





<b>MVP Health Care Premier Plus Platinum and Premier Plus Gold Individual - HMO Network</b>						
	Premier Plus Platinum 1	Premier Plus Platinum 2	Premier Plus Gold 1	Premier Plus Gold 2 QHDHP	Premier Plus Gold 4	Premier Plus Gold 5
Individual	\$655.28	\$663.56	\$556.68	\$529.46	\$595.58	\$562.52
Employee/Children	\$1,113.98	\$1,128.05	\$946.36	\$900.08	\$1,012.49	\$956.28
Double	\$1,310.56	\$1,327.12	\$1,113.36	\$1,058.92	\$1,191.16	\$1,125.04
Family	\$1,867.55	\$1,891.15	\$1,586.54	\$1,508.96	\$1,697.40	\$1,603.18
<b>Medical Deductible (Individual/Family)</b>	\$0 / \$0	\$0 / \$0	\$950 / \$1,900 Emb	\$1,600 / \$3,200 Agg	\$0 / \$0	\$1,200 / \$2,400
<b>Out of Pocket/Coinsurance Maximum</b>	\$3,300 / \$6,600 Emb	\$2,700 / \$5,400 Emb	\$6,550 / \$13,100	\$6,550 / \$13,100 Emb	\$6,750 / \$13,500	\$4,700 / \$9,400
<b>Preventive Care</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>Primary Care</b>	3 visits at \$0, then \$5	\$5	3 visits at \$0, then \$15 NoDD	\$5 *	\$40	\$30 NoDD
<b>Specialist Visit</b>	\$45	\$35	\$50 *	\$25 *	\$50	\$50 NoDD
<b>Hospital Facility Visit-Inpatient/Outpatient</b>	\$300 / \$100	\$300 / \$200	\$500 * / \$200 *	\$200 * / \$100 *	\$1,000 / \$300	20% * / 20% *
<b>Emergency Room</b>	\$200	\$200	\$350 NoDD	\$75 *	\$500	\$300 NoDD
<b>Ambulance</b>	\$200	\$200	\$350 No DD	\$75 *	\$500	\$300 NoDD
<b>Urgent Care</b>	\$45	\$35	\$50 NoDD	\$25 *	\$50	\$50 NoDD
<b>Durable Medicare Equipment (DME)</b>	50% Coinsurance	50% Coinsurance	50% Coinsurance *	50% Coinsurance *	50% Coinsurance	50% Coinsurance *
<b>Telemed</b>	\$5	\$5	\$15 NoDD	\$5 *	\$40	\$30 NoDD
<b>Pediatric Vision Care</b>	\$45	\$35	\$50 *	\$25 *	\$50	\$50
<b>Prescription Co-payment</b>	\$10 / \$40 / \$60	\$5 / \$30 / \$50	\$10 / \$40 / \$60 *	\$5 / \$15 / \$25 *	\$10 / \$40 / \$60	\$5 / \$30 / \$50
<b>Pharmacy Deductible Ind/Fam</b>	\$0 / \$0	\$0 / \$0	\$100 / \$200 (Name Brand Only)	Integrated w/medical	\$0 / \$0	\$0 / \$0
<b>Preventive Drug List</b>	No	No	No	Yes	No	No
	Platinum 1	Platinum 2	Gold 1	Gold 2 QHDHP	Gold 4	Gold 5
<b>Pediatric Dental is required by the ACA for dependents under the age of 19 - Monthly premium is \$30.36 for child(ren)</b>						
Domestic Partner Rider is included covering Same or Opposite Sex - Mail order RX not covered - Plans include \$1,000 out-of-area coverage for dependents						
* Deductible applied to this benefit - Member amount after deductible is met.						
<b>Aggregate:</b> Out of pocket maximum must be met by any one or any combination of members before the plans will make payments.						
<b>Embedded:</b> Each member will pay towards, but never exceeds, their individual deductible and/or OOPM until the larger Family deductible and/or OOPM is met.						
<b>To participate in the Chamber's insurance program, businesses must maintain their Chamber Membership.</b>						
<b>Open Enrollment is during the month of November for January 1st coverage. All paperwork must be received by Wednesday, November 30th.</b>						
This comparison has been prepared as a guide to assist you in evaluating the program. It is not a complete comparison or contract and in no way details all the benefits, limitations or exclusions. Rates and terms are subject to change. Plan summaries are available upon request. Monthly premium rates shown do not include administrative fees.						

