GoldAnywhere PPO - Standard with Part D Prescription Drug Employer Group 2018 Benefits

BENEFITS	YOU PAY	
	In-Network	**Out-of-Network**
DOCTOR VISITS		
Primary Care	$15	$25
Specialist	$20	$25
Chiropractor	$20	$20
Allergy Injection (allergy serum covered)	$15 Primary Care $20 Specialist	$25 Primary Care $25 Specialist
Acupuncture (10 visits)	50%	50%
PREVENTIVE CARE		
Annual Wellness Exam	Covered in full	$25
Medicare-covered screenings – mammogram, prostate, Pap tests, bone mass measurement	Covered in full (Office visit copay may apply)	Covered in full (Office visit copay may apply)
Pneumonia and Flu Shots	Covered in full (Office visit copay may apply)	Covered in full (Office visit copay may apply)
HOSPITAL SERVICES		
Inpatient Acute Hospital Stays Inpatient Mental Health Care (190 days per lifetime)	$100 per stay $300 maximum per year	20%
Observation Stays	Covered in full	20%
OUTPATIENT SERVICES		
Ambulatory Surgical Center – same day surgery & other services	Covered in full	20%
Outpatient Hospital – same day surgery & other services	Covered in full	20%
Home Health Services	Covered in full	20%
Hospice	Covered by Medicare	
EMERGENCY CARE		
Emergency Room Care – worldwide coverage	$75	$75
Urgently Needed Care – worldwide coverage	$20	$20
Ambulance Transportation	$35 (per use)	$35 (per use)
DIAGNOSTIC SERVICES – office visit copay may apply		
X-rays (Radiology)	$20	$25
Lab Tests	$0	20%
CT Scans, PET Scans, MRIs, Nuclear Medicine	$20	20%
REHABILITATION		
Skilled Nursing Facility	$0 each day, days 1-20; $160 each day, days 21-100	20%
Physical, Occupational, and Speech Therapy (therapy caps apply)	$20	$25

MEMBER PROTECTION	YOU PAY
Maximum Annual Out-of-Pocket Protection (Excludes: Part D costs, acupuncture, eyewear, hearing aids and dental if applicable)	$4,000 Combined

BENEFITS	YOU PAY	
ADDITIONAL COVERAGE	**In-Network**	**Out-of-Network**
Diabetic Glucose Strips – must be preferred brands *	0%	20%
Other Diabetic Supplies	10%	20%
Durable Medical Equipment (DME)	20%	20%
Prosthetic Devices – such as artificial limb, braces	20%	20%
Part B Drugs (including chemotherapy)	20%	20%
Radiation Therapy	20%	20%
Outpatient Dialysis	20%	20%
Eyewear Allowance Dental Coverage Hearing Aid Allowance	$100 eyewear allowance every two years $300 per calendar year for any dental services $600 every 3 yrs. (also TruHearing® 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	$8 copayment	$16 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
Coverage Gap Stage	If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach $3,750, you will pay 44% for generic drugs, 35% 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 drugs.	
Catastrophic Coverage Stage	When you have paid $5,000 out of pocket, your cost for prescriptions is reduced to 5% or $3.35 for generics and $8.35 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.
Wellness Rewards	$75 gift card when certain preventive services are completed.
The SilverSneakers® Fitness Program	Free fitness center membership benefits at a participating fitness center near you, including use of equipment and other amenities.

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).

* Preferred Brand Diabetic Test Strips: Precision, OneTouch and Freestyle Brands