2024 Summary of Benefits

MVP Health Plan, Inc.

MVP® Medicare WellSelect®with Part D (PPO)

MVP Medicare Patriot Plan℠ with Part D (PPO)

H9615: Plan 010, Plan 018

This is a summary of drug and health services covered by MVP Health Plan January 1, 2024 - December 31, 2024.

MVP Health Plan, Inc. is an HMO-POS/PPO organization with a Medicare contract. Enrollment in MVP Health Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join **MVP® Medicare WellSelect® with Part D (PPO)** or **MVP Medicare Patriot Plan℠ with Part D (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our Hudson Valley service area includes the following counties in New York: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester.

MVP® Medicare WellSelect® with Part D (PPO) and **MVP Medicare Patriot Plan℠ with Part D (PPO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are in our network, you will pay less for your covered services. But if you want to, you can also use providers that are not in our network and will pay more for your covered services.

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Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan℠ with Part D (PPO)	What you should know
Monthly Plan Premium	You pay $0.	You pay $42.40	You must continue to pay your Part B premium. ($164.90 in 2023). This amount may change in 2024.
Deductible	This plan does not have a medical deductible.	This plan does not have a medical deductible.	
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$7,550 In-Network and $11,300 In/Out-of-Network combined annually.	$7,550 In-Network and $11,300 In/Out-of-Network combined annually.	The most you pay for co-pays, co-insurance, and other costs for medical services for the year.
Inpatient Hospital Coverage (Services may require Authorization)	In-Network: You pay $385 co-pay per day for days 1 through 5. You pay $0 co-pay per day for days 6 through 90. You pay $0 co-pay per day for days 91 and beyond. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay $400 co-pay per day for days 1 through 5. You pay $0 co-pay per day for days 6 through 90. You pay $0 co-pay per day for days 91 and beyond. Out-of-Network: 40% co-insurance.	Our plan covers an unlimited number of days for an inpatient hospital stay. Co-payment is applied to each new inpatient hospital stay. Medicare benefit periods do not apply.
Outpatient Hospital Coverage (Services may require Authorization)	In-Network: You pay $350 co-pay for Outpatient Hospital surgery. You pay $225 co-pay for care in a certified ambulatory surgical center. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay $350 co-pay for Outpatient Hospital surgery. You pay $200 co-pay for care in a certified ambulatory surgical center. Out-of-Network: 40% co-insurance.	Physician surgery co-pay also applies for outpatient hospital or ambulatory surgery.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan℠ with Part D (PPO)	What you should know
Doctor Visits • Primary Care Providers	In-Network: You pay $0 co-pay per PCP visit. Out-of-Network: You pay $5 co-pay per PCP visit.	In-Network: You pay $0 co-pay per PCP visit. Out-of-Network: You pay $5 co-pay per PCP visit.	Cost-sharing applies to each service you receive, including multiple services from the same provider.
• Specialists (Services may require Authorization)	In-Network: You pay $45 co-pay per Specialist visit. Out-of-Network: You pay $50 co-pay per Specialist visit.	In-Network: You pay $40 co-pay per Specialist visit. Out-of-Network: You pay $50 co-pay per Specialist visit.	
Preventive Care	In-Network/Out-of-Network: You pay $0 co-pay.	In-Network/Out-of-Network: You pay $0 co-pay.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost.
Emergency Care	In-Network/Out-of-Network: You pay $95 co-pay per visit.	In-Network/Out-of-Network: You pay $95 co-pay per visit.	If you are admitted to the hospital within 24 hours, co-pay is waived. Emergency care is provided worldwide.
Urgently Needed Services	In-Network/Out-of-Network: You pay $30 co-pay per visit.	In-Network/Out-of-Network: You pay $30 co-pay per visit.	Urgently needed services are provided worldwide.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan℠ with Part D (PPO)	What you should know
Diagnostic Services/Labs/ Imaging • Diagnostic radiology service (e.g., MRI)	In-Network: You pay $60-150 co-pay. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay $50-$200 co-pay. Out-of-Network: You pay 40% co-insurance.	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. Cost-sharing applies to each service you receive, including multiple services from the same provider.
• Lab services	In-Network: You pay $0 co-pay. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay $0 co-pay. Out-of-Network: You pay 40% co-insurance.	
• Diagnostic tests and procedures	In-Network: You pay $20 co-pay. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay $10 co-pay. Out-of-Network: You pay 40% co-insurance.	
• Outpatient x-rays (Services may require Authorization)	In-Network/Out-of-Network: You pay $60 co-pay.	In-Network: You pay $50 co-pay. Out-of-Network: You pay $60 co-pay.	

