MVP HEALTH CARE

SIDE-BY-SIDE COMPARISON OF 2021 PLAN BENEFITS

MEDICARE ADVANTAGE BENEFITS

SERVICES	Preferred GOLD HMO-POS 2020	Preferred GOLD HMO-POS 2021
OFFICE VISIT PHYSICIAN SERVICES		
Diagnostic Office Visit	PCP: $10 co-payment per visit Specialist: $15 co-payment per visit	PCP: $10 co-payment per visit Specialist: $15 co-payment per visit
Well-Child Care	PCP: $10 co-payment per visit	PCP: $10 co-payment per visit
Allergy Tests and Injections	PCP: $10 co-payment per visit Specialist: $15 co-payment per visit	PCP: $10 co-payment per visit Specialist: $15 co-payment per visit
Eye Exams	Routine eye exams covered once every year with a $15 co-payment Eye exams associated with disease or injury, $15 co-payment	Routine eye exams covered once every year with a $15 co-payment Eye exams associated with disease or injury, $15 co-payment
Eyewear	$100 benefit every 2 years (24months)	$100 benefit every 2 years (24 months)
Hearing Evaluations	PCP: $10 co-payment per visit Specialist: $15 co-payment per visit	PCP: $10 co-payment per visit Specialist: $15 co-payment per visit
Hearing Aids	$600 benefit every three years (also TruHearing® Discounts)	$600 benefit every three years (also TruHearing® Discounts)
Diagnostic Laboratory	Covered in full	Covered in full
Diagnostic X-ray	$15 co-payment per visit	$15 co-payment per visit
Surgical Care/ Ambulatory	Covered in full	Covered in full
Physical/Speech/ Occupational Therapy	$15 co-payment per visit; Combined annual therapy cap of **$2,010** between PT and ST. Annual maximum of **$2,010** for OT	$15 co-payment per visit; Combined annual therapy cap of **$2,010** between PT and ST. Annual maximum of **$2,010** for OT
Chiropractic Services	$15 co-payment when medically necessary	$15 co-payment when medically necessary

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MVP HEALTH CARE

SIDE-BY-SIDE COMPARISON OF 2021 PLAN BENEFITS

MEDICARE ADVANTAGE BENEFITS

SERVICES	Preferred GOLD HMO-POS	Preferred GOLD HMO-POS 2021
OFFICE VISIT PHYSICIAN SERVICES		
Chemotherapy and Immunology	$15 co-payment when medically necessary	$15 co-payment when medically necessary
Radiation Therapy	Covered in full	Covered in full

MATERNITY		
Hospital Charges for Mother (including Delivery Room and Newborn Nursery Care)	Semi-private accommodations and all medically necessary services are covered in full.	Semi-private accommodations and all medically necessary services are covered in full.
Prenatal and Postnatal Care	$10 co-payment per visit $15 co-payment for pregnancy-related radiological procedures, such as ultrasound and amniocentesis.	$10 co-payment per visit $15 co-payment for pregnancy-related radiological procedures, such as ultrasound and amniocentesis.

INPATIENT SERVICES		
Hospital Services Private room covered when medically necessary and authorized by an MVP Medical Director.	Unlimited days of semi-private room accommodations and all medically necessary services for acute care are covered in full.	Unlimited days of semi-private room accommodations and all medically necessary services for acute care are covered in full.

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MEDICARE ADVANTAGE BENEFITS

SERVICES	Preferred GOLD HMO-	Preferred GOLD HMO-POS
INPATIENT SERVICES		
Skilled Nursing Facility Private room covered when medically necessary and authorized by An MVP Medical Director.	Days 1-20 are covered in full; Day 21-100 are covered with a $135 co-payment per day.	Days 1-20 are covered in full; Day 21-100 are covered with a $135 co-payment per day.
Hospice	Covered under Medicare	Covered under Medicare
Surgery and Anesthesia	Covered in full	Covered in full

EMERGENCY SERVICES		
Ambulance	Covered with a $50 co-payment	Covered with a $50 co-payment
Life Threatening and Urgent Medical Emergencies	In Emergency Room, $65 co-payment per visit or waived when admitted within 24 hours Urgent Care Centers, $15 co-payment	In Emergency Room, $65 co-payment per visit or waived when admitted within 24 hours Urgent Care Centers, $15 co-payment

PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES		
Mental Health Inpatient	Unlimited days of semi-private room accommodations and all medically necessary services for acute care are covered in full. (Lifetime maximum of 190 days in a psychiatric hospital).	Unlimited days of semi-private room accommodations and all medically necessary services for acute care are covered in full. (Lifetime maximum of 190 days in a psychiatric hospital).
Mental Health Outpatient	$15 co-payment per visit	$15 co-payment per visit
Substance Abuse Inpatient	Covered in full	Covered in full
Substance Abuse Outpatient	$15 co-payment per visit	$15 co-payment per visit

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SIDE-BY-SIDE COMPARISON OF 2021 PLAN BENEFITS

