

2010 MVP Benefit Comparison for GRAR Members

Services	MVP TriVantage EPO T03S			MVP Hybrid EPO	MVP Preferred EPO
	Active Lifestyles - T03SA	Family Focus - T03SB	Healthy Alternatives - T03SC	E0016S	E0050S
Annual Deductible	N/A	N/A	N/A	\$1,000/\$2,000/\$2,500	N/A
Annual Out of Pocket Max	N/A	N/A	N/A	\$3,000/\$6,000/\$7,500	N/A
Coinsurance	N/A	N/A	N/A	20%	N/A
Referrals	Not Required	Not Required	Not Required	Not Required	Not Required
PCP Office Visit	\$15 Copay	\$20 Adults/\$5 Children	\$25 Copay	\$30 Copay	\$25 Copay
Specialist Visit	\$40 Copay	\$40 Copay	\$40 Copay	\$30 Copay	\$40 Copay
Routine Eye Exams	\$15 Adults/\$20 Children	\$20 Adults/\$5 Children	\$25 Adults/\$20 Children	\$30 Copay	\$40 Copay
Eyewear	80% Lens Coverage (\$160 Max)	80% Lens Coverage (\$160 Max)	80% Lens Coverage (\$160 Max)	80% Lens Coverage (\$160 Max)	Not Covered
Hospital Inpatient	\$300 Copay	\$300 Copay (\$0 Children)	\$300 Copay	20% Coinsurance*	\$500 Copay
Outpatient Surgery	\$100 Copay	\$100 Copay	\$100 Copay	20% Coinsurance*	\$150 Copay
Emergency Room Care	\$50 Copay	\$75 Copay	\$75 Copay	\$200 Copay	\$100 Copay
Outpatient Mental Health	\$40 Copay (20 visits)	\$40 Copay (20 visits)	\$40 Copay (20 visits)	\$30 Copay (20 visits)	\$40 Copay (20 visits)
Inpatient Mental Health 30 Day Annual Max	\$300 Copay	\$300 Copay (\$0 Children)	\$300 Copay	20% Coinsurance*	\$500 Copay
Prescription Coverage Mail Order: 2.5 copays for 90 day supply	Tier 1/\$10 Tier 2/\$30 Tier 3/\$50 \$1000 Annual Max per Member	Tier 1/\$10 Tier 2/\$30 Tier 3/\$50 \$1000 Annual Max per Member	Tier 1/\$10 Tier 2/\$30 Tier 3/\$50 \$1000 Annual Max per Member	Tier 1/\$10 Tier 2/\$30 Tier 3/\$50 \$1000 Total Policy Annual Max	\$10 Copay Generic Drug Coverage Only
Dependent Coverage	To Age 26	To Age 26	To Age 26	To Age 26	To Age 23
Extra Benefits www.mvphealthcare.com	\$300 Lifestyle Benefit \$300 WellStyle Rewards	\$300 Lifestyle Benefit \$300 WellStyle Rewards	\$300 Lifestyle Benefit \$300 WellStyle Rewards	\$300 WellStyle Rewards	\$300 WellStyle Rewards
Special Information	Preventive Care Covered In Full Domestic Partner Coverage CIGNA National Network Annual Eye Exam	Preventive Care Covered In Full Domestic Partner Coverage CIGNA National Network Annual Eye Exam	Preventive Care Covered In Full Domestic Partner Coverage CIGNA National Network Annual Eye Exam	Preventive Care Covered In Full Domestic Partner Coverage CIGNA National Network 1 eye exam every 2 years	Preventive Care Covered In Full Domestic Partner Coverage CIGNA National Network Annual Eye Exam
Employer Group					
Single	\$360.98	\$360.98	\$360.98	\$289.35	\$327.82
Family of 2	\$712.96	\$712.96	\$712.96	\$569.71	\$646.64
Family	\$962.14	\$962.14	\$962.14	\$767.04	\$865.24
Sole Proprietor					
Single	\$413.77	\$413.77	\$413.77	\$331.40	\$375.64
Family of 2	\$818.55	\$818.55	\$818.55	\$653.82	\$742.28
Family	\$1,105.11	\$1,105.11	\$1,105.11	\$880.75	\$993.68

*Services subject to deductible and coinsurance.