



Preferred Gold HMO-POS - Standard with Part D Prescription Drug Employer Group 2016 Benefits

BENEFITS		YOU PAY
DOCTOR VISITS		
Primary Care		\$15
Specialist		\$30
Chiropractor		\$20
Allergy Injection (allergy serum covered)		\$15 Primary Care; \$30 Specialist
Acupuncture (10 visits)		50%
PREVENTIVE CARE		
Yearly Wellness Exam		Covered in full
Medicare-covered screenings – mammogram, prostate, Pap tests, bone mass measurement		Covered in full (Office visit copay may apply)
Pneumonia and Flu Shots		Covered in full (Office visit copay may apply)
HOSPITAL SERVICES		
Inpatient Acute Hospital Stays Inpatient Mental Health Care (190 days per lifetime)		\$250 per stay \$750 maximum per year
Observation Stays		\$60
OUTPATIENT SERVICES		
Ambulatory Surgical Center – same day surgery & other services		\$30
Outpatient Hospital – same day surgery & other services		\$60
Home Health Services		Covered in full
Hospice		Covered by Medicare
EMERGENCY CARE		
Emergency Room Care – worldwide coverage		\$75
Urgently Needed Care – worldwide coverage		\$30
Ambulance Transportation		\$100 (per use)
DIAGNOSTIC SERVICES – office visit copay may apply		
X-rays (Radiology)		\$30
Lab Tests		\$10
CT Scans, PET Scans, MRIs, Nuclear Medicine		\$60
REHABILITATION		
Skilled Nursing Facility		\$25 each day, days 1-20; \$160 each day, days 21-100
Physical, Occupational, and Speech Therapy (therapy caps apply)		\$30
OUT-OF-NETWORK AND TRAVEL COVERAGE (POS)		
Care from providers (doctors, hospitals and other facilities) that are not part of MVP's network. (Not all services are covered out of network.)		No Deductible. Member pays 30%. \$5000 maximum annual benefit.

MEMBER PROTECTION		YOU PAY
Maximum Annual Out-of-Pocket Protection – In and Out of Network (Excludes: Part D costs, acupuncture, eyewear, hearing aids and dental if applicable)		\$4000

BENEFITS		YOU PAY
ADDITIONAL COVERAGE		
Diabetic Glucose Strips – Preferred brand		0%
Diabetic Glucose Strips – Non-preferred brand		10%
Other Diabetic Supplies		10%
Durable Medical Equipment (DME)		20%
Prosthetic Devices – such as artificial limbs, braces		20%
Part B Drugs professionally administered (chemotherapy)		20%
Part B Drugs purchased at pharmacy		20%
Eyewear Allowance Hearing Aid	\$100 eyewear allowance every two years TruHearing® hearing aid discounts	

ENHANCED PRESCRIPTION DRUG COVERAGE		
Initial Coverage Stage	Retail Pharmacy (30 day supply)	Mail Order (up to a 90 day supply)
Tier 1 – Preferred generic drugs	\$0 copayment	\$0 copayment
Tier 2 – Generic drugs	\$10 copayment	\$20 copayment
Tier 3 – Preferred brand-name drugs	\$35 copayment	\$70 copayment
Tier 4 – Non-preferred brand drugs	\$90 copayment	\$180 copayment
Tier 5 – Specialty drugs	33% coinsurance	Not Available
Tier 6 – Select vaccines	\$0 copayment	Not Available
Coverage Gap Stage	If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach \$3,310, you will pay 58% for generic drugs, 45% for Medicare-contracted Brand-name drugs, and 100% of the drug cost for Non-Medicare-contracted Brand-name drugs. You will continue to pay \$0 for Tier 1 and 6 drugs.	
Catastrophic Coverage Stage	When you have paid \$4,850 out of pocket, your cost for prescriptions is reduced to 5% or \$2.95 for generics and \$7.40 for all other drugs, whichever is greater.	
Additional Coverage	Non-Part D drugs are not covered.	

WELL-BEING PROGRAMS	
24 Hour Nurse Line	Nurse available 24 hours per day, 7 days per week to answer health questions via telephone or email.
HealthDollars sm	\$100 in HealthDollars to use toward health programs such as weight loss and smoking cessation.
The SilverSneakers® Fitness Program	Free fitness center membership benefits at a participating fitness center near you, including use of equipment and other amenities, at no charge.

Exclusions & Non-covered Services

Neither MVP nor Original Medicare will pay for certain items or services, including cosmetic surgery, custodial care, and experimental procedures and items. For a complete list of excluded services, refer to your Evidence of Coverage (your contract). Unless expressly indicated in the contract, all non-medically necessary services are not covered. Even if you receive the services at an emergency facility, the excluded services are still not covered.

This information is a brief summary, not a comprehensive description of benefits. For more information, refer to your Evidence of Coverage (your contract).