<b>MVP Health Care Premier Plus Silver Individual Plans - HMO Network</b>				
				
	Premier Plus Silver 1	Premier Plus Silver 2	Premier Plus Silver 3 QHDHP	Premier Plus Silver 9
Individual	\$481.78	\$440.36	\$454.58	510.84
Employee/Children	\$819.03	\$748.61	\$772.79	868.43
Double	\$963.56	\$880.72	\$909.16	1,021.68
Family	\$1,373.07	\$1,255.03	\$1,295.55	1,455.89
<b>Medical Deductible (Individual/Family)</b>	<b>\$1,800 / \$3,600 Emb</b>	<b>\$3,400 / \$6,800 Emb</b>	<b>\$2,500 / \$5,000 Agg</b>	<b>\$4,000 / \$8,000 Emb</b>
<b>Out of Pocket/Coinsurance Maximum</b>	<b>\$6,800 / \$13,600</b>	<b>\$7,150 / \$14,300</b>	<b>\$5,000 / \$10,000 Emb</b>	<b>\$7,150 / \$14,300 Emb</b>
<b>Preventive Care</b>	\$0	\$0	\$0	\$0
<b>Primary Care</b>	\$40 NoDD	3 visits at \$0, then \$40 NoDD	\$30 *	\$30 NoDD
<b>Specialist Visit</b>	<b>\$60 *</b>	<b>\$70 *</b>	<b>\$60 *</b>	<b>\$50 NoDD</b>
<b>Hospital Facility Visit-Inpatient/Outpatient</b>	20% * / \$300 *	20% * / \$200 *	\$500 * / \$200 *	20% * / 20% *
<b>Emergency Room</b>	<b>\$500 *</b>	\$500 NoDD	\$300 *	\$150 NoDD
<b>Ambulance</b>	<b>\$500 *</b>	<b>\$500 NoDD</b>	<b>\$300 *</b>	<b>\$150 NoDD</b>
<b>Urgent Care</b>	<b>\$60 *</b>	\$70 NoDD	<b>\$60 *</b>	\$50 NoDD
<b>Durable Medicare Equipment (DME)</b>	50% Coinsurance	50% Coinsurance *	50% Coinsurance *	50% Coinsurance *
<b>Telemed</b>	\$40 NoDD	\$40 NoDD	\$30 *	\$30 NoDD
<b>Pediatric Vision Care</b>	\$60 *	\$70 *	\$60 *	\$50
<b>Prescription Co-payment</b>	<b>\$10 / \$45 / \$90</b>	\$15 / \$40 / \$70 *	<b>\$10 / \$45 / \$90 *</b>	\$10 / \$35 / \$70
<b>Pharmacy Deductible Ind/Fam</b>	\$0 / \$0	Integrated w/medical	Integrated w/medical	\$0 / \$0
<b>Preventive Drug List</b>	No	No	Yes	No
	<b>Silver 1</b>	<b>Silver 2</b>	<b>Silver 3 QHDHP</b>	<b>Silver 9</b>
<b>Pediatric Dental is required by the ACA for dependents under the age of 19 - Monthly premium is \$30.36 for child(ren)</b>				
Domestic Partner Rider is included covering Same or Opposite Sex - Mail order RX not covered - Plans include \$1,000 out-of-area coverage for dependents				
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<b>MVP Health Care Premier Plus Individual Bronze Plans - HMO Network</b>				
				
