

2024 Summary of Benefits

MVP Health Plan, Inc.

MVP Medicare WellSelect[®] with Part D (PPO)

MVP Medicare WellSelect[®] Plus with Part D (PPO)

MVP Medicare Patriot PlanSM with Part D (PPO)

H9615: Plan 008, Plan 007, and 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)**, **MVP Medicare WellSelect[®] Plus with Part D (PPO)**, or **MVP Medicare Patriot PlanSM 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 Capital District/Southern Tier/Central NY service area includes the following counties in New York: Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Greene, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, Tioga, Tompkins, Warren, and Washington.

MVP[®] Medicare WellSelect with Part D (PPO), MVP Medicare WellSelect[®] Plus with Part D (PPO), or MVP Medicare Patriot PlanSM with Part D (PPO) has 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.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
Monthly Plan Premium	You pay \$0.	You pay \$122.40	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.	This plan does not have a medical deductible.	
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i>	\$7,550 In-Network and \$11,300 In/Out-of-Network combined annually.	\$6,500 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 <i>(Services may require Authorization)</i>	In-Network: You pay \$325 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.	In-Network: You pay \$300 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.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
Preventive Care	In-Network/Out-of-Network: You pay \$0 co-pay.	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.	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.	In-Network/Out-of-Network: You pay \$30 co-pay per visit.	Urgently needed services are provided worldwide.
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-\$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.

Premiums and Benefits	MVP Medicare WellSelect® with Part D (PPO)	MVP Medicare WellSelect® Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
<p>Lab services</p> <p>Diagnostic tests and procedures</p> <p>Diagnostic Services/Labs/Imaging (continued)</p> <p>Outpatient x-rays (Services may require Authorization)</p>	<p>In-Network: You pay \$0 co-pay. Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network: You pay \$20 co-pay. Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network/Out-of-Network: You pay \$50 co-pay.</p>	<p>In-Network: You pay \$0 co-pay. Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network: You pay \$10 co-pay. Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network: You pay \$40 co-pay. Out-of-Network: You pay \$60 co-pay.</p>	<p>In-Network: You pay \$0 co-pay. Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network: You pay \$10 co-pay. Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network: You pay \$50 co-pay. Out-of-Network: You pay \$60 co-pay.</p>	<p>Please contact the plan for more information.</p> <p>Cost-sharing applies to each service you receive, including multiple services from the same provider.</p>

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
<p>Hearing Services</p> <p>Diagnostic Hearing exam</p> <p>Routine Hearing exam</p> <p>Hearing aid</p>	<p>In-Network: You pay \$0 co-pay. Out-of-Network: You pay \$60 co-pay.</p> <p>In-Network: You pay \$0 co-pay. Out-of-Network: You pay \$60 co-pay.</p> <p>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.</p>	<p>In-Network: You pay \$0 co-pay. Out-of-Network: You pay \$60 co-pay.</p> <p>In-Network: You pay \$0 co-pay. Out-of-Network: You pay \$60 co-pay.</p> <p>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.</p>	<p>In-Network: You pay \$0 co-pay. Out-of-Network: You pay \$60 co-pay.</p> <p>In-Network: You pay \$0 co-pay. Out-of-Network: You pay \$60 co-pay.</p> <p>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.</p>	<p>Routine Hearing exams are limited to one per calendar year.</p> <p>Hearing Aids must be ordered through TruHearing. Limit 1 hearing aid per ear per calendar year.</p>

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know

<p>Preventive and Comprehensive Dental Services</p> <p>Preventive Dental (Oral Exams, Prophylaxis, Fluoride, X-Rays)</p> <p>Comprehensive Dental (Diagnostic Services, Restorative Services, Endodontics, Periodontics, Extractions, Prosthodontics, Oral/Maxillofacial Surgery, Other Services)</p>	<p>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).</p> <p>In-network: You pay a \$0 copayment.</p> <p>Out-of-network: You pay a 0% coinsurance.</p> <p>In-network: You pay a \$0 copayment.</p> <p>Out-of-network: You pay a 0% coinsurance.</p>	<p>Annual Maximum Plan Benefit Coverage Amount: \$2,000 combined Preventive and Comprehensive services, per calendar year for in and out-of-network benefits (services above the limit are your responsibility).</p> <p>In-network: You pay a \$0 copayment.</p> <p>Out-of-network: You pay a 20% coinsurance.</p> <p>In-network: You pay a \$0 copayment.</p> <p>Out-of-network: You pay a 20%-50% coinsurance.</p>	<p>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).</p> <p>In-network: You pay a \$0 copayment.</p> <p>Out-of-network: You pay a 20% coinsurance.</p> <p>In-network: You pay a \$0 copayment.</p> <p>Out-of-network: You pay a 20%-50% coinsurance</p>	<p>Payment and services 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. Limits may apply based on type of service. See the Evidence of Coverage for more information.</p>
---	--	--	---	--

