coinsurance*	40% coinsurance*	30 combined PT/OT/ST visits per Year
Allergy Services	0% coinsurance*	40% coinsurance*	None
Chemotherapy Visit	0% coinsurance*	40% coinsurance*	None
Inpatient Services - Hospital	In-Network	Out-of-Network	
Medical/Surgical Admissions	0% coinsurance*	40% coinsurance*	Per continuous confinement
Surgical Services	0% coinsurance*	40% coinsurance*	None
Inpatient Physical Rehabilitation	0% coinsurance*	40% coinsurance*	30 days per Plan Year combined therapies

\*Deductible applies to this benefit



	Coverage Information		Limits and Exclusions
Outpatient Hospital Services	In-Network	Out-of-Network	
Hospital Rehab Services (PT/OT/ST)	0% coinsurance*	40% coinsurance*	30 visits per Plan Year combined therapies
Diagnostic Laboratory Services **	0% coinsurance*	40% coinsurance*	None
Diagnostic X-ray **	0% coinsurance*	40% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)**	0% coinsurance*	40% coinsurance*	None
Ambulatory/Outpatient Surgery **	0% coinsurance*	40% coinsurance*	None
Emergency Care	In-Network	Out-of-Network	
Emergency Room (ER) Visit	0% coinsurance*	0% coinsurance*	None
Urgent Care Centers	0% coinsurance*	40% coinsurance*	None
Ambulance (Emergency Medical Transportation)	0% coinsurance*	0% coinsurance*	None
Maternity Services	In-Network	Out-of-Network	
Maternity – Prenatal Care	Covered in Full	40% coinsurance*	None
Maternity – Physician Delivery	0% coinsurance*	40% coinsurance*	None
Maternity – Inpatient Hospital Services	0% coinsurance*	40% coinsurance*	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
Behavioral Health Services	In-Network	Out-of-Network	
Mental Health Inpatient Hospital	0% coinsurance*	40% coinsurance*	Including Residential Treatment
Mental Health Outpatient	0% coinsurance*	40% coinsurance*	None
Substance Use Disorder Inpatient Hospital	0% coinsurance*	40% coinsurance*	Including Residential Treatment
Substance Use Disorder Outpatient	0% coinsurance*	40% coinsurance*	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
Residential Treatment	0% coinsurance*	40% coinsurance*	None
Other Services	In-Network	Out-of-Network	
Physician Administered Drugs	0% coinsurance*	40% coinsurance*	None
Skilled Nursing Facility	0% coinsurance*	40% coinsurance*	60 days per Plan Year
Home Health Care	0% coinsurance*	40% coinsurance*	60 visits per Plan Year
Hospice	0% coinsurance*	Inpt: 40% coinsurance*/Outpt: 40%	210 days per Plan Year; Five (5) visits for family bereavement
Durable Medical Equipment	0% coinsurance*	40% coinsurance*	None
Diabetic Supplies & Equipment	0% coinsurance*	40% coinsurance*	None
Chiropractic Benefit	0% coinsurance*	40% coinsurance*	None
Acupuncture	Not covered	Not covered	None

\*Deductible applies to this benefit



	Coverage Information		Limits and Exclusions
<b>Prescription Drug Coverage</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Tier 1</b>	0% coinsurance*	See available Riders	30 day retail/90 day mail order
<b>Tier 2</b>	0% coinsurance*	See available Riders	\$100 max out of pocket on 30 day supply of Insulin
<b>Tier 3</b>	0% coinsurance*	See available Riders	30 day retail/90 day mail order
<b>Prescription Drug Deductible</b>	Subject to annual deductible	Subject to annual deductible	None
<b>Vision Care</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Adult Vision Care</b>	Not covered	Not covered	None
<b>Pediatric Vision Care</b>	Not covered	Not covered	None
<b>Other Plan Features</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Gia® Virtual Care</b>	0% coinsurance*	Not covered	None
<b>Wellness Benefits</b>	\$600 allowance	Included in In-Network benefit	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> .		

MVP virtual care services through Gia are available at no cost-share for most members, except those enrolled in a qualified high-deductible health plan (QHDHP). QHDHP members must meet the annual deductible before Gia services are covered in full. In-person visits and referrals are subject to cost-share per plan. Members enrolled in a Medicare Rx plan without additional MVP medical coverage do not have access to MVP virtual care services through Gia.

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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