Preferred Gold HMO-POS
MVP Part D Prescription Drug

Employer Group
2012 Benefits

Covered Service	Copayment (per person, per visit)
Annual Medical Out-of-Pocket Maximum	$4,000
(Excludes: Part D costs, acupuncture, eyewear, hearing aids and dental if applicable)	
Primary Care	
General Office Visit	$15
Specialist	
Specialist Office Visit	$30
Hospital-Inpatient	
Unlimited days of medically necessary semi-private room (private room if medically necessary)	$250 per stay $750 maximum per year
Emergency Care	
Worldwide coverage for:	
Ambulance transport when medically necessary	$75 (per use)
Emergency room treatment of illness or injury	$65 copay unless admitted to hospital (not waived for observation stays)
Urgent Care	
Coverage for treatment in an urgent care center	$30
Preventive Care	
Periodic health assessment for adults	$0
Adult immunizations and vaccinations (pneumonia, flu and Hepatitis B)	$0
Allergy injection, testing and evaluation (allergy serum covered)	$15 Primary Care/$30 Specialist
Routine gynecological exam (annual)	$15 Primary Care /$30 Specialist
Mammograms	$0
Mental Health	
Inpatient—Up to 190 days in a psychiatric hospital per lifetime	$250 per stay $750 maximum per year
Outpatient	$30
Outpatient Substance Abuse/Dependence	$30 (per visit)
Vision Care	
Eye exams	$30
Eyewear	
Eyewear after cataract surgery	20%
Routine eyewear	$100 annual allowance

Covered Service	Copayment (per person, per visit)
Hearing Coverage	
Hearing exam	$30
Other Services	
Outpatient/ambulatory procedures	$0
Chiropractic care	$20
Laboratory tests	$10
Skilled nursing facility per benefit period	$0 days 1-20; $135 days 21-100
Home health services	$0
X-rays	$30
CT scan, PET scan, MRI, nuclear medicine	$40
Physical, occupational, and speech therapy	$30
Hospice care	Covered by Medicare
Prosthetic devices (artificial limb, brace, etc.)	20%
Professional administration of drugs	$30
Durable medical equipment	20%
Acupuncture (10 visits)	50%
Out-of-Network Coverage	
Limited services from non-participating providers	No Deductible. Member pays 30% $5000 maximum annual benefit

Enhanced Part D Prescription Drug Coverage

- $8 copayment for Tier 1 - Preferred Generic drugs
- $35 copayment for Tier 2 - Preferred Brand-name drugs
- $90 copayment for Tier 3 - Non-preferred drugs
- 33% copayment for Tier 4 - Specialty drugs
- $0 copayment for Tier 5 - No Cost Generics

Gap Coverage: If total drug costs (paid by both you and MVP Health Plan, Inc.) reach $2,930:

- You pay $8 or 86%, whichever is less, for Tier 1 Drugs
- You pay 50% of your copayment for Medicare-contracted Brand-name drugs
- You pay 100% of the cost for Non-Medicare-contracted Brand-name drugs
- You pay $0 for Tier 5 drugs

Catastrophic Coverage: When you have paid $4,700 out of pocket, your cost for prescriptions is reduced to 5% or $2.60 for generics and $6.50 for all other drugs, whichever is greater.

Mail Order pharmacy: 90-day supply available at 2 times the retail cost of a 30-day supply ($16/$70/$180/33%/$0).

Additional Coverage: Your Enhanced Part D plan also covers the following: Weight-gain drugs, benzodiazepines, barbiturates, erectile dysfunction drugs, and weight-loss agents.

Health and Wellness

- 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. (Any unused portion of this benefit cannot be carried over from one calendar year to the next.)
- 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

Such services as cosmetic surgery, custodial care, non-standard and unevaluated treatments and services provided in conjunction with a non-covered service, among others. Unless expressly indicated in the contract, all non-medically necessary services are 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).

PG-STD-RX 8/35/90/33%/0 FG
MR018A/018B/018CX MRX041A/B
2012