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan℠ with Part D (PPO)	What you should know
Hearing Services			
• Diagnostic Hearing exam	In-Network: You pay $0 co-pay. Out-of-Network: You pay $60 co-pay.	In-Network: You pay $0 co-pay. Out-of-Network: You pay $60 co-pay.	Routine Hearing exam limited to one per calendar year. Hearing Aids must be ordered through TruHearing. Limit 1 hearing aid per ear per calendar year.
• Routine Hearing exam	In-Network: You pay $0 co-pay. Out-of-Network: You pay $60 co-pay.	In-Network: You pay $0 co-pay. Out-of-Network: You pay $60 co-pay.	
• Hearing aid	In-Network $699-$999 per hearing aid or get up to $600 toward the cost of two hearing aids every year. Out-of-Network: Not covered	In-Network $699-$999 per hearing aid or up to $600 toward the cost of two hearing aids every year. Out-of-Network: Not Covered.	

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Over-the-Counter (OTC) Items			
• OTC Allowance	$75.00 Allowance per quarter	$50.00 Allowance per quarter	Allowance is received quarterly to be used towards eligible over-the-counter medicine and health-related purchases from select pharmacies or by mail order. Allowance amount does not carry over from quarter to quarter
• Arthritis Post-Joint Replacement Procedure Care Kit	Customizable care kit	Customizable care kit	Must have a prior authorization or have undergone a joint replacement within the plan year with a diagnosis of Rheumatoid Arthritis or Osteoarthritis, can receive a customizable care kit with items such as, but not limited to, a reacher, shoehorn, non-slip bathmat, tieless shoelaces, and long handled shower sponge through our approved contracted vendor.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan℠ with Part D (PPO)	What you should know
Preventive Dental Services • Preventive Dental (Oral Exams, Prophylaxis, Fluoride, X-Rays)	Annual Maximum Plan Benefit Coverage Amount: $1,500 combined Preventive and Comprehensive services, per calendar year for in and out-of-network benefits (services above the limit are your responsibility).	Annual Maximum Plan Benefit Coverage Amount: $1,750 combined Preventive and Comprehensive services, per calendar year for in and out-of-network benefits (services above the limit are your responsibility).	Payment limited to established Fee Schedule. If your provider does not participate in the Plan's network and charges more than the maximum allowable benefit, you will be responsible for the additional cost. See the Evidence of Coverage for more information.
• Comprehensive Dental (Diagnostic Services, Restorative Services, Endodontics, Periodontics, Extractions, Prosthodontics, Oral/Maxillofacial Surgery, Other Services)	In-network: You pay a $0 copayment. Out-of-network: You pay a 0% coinsurance. In-network: You pay a $0 copayment. Out-of-network: You pay a 0% coinsurance.	In-network: You pay a $0 copayment. Out-of-network: You pay a 20% coinsurance. In-network: You pay a $0 copayment. Out-of-network: You pay a 20%-50% coinsurance	

Vision Services • Diagnostic eye exam	In-Network: You pay $20 co-pay. Out-of-Network: You pay $60 co-pay.	In-Network: You pay $20 co-pay. Out-of-Network: You pay $60 co-pay.	Routine eye exam is limited to one per calendar year.
• Routine eye exam	In-Network/Out-of-Network: You pay $0 co-pay.		
• Post-cataract surgery eyewear	In-Network: You pay 20% co-insurance. Out-of-Network: You pay 40% co-insurance.	In-Network/Out-of-Network: You pay $0 co-pay.	
• Eyewear allowance	In-Network/Out-of-Network: $150 every year eyewear allowance.	In-Network: You pay 20% co-insurance. Out-of-Network: You pay 40% co-insurance. In-Network/Out-of-Network: $175 every year eyewear allowance.	

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan℠ with Part D (PPO)	What you should know
Mental Health Services • Inpatient visit	In-Network: You pay $370 co-pay per day for days 1 through 5. You pay $0 co-pay per day for days 6 through 90. You pay $0 co-pay per day for days 91 and beyond. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay $370 co-pay per day for days 1 through 5. You pay $0 co-pay per day for days 6 through 90. You pay $0 co-pay per day for days 91 and beyond. Out-of-Network: You pay 40% co-insurance.	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.
• Outpatient group therapy visit/Outpatient individual therapy visit (Services may require Authorization)	In-Network: You pay $10 co-pay per outpatient group/individual therapy visit. Out-of-Network: You pay $50 co-pay.	In-Network: You pay $10 per outpatient group / individual therapy visit. Out-of-Network: You pay $50 co-pay.	
Skilled Nursing Facility (SNF) (Services may require Authorization)	In-Network: You pay $0 co-pay per day for days 1 through 20. You pay $203 co-pay per day for days 21 through 100. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay $0 co-pay per day for days 1 through 20. You pay $203 co-pay per day for days 21 through 100. Out-of-Network: You pay 40% co-insurance.	Our plan covers up to 100 days in a SNF.