Premiums and Benefits	MVP Medicare WellSelect® with Part D (PPO)	MVP Medicare WellSelect® Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
<p>Vision Services</p> <p>Diagnostic eye exam</p> <p>Routine eye exam</p> <p>Post-cataract surgery eyewear</p> <p>Eyewear allowance</p>	<p>In-Network: You pay \$20 co-pay.</p> <p>Out-of-Network: You pay \$60 co-pay.</p> <p>In-Network/Out-of-Network: You pay \$0 co-pay.</p> <p>In-Network: You pay 20% co-insurance.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network/Out-of-Network: \$150 every year eyewear allowance.</p>	<p>In-Network: You pay \$20 co-pay.</p> <p>Out-of-Network: You pay \$60 co-pay.</p> <p>In-Network/Out-of-Network: You pay \$0 co-pay.</p> <p>In-Network: You pay 20% co-insurance.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network/Out-of-Network: \$225 every year eyewear allowance.</p>	<p>In-Network: You pay \$20 co-pay.</p> <p>Out-of-Network: You pay \$60 co-pay.</p> <p>In-Network/Out-of-Network: You pay \$0 co-pay.</p> <p>In-Network: You pay 20% co-insurance.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network/Out-of-Network: \$175 every year eyewear allowance.</p>	<p>Routine eye exams limited to one per calendar year.</p>

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
<p>Skilled Nursing Facility (SNF) (Services may require Authorization)</p>	<p>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.</p>	<p>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.</p>	<p>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.</p>	<p>Our plan covers up to 100 days in a SNF.</p>
<p>Physical Therapy (Services may require Authorization)</p>	<p>In-Network: You pay \$30 co-pay per visit. Out-of-Network: You pay \$60 co-pay per visit.</p>	<p>In-Network: You pay \$20 co-pay per visit. Out-of-Network: You pay \$60 co-pay per visit.</p>	<p>In-Network: You pay \$40 co-pay per visit. Out-of-Network: You pay \$60 co-pay per visit.</p>	<p>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.</p>

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
<p>Ambulance (Services may require Authorization)</p>	<p>In-Network/Out-of-Network: You pay \$200 co-pay for ground ambulance.</p> <p>In-Network/Out-of-Network: You pay \$500 co-pay for air ambulance.</p>	<p>In-Network/Out-of-Network: You pay \$175 co-pay for ground ambulance.</p> <p>In-Network/Out-of-Network: You pay \$300 co-pay for air ambulance.</p>	<p>In-Network/Out-of-Network: You pay \$150 co-pay for ground ambulance.</p> <p>In-Network/Out-of-Network: You pay \$300 co-pay for air ambulance.</p>	<p>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.</p>

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
Transportation	You pay \$0 co-pay. 24 one-way rides per year for medical appointments.	You pay \$0 co-pay. 30 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)
Medicare Part B Drugs (Services may require Authorization) Insulin Drugs	In-Network: You pay 0%-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. 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. 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. Out-of-Network: You pay 40% co-insurance.	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.

Premiums and Benefits	MVP Medicare WellSelect® with Part D (PPO)	MVP Medicare WellSelect® Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
<p>Foot Care (podiatry services)</p> <p>Diagnostic foot exams and treatment</p> <p>Routine foot care (Services may require Authorization)</p>	<p>In-Network: You pay \$45 co-pay.</p> <p>Out-of-Network: You pay \$60 co-pay.</p> <p>In-Network: You pay \$0 co-pay.</p> <p>Out-of-Network: You pay \$60 co-pay.</p>	<p>In-Network: You pay \$50 co-pay.</p> <p>Out-of-Network: You pay \$60 co-pay.</p> <p>In-Network: You pay \$0 co-pay.</p> <p>Out-of-Network: You pay \$60 co-pay.</p>	<p>In-Network: You pay \$40 co-pay.</p> <p>Out-of-Network: You pay \$60 co-pay.</p> <p>In-Network: You pay \$0 co-pay.</p> <p>Out-of-Network: You pay \$60 co-pay.</p>	<p>Routine foot exams and treatment only if you have diabetes-related nerve damage and/or meet certain conditions.</p>

