MVP PREMIER PLUS SCHEDULE OF BENEFITS
Gold 4
MVP Health Plan, Inc.
Embedded Deductible
Off Exchange

COST-SHARING	**Participating Member Responsibility for Cost-Share**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $0 $0		
Prescription Drug Deductible • Individual • Family	 $0 $0	Non-Participating Provider services are not covered except as required for Emergency Care and Urgent Care.	
Out-of-Pocket Limit • Individual • Family	 $6,350 $12,700		
OFFICE VISITS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Specialist Office Visits (or Home Visits	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Adult Immunizations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Mammography Screenings*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Sterilization Procedures for Women*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	

• Vasectomy	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
• Bone Density Testing*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Screening for Prostate Cancer	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• All other preventive services required by USPSTF and HRSA.	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Non-Participating Provider services are not covered and You pay the full cost	
EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$300 Copayment	$300 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	$300 Copayment	$300 Copayment	See Benefit For Description
Emergency Department Copayment waived if Hospital admission.	$300 Copayment	$300 Copayment	See Benefit For Description
Urgent Care Center	$40 Copayment	$40 Copayment	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	12 visits per Plan Year
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	$150 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
• Performed as Outpatient Hospital Services	$150 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Allergy Testing & Treatment • Performed in a PCP Office	$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
• Performed in a Specialist Office	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Ambulatory Surgical Center Facility Fee	$300 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description

Anesthesia Services (all settings	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Autologous Blood Banking	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	See Benefits For Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $40 Copayment $40 Copayment Included as part of inpatient Hospital service Cost-Sharing	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefits For Description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $40 Copayment $40 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Chiropractic Services	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Clinical Trials	Use Cost-Sharing for Appropriate Service	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $40 Copayment $40 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 $25 Copayment $40 Copayment $40 Copayment	 $25 Copayment $40 Copayment $40 Copayment	See Benefit For Description Dialysis Performed by Non-Participating Providers is Limited to 10 Visits Per Calendar Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	54 visits per condition, per lifetime combined therapies

Home Health Care	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	60 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $25 Copayment $40 Copayment $40 Copayment $40 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	$0 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $40 Copayment $40 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care	 Covered In Full $500 Copayment per admission $0 Copayment Covered in Full Included as part of the surgeon's cost share for delivery.	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding

Outpatient Hospital Surgery Facility Charge	$300 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Preadmission Testing	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment $150 Copayment $150 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $40 Copayment $40 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	54 visits per condition, per lifetime combined therapies.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Specialist Office Surgery • PCP Office Surgery	 $0 Copayment $0 Copayment $0 Copayment $40 Copayment $25 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description **All Transplants Must be Performed at Designated Facilities**

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 $25 Copayment $25 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	 See Benefit For Description
Durable Medical Equipment & Braces	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
External Hearing Aid	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	One Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient	 $500 Copayment $40 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	 210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Prosthetic Devices • External • Internal	 50% Coinsurance $0 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	 One prosthetic device, per limb, per lifetime Unlimited See Benefit For Description
Out of Service Area	Use Cost Sharing for Appropriate Service	Up to $1000 in out of service area covered benefits per Dependent Child per plan year.	See Benefit For Description
INPATIENT SERVICES & FACILITIES	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description

Observation Stay	$300 Copayment	$300 Copayment	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	60 Consecutive Days Per Condition, Per Lifetime
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Outpatient Substance Use Services	$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Unlimited; Up to 20 Visits a Calendar Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30 Day Supply Tier 1 Tier 2 Tier 3	 $5 Copayment $45 Copayment 50% Coinsurance	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Enteral Formula 30 Day Supply Tier 1 Tier 2 Tier 3	 $5 Copayment $45 Copayment 50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description Mail Order Not Available

WELLNESS BENEFITS	Participating Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Gym Reimbursement	Up to $125 reimbursement per contract for gym and fitness club membership, youth sports and fitness fees or healthy weight support.	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
PEDIATRIC VISION CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Vision Care			
• Exams	$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	One Exam Per 12-Month Period; One Prescribed Standard Lenses & Frames in a 12-Month Period
• Lenses & Frames	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	
• Contact Lenses	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	