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Physical Therapy (Services may require Authorization)	In-Network: You pay $30 co-pay per visit. Out-of-Network: You pay $60 co-pay per visit.	In-Network: You pay $40 co-pay per visit. Out-of-Network: You pay $60 co-pay per visit.	Annual dollar limits apply to all outpatient therapy services. Dollar limit also applies to therapy services in a Skilled Nursing Facility (SNF) and hospital outpatient departments.
Ambulance (Services may require Authorization)	In-Network/Out-of-Network: $200 co-pay for ground ambulance. In-Network/Out-of-Network: $500 co-pay for air ambulance.	In-Network/Out-of-Network: You pay $150 co-pay for ground ambulance. In-Network/Out-of-Network: You pay $300 co-pay for air ambulance.	Paramedic Intercept may also be covered. These Advanced Life Support Services are separate from ambulance transportation and are covered if all of the following exist: 1. furnished in a rural area according to CMS or State; 2. through a contract with a volunteer ambulance service; 3. are medically necessary.
Transportation	You pay $0 co-pay. 26 one-way rides per year for medical appointments.	You pay $0 co-pay. 24 one-way rides per year for medical appointments non-VA providers (30-mile, one-way capitation per trip) and unlimited rides to VA facility (45-mile one-way capitation per trip)	Must use plan approved vendor. (30-mile, one-way capitation)

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Medicare Part B Drugs (Services may require Authorization)	In-Network: You pay 0-20% co-insurance. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay 20% co-insurance. Out-of-Network: You pay 40% co-insurance. In-Network: You pay 0%-20% co-insurance and your maximum cost share will not exceed $35.	The co-insurance You pay is based on the type of Part B drugs purchased at a pharmacy, administered by a pharmacist, or administered by your doctor. (An office visit co-pay may also apply.) Part B drugs may be subject to Step Therapy requirements
Foot Care (podiatry services) • Diagnostic Foot exams and treatment • Routine foot care (Services may require Authorization)	In-Network: You pay $45 co-pay. Out-of-Network: You pay $50 co-pay. In-Network: You pay $0 co-pay. Out-of-Network: You pay $50 co-pay	In-Network: You pay $40 co-pay. Out-of-Network: You pay $60 co-pay. In-Network: You pay $0 co-pay. Out-of-Network: You pay $60 co-pay.	Routine foot exams and treatment only if you have diabetes-related nerve damage and/or meet certain conditions.
Medical Equipment/ Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen)	In-Network: You pay 20% co-insurance. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay 20% co-insurance. Out-of-Network: You pay 40%	

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• Prosthetics (e.g., braces, artificial limbs)	In-Network: You pay 0-20% co-insurance. Out-of-Network: You pay 40% co-insurance.	co-insurance. In-Network: You pay 0-20% co-insurance. Out-of-Network: You pay 40% co-insurance.	
• Diabetes supplies (Services may require Authorization)	In-Network: You pay $0 co-pay for a 30-day supply of Freestyle, OneTouch, Precision and Prodigy brand blood glucose test strips and glucometers; you pay $0 co-pay for a 30-day supply of non-preferred strips that have prior authorization. Out-of-Network: You pay 40% co-insurance.	In-Network: You pay $0 co-pay for a 30-day supply of OneTouch, Precision, Freestyle, Prodigy brand blood glucose test strips and glucometers; you pay $0 co-pay for a 30-day supply of non-preferred strips that have prior authorization. Out-of-Network: You pay 40% co-insurance.	
Medical Equipment/Supplies (continued)			Must have diagnoses of Hypertension. One approved basic blood pressure cuff from our contracted vendor will be covered per year.
• Blood Pressure Cuff	One basic blood pressure cuff per year at no cost.	One basic blood pressure cuff per year at no cost.	
• Home and Bathroom Safety Devices and Modifications	$250 allowance per year in total for select items from our contracted vendor.	$250 allowance per year in total for select items from our contracted vendor.	Must have diagnoses related to Stroke. Bathroom safety items on a selected list from our contracted vendor including, but not limited to shower seats,