MEDICARE ADVANTAGE BENEFITS

SERVICES	Preferred GOLD HMO-	Preferred GOLD HMO-POS
PRESCRIPTION SERVICES		
Prescription Drugs Under the Generic MAC program, if there is an A-rated generic drug, you have the option of choosing the brand name drug but will be responsible for the difference in cost between the generic and the brand name drug plus your co-payment. **Not Covered:** Non-standard/unevaluated medications and cosmetic drugs. **Generic MAC program does not apply to Preferred Gold.**	**Retail:** Up to a 30-day supply of approved drugs is covered with a $0 co-pay for Tier 1 preferred generic drugs, $10 co-pay for Tier 2 generic drugs, $30 co-pay for Tier 3 preferred brand-name drugs, $60 co-pay for Tier 4 non-preferred drugs, $60 co-pay for Tier 5 specialty drugs **Mail Order Program:** Up to a 90-day supply of approved drugs is covered with a $0 co-payment for Tier 1 preferred generic drugs, $20 co-payment for Tier 2 generic drugs, $60 co-payment for Tier 3 preferred brand-name drugs, $120 co-payment for Tier 4 non-preferred drugs, Tier 5 specialty drugs are not available **Coverage Gap Stage** If your total drug costs (paid by both you and MVP Health Plan, Inc.) reach $4,020, you will pay either the copayments as listed above or less. You will continue to pay $0 for Tier 1 drugs. **Catastrophic Coverage Stage** When you have paid $6,350 out of pocket, your cost for prescriptions is reduced to 5% or $3.60 for generics and $8.95 for all other drugs, whichever is greater. You will never pay more in Catastrophic Coverage than you did in the Initial Coverage stage. **Additional Coverage** Your plan also covers the following: Erectile dysfunction drugs, weight-loss agents, and additional barbiturates (butalbital/aspirin/caffeine).	**Retail:** Up to a 30-day supply of approved drugs is covered with a $0 co-pay for Tier 1 preferred generic drugs, $10 co-pay for Tier 2 generic drugs, $30 co-pay for Tier 3 preferred brand-name drugs, $60 co-pay for Tier 4 non-preferred drugs, $60 co-pay for Tier 5 specialty drugs **Mail Order Program:** Up to a 90-day supply of approved drugs is covered with a $0 co-payment for Tier 1 preferred generic drugs, $20 co-payment for Tier 2 generic drugs, $60 co-payment for Tier 3 preferred brand-name drugs, $120 co-payment for Tier 4 non-preferred drugs, Tier 5 specialty drugs are not available **Coverage Gap Stage** 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. **Catastrophic Coverage Stage** 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. **Additional Coverage** Your plan also covers the following: Erectile dysfunction drugs, weight-loss agents, and additional barbiturates (butalbital/aspirin/caffeine).

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SIDE-BY-SIDE COMPARISON OF 2021 PLAN BENEFITS

MEDICARE ADVANTAGE BENEFITS

SERVICES	Preferred GOLD HMO-	Preferred GOLD HMO-POS
PRESCRIPTION SERVICES		
Diabetic Supplies and Insulin/Oral Agents	**Diabetic Glucose strips:** Must be preferred brands covered at 0% co-insurance. Other diabetic supplies are covered at 10% co-insurance. **Retail:** There is a co-payment for each 30 day supply of $0 Tier 1 preferred generic drugs, $10 co-payment for Tier 2 generic drugs, $30 co-payment for Tier 3 preferred brand name drugs, $60 co-payment for Tier 4 non preferred drugs, and $60 co-payment for tier 5 specialty drugs. **Mail Order Program:** Up to a 90 day supply of approved drugs is covered with a co-payment of $0 for Tier 1 preferred generic drugs, a $20 co-payment for Tier 2 generic drugs, a $60 co-payment for Tier 3 preferred brand name drugs, a $120 co-payment for Tier 4 non preferred drugs, and Tier 5 specialty drugs are not available. You pay 10% of the cost of Diabetic supplies not covered under the Part D prescription drug benefit.	**Diabetic Glucose strips:** Must be preferred brands covered at 0% co-insurance. Other diabetic supplies are covered at 10% co-insurance. **Retail:** There is a co-payment for each 30 day supply of $0 Tier 1 preferred generic drugs, $10 co-payment for Tier 2 generic drugs, $30 co-payment for Tier 3 preferred brand name drugs, $60 co-payment for Tier 4 non preferred drugs, and $60 co-payment for tier 5 specialty drugs. **Mail Order Program:** Up to a 90 day supply of approved drugs is covered with a co-payment of $0 for Tier 1 preferred generic drugs, a $20 co-payment for Tier 2 generic drugs, a $60 co-payment for Tier 3 preferred brand name drugs, a $120 co-payment for Tier 4 non preferred drugs, and Tier 5 specialty drugs are not available. You pay 10% of the cost of Diabetic supplies not covered under the Part D prescription drug benefit.
Injectable Medications	Physician administered injectable drugs (including chemotherapy) will be covered with a $15 co-payment on the drug.	Physician administered injectable drugs (including chemotherapy) will be covered with a $15 co-payment on the drug.

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MEDICARE ADVANTAGE BENEFITS

SERVICES	Preferred GOLD HMO-POS	Preferred GOLD HMO-POS
OTHER SERVICES		
Home Care	$0 co-payment per visit	$0 co-payment per visit
Internal Prosthetics	20% Co-insurance	20% Co-insurance
Durable Medical Equipment	Coverage is limited to 80% of Covered Expenses and must be prescribed (and, in some cases, Pre-Certified and/or Prior- Justified) by a Plan Physician and obtained through a Participating DME Provider.	Coverage is limited to 80% of Covered Expenses and must be prescribed (and, in some cases, Pre-Certified and/or Prior-Justified) by a Plan Physician and obtained through a Participating DME Provider.
External Prosthetics and Orthopedic Braces and Supports	Coverage is limited to 80% of Covered Expenses and must be prescribed (and, in some cases, Pre-Certified and/or Prior-Justified) by a Plan Physician and obtained through a Participating Provider.	Coverage is limited to 80% of Covered Expenses and must be prescribed (and, in some cases, Pre-Certified and/or Prior-Justified) by a Plan Physician and obtained through a Participating Provider.
Acupuncture	50% coverage up to 10 visits per year	50% coverage up to 10 visits per year

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