



## Preferred Gold HMO-POS - Buy-Up with Part D Prescription Drug Employer Group 2021 Benefits

BENEFITS		YOU PAY
<b>DOCTOR VISITS</b>		
Primary Care		\$10
Specialist		\$15
Chiropractor		\$15
Allergy Injection (allergy serum covered)		\$10 Primary Care; \$15 Specialist
Acupuncture (10 visits)		50%
<b>PREVENTIVE CARE</b>		
Annual 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)
<b>HOSPITAL SERVICES</b>		
Inpatient Acute Hospital Stays Inpatient Mental Health Care (190 days per lifetime)		\$0 per stay
Observation Stays		Covered in full
<b>OUTPATIENT SERVICES</b>		
Ambulatory Surgical Center – same day surgery & other services		Covered in full
Outpatient Hospital – same day surgery & other services		Covered in full
Home Health Services		Covered in full
Hospice		Covered by Medicare
<b>EMERGENCY CARE</b>		
Emergency Room Care – worldwide coverage		\$65
Urgently Needed Care		\$15
Ambulance Transportation		\$50 (per use)
<b>DIAGNOSTIC SERVICES – office visit copay may apply</b>		
X-rays (Radiology)		\$15
Lab Tests		\$0
CT Scans, PET Scans, MRIs, Nuclear Medicine		\$15
<b>REHABILITATION</b>		
Skilled Nursing Facility		\$0 each day, days 1-20; \$135 each day, days 21-100
Physical, Occupational, and Speech Therapy (therapy caps apply)		\$15
<b>OUT-OF-NETWORK AND TRAVEL COVERAGE (POS)</b>		
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 Network (Excludes: Part D costs, acupuncture, eyewear, hearing aids and dental if applicable)		\$4000

BENEFITS		YOU PAY
<b>ADDITIONAL COVERAGE</b>		
Diabetic Glucose Strips – must be preferred brands*		0%
Other Diabetic Supplies		10%
Durable Medical Equipment (DME)		20%
Part B Drugs Purchased at Pharmacy		20%
Part B Drugs Professionally Administered (chemotherapy)		\$15
Radiation Therapy		\$0
Outpatient Dialysis		\$0
Eyewear Allowance Hearing Aid		\$100 eyewear allowance every two years TruHearing® hearing aid discounts

ENHANCED PRESCRIPTION DRUG COVERAGE 182		
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 drugs	50% coinsurance	50% coinsurance
Tier 5 – Specialty drugs	33% coinsurance	Not Available
<b>Coverage Gap Stage</b>	If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach \$4,130, you will pay either the copayments as listed above or less. You will continue to pay \$0 for Tier 1 drugs.	
<b>Catastrophic Coverage Stage</b>	When you have paid \$6,550 out of pocket, your cost for prescriptions is reduced to 5% or \$3.70 for generics and \$9.20 for all other drugs, whichever is greater. You will never pay more in Catastrophic Coverage than you did in the Initial Coverage stage	
<b>Additional Coverage</b>	Your plan also covers the following: Erectile dysfunction drugs, weight-loss agents, and additional barbiturates (butalbital/aspirin/caffeine).	

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.
WellBeing Rewards	Up to \$200 in rewards for healthy activities.
SilverSneakers® Fitness Program	Free fitness membership--visit any participating fitness center or join online classes from home.

### 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. Some services may require prior authorization from MVP. For more information, refer to your Evidence of Coverage (your contract).