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			raised toilet seats, bathtub seats, and grab bars. Only the approved items will be covered and only through our approved contracted vendor.
Meal Benefit	14 meals post inpatient hospital discharge	14 meals post inpatient hospital discharge.	Post-hospitalization meals are covered through contracted vendor and set-up through Care Management program. 14 meals/7 days benefit. No limit to number of times benefit can be accessed in a calendar year so long as it is preceded by a hospitalization.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan℠ with Part D (PPO)	What you should know
Wellness Programs • SilverSneakers®	No cost for SilverSneakers® membership and to use SilverSneakers® fitness locations and virtual resources. Plus, you get access to GetSetUp, with thousands of live online classes to ignite your interests in topics like cooking, technology, and art.	No cost for SilverSneakers® membership and to use SilverSneakers® fitness locations and virtual resources. Plus, you get access to GetSetUp, with thousands of live online classes to ignite your interests in topics like cooking, technology, and art.	
• ***Be Well*** Rewards Program	With the MVP ***Be Well*** Rewards Program, Medicare members are rewarded with 100 points once they complete an annual wellness visit. Then members can redeem their reward points for a $100 gift card.	With the MVP ***Be Well*** Rewards Program, Medicare members are rewarded with 100 points once they complete an annual wellness visit. Then members can redeem their reward points for a $100 gift card.	
MVP Virtual Care Services	In-Network/Out-of-Network: You pay $0 co-pay per visit using remote access technology.	In-Network/Out-of-Network: You pay $0 co-pay per visit using remote access technology.	Must use plan-approved vendor(s). Using your smartphone, tablet, or laptop, you can access doctors via video.

Outpatient Prescription Drugs					
Benefits	**MVP® Medicare WellSelect® with Part D**		**MVP Medicare Patriot Plan℠ with Part D (PPO)**		**What you should know**
	Retail Rx 30-day supply	**Mail Order up to 90-day supply**	**Retail Rx 30-day supply**	**Mail Order up to 90-day supply**	You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Deductible	$250 Deductible. Tier 1, Tier 2, and Plan-covered Insulin drugs are not subject to the deductible.		$250 Deductible. Tier 1, Tier 2 and Select Insulin Drugs are not subject to deductible		
Initial Coverage					
Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drugs Tier 5: Specialty Tier Plan-covered Insulin	You pay $0. You pay $12. You pay $47. You pay 25%. You pay 27%. You pay up to $35.	You pay $0. You pay $24. You pay $94. You pay 25%. Not available. You Pay up to $70.	You pay $0. You pay $15. You pay $45. You pay 25%. You pay 27%. You pay up to $35.	You pay $0. You pay $30. You pay $90. You pay 25%. Not available. You pay up to $70.	You pay this amount for each prescription until your yearly drug costs reach $5,030. If you reside in a long-term care facility, only 31-day supply is available, and you pay the same as at a retail pharmacy.
Coverage Gap					

Outpatient Prescription Drugs					
Benefits	**MVP® Medicare WellSelect® with Part D**		**MVP Medicare Patriot Plan℠ with Part D (PPO)**		**What you should know**
Tier 1: Preferred Generic Other Generic Drugs (Tiers 2-5) Brand Name Drugs (Tiers 2-5) Plan-covered Insulin	You pay 25%. You pay 25%. You pay 25%. You pay up to $35.	You pay 25%. You pay 25%. You pay 25%. You pay up to $70.			You pay this amount for each prescription until your yearly out-of-pocket costs reach $8,000.
Catastrophic Coverage					
Tiers 1-5: You pay $0 co-payment for all drug tiers					You pay this amount after your yearly out-of-pocket costs reach $8,000.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **http://www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille, large print or audio.

For more information, please call us at the phone number below or visit us at **mvphealthcare.com.com**.
Toll-free **1-800-324-3899**, TTY users should call 711.
From October 1 – March 31, you can call us seven days a week from 8 am–8 pm Eastern Time.
From April 1 – September 30, you can call us Monday – Friday from 8 am–8 pm Eastern Time.

You can see our plan's provider directory at **mvphealthcare.com**

You can see our plan's pharmacy directory at **mvphealthcare.com/partD**

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions at **mvphealthcare.com/partD**

MVP Health Plan, Inc. is an HMO-POS/PPO organization with a Medicare contract. Enrollment in MVP Health Plan depends on contract renewal. Out-of-network/non-contracted providers are under no obligation to treat MVP Health Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. MVP virtual care services through Gia are available at no cost-share for most members. In-person visits and referrals are subject to cost-share per plan.

MVP Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sexual orientation and gender identity).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-946-8010 (TTY 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-946-8010 (TTY 711).

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