	Premier Plus Bronze 1	Premier Plus Bronze 2	Premier Plus Bronze 3	Premier Plus Bronze 6
Individual	\$398.90	\$373.09	\$386.90	388.70
Employee/Children	\$678.13	\$634.25	\$657.73	660.79
Double	\$797.80	\$746.18	\$773.80	777.40
Family	\$1,136.87	\$1,063.31	\$1,102.67	1,107.80
<b>EMBEDDED</b>				
Medical Deductible (Individual/Family)	\$3,900 / \$7,800	\$5,100/ \$10,200	\$5,900 / \$11,800	\$6,550 / \$13,100
Out of Pocket/Coinsurance Maximum	\$7,150 / \$14,300	\$7,150 / \$14,300	\$6,550 / \$13,100	\$6,550 / \$13,100
Preventive Care	\$0	\$0	\$0	\$0
Primary Care	\$40 *	1 visit at \$0 NoDD, then \$40% *	\$30 *	0% *
Specialist Visit	\$80 *	40% *	\$50 *	0% *
Hospital Facility Visit-Inpatient/Outpatient	\$1,500 * / \$300 *	40% * / 40% *	30% * / \$100 *	0% * / 0% *
Emergency Room	\$500 *	40% *	\$500 *	\$0% *
Ambulance	\$500 *	40% Coinsurance *	\$500 *	\$0 *
Urgent Care	\$80 *	40% *	\$50 *	0% *
Durable Medicare Equipment (DME)	50% Coinsurance *	40% Coinsurance *	50% Coinsurance *	0% Coinsurance *
Teleded	\$40 *	40% *	\$30 *	0% *
Pediatric Vision Care	\$80 *	40% Coinsurance *	\$50 *	\$0 *
Prescription Co-payment	\$10 / \$45 / \$90 *	\$5 / \$60 / \$80 *	\$10 / \$45 / \$90 *	0% / 0% / 0% *
Pharmacy Deductible Ind/Fam	\$200 / \$400	Integrated w/medical	Integrated w/medical	Integrated w/medical
Preventive Drug List	No	No	Yes	Yes
	<b>Bronze 1</b>	<b>Bronze 2</b>	<b>Bronze 3</b>	<b>Bronze 6</b>
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Domestic Partner Rider is included covering Same or Opposite Sex - Mail order RX not covered - Plans include \$1,000 out-of-area coverage for dependents				
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MVP Health Care STANDARD Premier Plans: Platinum - Gold - Silver and Bronze - HMO Network							
							
	Standard Platinum	Standard Gold	Standard Gold 2	Standard Silver	Standard Silver 2	Standard Bronze 1	Standard Bronze 2
Individual	\$667.70	\$576.13	\$576.13	\$481.78	\$483.64	\$376.09	\$377.29
Employee/Children	\$1,135.09	\$979.42	\$979.42	\$819.03	\$822.19	\$639.35	\$641.39
Double	\$1,335.40	\$1,152.26	\$1,152.26	\$963.56	\$967.28	\$752.18	\$754.58
Family	\$1,902.95	\$1,641.97	\$1,641.97	\$1,373.07	\$1,378.37	\$1,071.86	\$1,075.28
<b>EMBEDDED</b>							
Medical Deductible (Individual/Family)	\$0 / \$0	\$600 / \$1,200	\$650 / \$1,300	\$2,000 / \$4,000	\$2,350 / \$4,700	\$5,500 / \$11,000	\$4,000 / \$8,000
Out of Pocket/Coinsurance Maximum	\$2,000 / \$4,000	\$4,000 / 8,000	\$5,000 / \$10,000	\$6,750 / \$13,500	\$7,150 / \$14,300	\$6,550 / \$13,100	\$7,150 / \$14,300
Preventive Care	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care	\$15	\$25 *	3 visits at \$25, then \$25 *	\$30 *	3 visits at \$35, then \$35 *	50% *	50% *
Specialist Visit	\$35	\$40 *	\$40 *	\$50 *	\$55 *	50% *	50% *
Hospital Facility Visit-Inpatient/Outpatient	\$500 / \$100	\$1,000 * / \$100 *	\$1,000 / \$100	\$1,500 * / \$100 *	\$1,500 * / \$100 *	50% * / 50% *	50% * / 50% *
Emergency Room	\$100	\$150 *	\$150 *	\$250 *	\$250 *	50% *	50% *
Ambulance	\$100	\$150 *	\$150 *	\$150 *	\$150 *	50% Coinsurance *	50% Coinsurance *
Urgent Care	\$55	\$60 *	\$60 *	\$70 *	\$70 *	50% *	50% *
Durable Medicare Equipment (DME)	10% Coinsurance	20% Coinsurance *	20% Coinsurance *	30% Coinsurance *	30% Coinsurance *	50% Coinsurance *	50% Coinsurance *
Telemed	\$15	\$25 *	\$25 *	\$30 *	\$35 *	50% *	50% *
Pediatric Vision Care	\$15	\$25 *	\$25 *	\$30 *	\$35 *	50% Coinsurance *	50% Coinsurance *
Prescription Co-payment	\$10 / \$30 / \$60	\$10 / \$35 / \$70	\$10 / \$40 / \$80	\$10 / \$35 / \$70	\$10 / \$40 / \$80	\$10 / \$35 / \$70 *	\$10 / \$35 / \$70 *
Pharmacy Deductible Ind/Fam	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$0 / \$0	Integrated w/Medical	Integrated w/Medical
Preventive Drug List	No	No	No	Yes	No	No	No
	<b>Platinum</b>	<b>Gold</b>	<b>Gold 2</b>	<b>Silver</b>	<b>Silver 2</b>	<b>Bronze 1</b>	<b>Bronze 2</b>
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