MVP Health Care Summary of Benefits

1-888-MVP-MBRS (1-888-687-6277) www.mvphealthcare.com

Monthly Rates	Individual - $393.11	Two Person - $786.22	Parent/Child(ren) - $746.90	Family – $1,100.70

		Individual	**Family**
In-Network Contract Year Deductible[1]		$250	$500[2]
Out-of-Network Contract Year Deductible[1]		$500	$1000[2]
In Network Annual Out-of-Pocket Maximum[3]		$800	$1600[2]
Out-of-Network Annual Out-of-Pocket Maximum[3]		$1500	$3000[2]
General Lifetime Maximum Benefit	$1,000,000		
Durable Medical Equipment/External Prosthetic Devices/ Ostomy Supplies Lifetime Maximum Benefit	$25,000		
Medical Foods Maximum Benefit per Member per year	$2,500		

BENEFIT	**In-Network Coinsurance**	**Out-of-Network Coinsurance**
Inpatient Hospital Services		
Maternity Care	20%	20%
Newborn Care	20%	20%
Breast Cancer Care	20%	20%
Physical Rehabilitation Care	20%	Not Available
Mental Health and Substance Abuse Services	20%	Not Available
Outpatient Hospital/Facility and Ambulatory Services[4]		
Mental Health and Substance Abuse Services (Facility)	20%	Not Available
Therapeutic Services	20%	20%
Pre-admission Testing	20%	20%
Diagnostic Tests and Screenings	20%	20%
Diagnostic Laboratory	20%	20%
Diagnostic Radiology	20%	20%
Therapy Services (PT/ST/OT)	20%	Not Available
Breast Cancer Care	20%	20%
Cardiac Rehabilitation	20%	Not Available
Covered Preventive Care Services:		
Well Baby and Child Care (including immunizations)	Covered in Full	Not Available
Adult periodic physicals	Covered in Full	Not Available
Adult Immunizations (Must be provided during annual physical. Except for Influenza, Tetanus, Diphtheria, Hepatitis B and Hepatitis A.)	Covered in Full	Not Available
Mammography Screenings	Covered in Full	Not Available
Prostate Cancer Screening	Covered in Full	Not Available

[1] This Deductible does not apply to the following Covered Services: Maternity Care (and maternity-related care, including Diagnostic Services and Laboratory Services), Newborn Care, In-Network Diabetes Equipment and Supplies, Durable Medical Equipment, External Prosthetic Devices, including Breast Prostheses, and Ostomy Supplies. Also, there is no Deductible for covered Services that are subject to Copayment.

[2] The family deductible and out-of-pocket maximum shall be satisfied when either one insured or a combination of insureds satisfies the annual family deductible during contract year.

[3] The following Member payments do not count toward the In-Network or Out-of-Network Annual Out of Pocket Maximum: Prescription Drug Copayments, and Charges in excess of Allowable Charges.

[4] Includes Pre-admission testing, Surgery, Therapeutic Services, Diagnostic Services and Laboratory Services.

BENEFIT	In-Network Coinsurance	Out-of-Network Coinsurance
Cervical Cytology Screening	Covered in Full	Not Available
Covered Professional Services & Supplies		
Provider Office Visits[5]	$10 Copayment	$10 Copayment
Therapeutic Services Office Setting	$10 Copayment	$10 Copayment
Maternity Care[6]	$10 Copayment	$10 Copayment
Child Birth Classes	You will be reimbursed up to $40	You will be reimbursed up to $40
Parenting Classes	You will be reimbursed up to $25	You will be reimbursed up to $25
Consultations (Inpatient setting)	20%	20%
Mental Health & Substance Abuse Services (office)	$10 Copayment	Not Available
Chiropractic Care (office setting)	$10 Copayment	Not Available
Inpatient Medical Care	20%	20%
Surgery		
Facility Setting	20%	20%
Office Setting	$10 Copayment	$10 Copayment
Second Surgical Opinions (office setting)	$10 Copayment	$10 Copayment
Assistant Surgeon (Inpatient setting)	20%	20%
Anesthesia Services (Inpatient setting)	20%	20%
Office Therapy Services (PT/ST/OT)	$10 Copayment	Not Available
Office Laboratory Services[7]	0%	20%
Diagnostic Radiology Services[7]	$10 Copayment	20%
Transplant Services/Donor Costs	20%	Not Available
Diabetes Equipment & Supplies[8]	20%	20%
Medical Foods	20%	Not Available
Durable Medical Equipment, External Prosthetic Devices, Ostomy Supplies and Breast Prostheses	20%	20%
Basic Infertility Services		
Facility Setting	20%	20%
Office Setting	$10 Copayment	$10 Copayment
OTHER BENEFITS		
Skilled Nursing Facility Services	20%	Not Available
Home Health Agency Services	20%	Not Available
Hospice Services	20%	Not Available
Emergency Services	20%	20%
Ambulance Services	20%	20%
Urgently-Needed Care	20%	20%
Abortion/Sterilization	20%	20%
Preventive Dental for Kids	$25 Copayment	$25 Copayment
Prescription Drug Coverage	$10 Generic Formulary $30 Brand Formulary $50 Non-Formulary	$10 Generic Formulary $30 Brand Formulary $50 Non-Formulary

[5] Includes office visits for: diagnosis and treatment, Second Surgical Opinions, Diabetes Treatment, Breast Cancer Care, and Diagnostic Services.

[6] Copayment applies to first diagnostic visit only (no Copayments apply thereafter).

[7] Processing/professional fees that are performed outside of the office setting are subject to Deductible and Coinsurance.

[8] For supplies, applicable per item per 30 day supply.