<p>Medical Equipment/Supplies</p> <p>Durable Medical Equipment (e.g., wheelchairs, oxygen)</p> <p>Prosthetics (e.g., braces, artificial limbs)</p> <p>Diabetes supplies (Services may require Authorization)</p> <p>Blood Pressure Cuff</p>	<p>In-Network: You pay 20% co-insurance.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network: You pay 0-20% co-insurance.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>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.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>One basic blood pressure cuff per year at no cost.</p>	<p>In-Network: You pay 20% co-insurance.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network: You pay 0-20% co-insurance.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>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.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>One basic blood pressure cuff per year at no cost.</p>	<p>In-Network: You pay 20% co-insurance.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>In-Network: You pay 0-20% co-insurance.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>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.</p> <p>Out-of-Network: You pay 40% co-insurance.</p> <p>One basic blood pressure cuff per year at no cost.</p>	<p>Must have diagnoses of Hypertension. One approved basic blood</p>
--	---	---	--	--

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
<p>Medical Equipment/Supplies (continued)</p> <p>Home and Bathroom Safety Devices and Modifications</p>	<p>\$250 allowance per year in total for select items from our contracted vendor.</p>	<p>\$250 allowance per year in total for select items from our contracted vendor.</p>	<p>\$250 allowance per year in total for select items from our contracted vendor.</p>	<p>pressure cuff from our contracted vendor will be covered per year.</p> <p>Must have diagnoses related to Stroke. Bathroom safety items on a selected list from our contracted vendor including, but not limited to shower seats, raised toilet seats, bathtub seats, and grab bars. Only the approved items will be covered and only through our approved contracted vendor.</p>

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
Meal Benefit	14 meals post inpatient hospital discharge.	14 meals post inpatient hospital discharge.	14 meals post inpatient hospital discharge.	<p>Post-hospitalization meals are covered through contracted vendor and set-up thru Care Management program.</p> <p>14 meals/7 days benefit.</p> <p>No limit to number of times benefit can be accessed in a calendar year so long as it is preceded by a hospitalization.</p>

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare WellSelect [®] Plus with Part D (PPO)	MVP Medicare Patriot Plan SM with Part D (PPO)	What you should know
MVP Virtual Care Services	You pay \$0 co-pay per visit using remote access technology.	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 (PPO)		MVP Medicare WellSelect® Plus with Part D (PPO)		MVP Medicare Patriot Plan SM with Part D (PPO)		What you should know
Mail Order up to 90-day supply	Retail Rx 30-day supply	Mail Order up to 90-day supply	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 not subject to deductible.		No deductible.		\$250 Deductible. Tier 1, Tier 2 and Select Insulin Drugs are not subject to deductible.		
Initial Coverage							
Tier 1: Preferred Generic	You pay \$0.	You pay \$0.	You pay \$0.	You pay \$0.	You pay \$0.	You pay \$0.	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
Tier 2: Generic	You pay \$12.	You pay \$24.	You pay \$10.	You pay \$20.	You pay \$15.	You pay \$30.	
Tier 3: Preferred Brand	You pay \$47.	You pay \$94.	You pay \$35.	You pay \$70.	You pay \$45.	You pay \$90.	
Tier 4: Non-Preferred Drugs	You pay 25%.	You pay 25%.	You pay 25%.	You pay 25%.	You pay 25%.	You pay 25%.	

Outpatient Prescription Drugs

Tier 5: Specialty Tier Plan-covered Insulin Drugs	You pay 27%. You pay up to \$35.	Not available. You pay up to \$70.	You pay 33%. You pay up to \$35.	Not available. You pay up to \$70.	You pay 27%. You pay up to \$35.	Not available. You pay up to \$70.	supply is available, and you pay the same as at a retail pharmacy.

Coverage Gap							
Tier 1: Preferred Generic	You pay 25%.	You pay 25%.	You pay \$0.	You pay \$0.	You pay \$0.	You pay \$0.	You pay this amount for each prescription until your yearly out-of-pocket costs reach \$8,000.
Other Generic Drugs (Tiers 2-5)	You pay 25%.						
Brand Name Drugs (Tiers 2-5)	You pay 25%.						
Plan-covered Insulin Drugs	You pay up to \$35.	You pay up to \$70.	You pay up to \$35.	You pay up to \$70.	You pay up to \$35.	You pay up to \$70.	
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.

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)。