

2026 Summary of Benefits

MVP Health Plan, Inc.

MVP Medicare Preferred Gold[®] with Part D (HMO-POS)

MVP Medicare Preferred Gold[®] without Part D (HMO-POS)

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

H3305: Plan 015 and Plan 007 H9615: Plan 021

This is a summary of drug and health services covered by MVP Health Plan January 1, 2026 December 31, 2026.

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 Preferred Gold[®] with Part D (HMO-POS)**, **MVP Medicare Preferred Gold[®] without Part D (HMO-POS)**, or **MVP Medicare WellSelect[®] 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 Rochester/Buffalo service area includes the following counties in New York: Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Seneca, Wayne, Wyoming, and Yates.

MVP Medicare Preferred Gold[®] with Part D (HMO-POS), and **MVP Medicare Preferred Gold[®] without Part D (HMO-POS)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. These plans have a POS (Point-of-Service) benefit.

- Services covered under POS are limited to \$4,000/year, and you pay 30% co-insurance for MVP Medicare Preferred Gold[®] with Part D and MVP Medicare Preferred Gold[®] without Part D.

Not all services are covered under POS. Services not covered under POS are noted in the attached table and also in your EOC (Evidence of Coverage).

MVP Medicare WellSelect® 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 Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
Monthly Plan Premium	You pay \$160.00.	You pay \$229.00.	You pay \$0	You must continue to pay your part B premium. (\$185.00 in 2025. This amount may change in 2026.)
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>	\$9,250 In-Network and \$13,900 In/Out-of-Network combined annually.	\$6,800 annually.	\$7,200 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 \$445 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.	You pay \$375 co-pay per day for days 1 through 5. You pay \$0 co-pay per day for days 6 through 90.	You pay \$375 co-pay per day for days 1 through 5. You pay \$0 co-pay per day for days 6 through 90.	Our plan covers an unlimited number of days for an inpatient hospital stay.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
	Out-of-Network: You pay 40% co-insurance.	You pay \$0 co-pay per day for days 91 and beyond.	You pay \$0 co-pay per day for days 91 and beyond.	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 20% co-insurance for outpatient hospital surgery. Out-of-Network: You pay 40% co-insurance.	You pay \$350 co-pay for Outpatient Hospital surgery.	You pay \$325 co-pay for Outpatient Hospital surgery.	Physician surgery co-pay also applies for outpatient hospital.
Ambulatory Surgical Center (ASC) Services (Services may require Authorization)	You pay 15% co-insurance for care in a certified ambulatory surgical center. Out-of-Network: You pay 40% co-insurance.	You pay \$250 co-pay for care in a certified ambulatory surgical center.	You pay \$200 co-pay for care in a certified ambulatory surgical center.	Physician surgery co-pay also applies for ambulatory surgery.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
Doctor Visits - Primary Care Providers - Specialists (Services may require Authorization)	In-Network: You pay \$0 per PCP visit. Out-of-Network: you pay 30% co-insurance per PCP visit. In-Network: You pay \$55 co-pay per Specialist visit. Out-of-Network: You pay 40% co-insurance per Specialist visit.	You pay \$0 co-pay per visit. You pay \$40 co-pay per visit.	You pay \$0 co-pay per visit. You pay \$30 co-pay per visit.	Cost sharing applies to each service you receive, including multiple services from the same provider.
Preventive Care	In-Network/Out-of-Network: You pay \$0 co-pay.	You pay \$0 co-pay.	You pay \$0 co-pay.	Any additional services approved by Medicare during the contract year will be covered. There are items not covered at \$0.
Emergency Care	In-Network/Out-of-Network: You pay \$115 co-pay per visit.	You pay \$115 co-pay per visit.	You pay \$115 co-pay per visit.	If you are admitted to the hospital within 24 hours, co-pay is waived.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
				Emergency care is provided worldwide.
Urgently Needed Services	In-Network/Out-of-Network: You pay \$40 co-pay per visit. In and Out-of-Network: You pay \$115 co-pay for Worldwide Urgent Care coverage.	You pay \$35 co-pay per visit. In and Out-of-Network: You pay \$115 co-pay for Worldwide Urgent Care coverage.	You pay \$40 co-pay per visit. In and Out-of-Network: You pay \$115 co-pay for Worldwide Urgent Care coverage.	Urgently needed services are provided worldwide.
Diagnostic Services/ Labs/ Imaging - Diagnostic radiology service (e.g., MRI) - Lab services - Diagnostic tests and procedures	In-Network: You pay \$55-\$400 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. In-Network: You pay 20% co-insurance. Out-of-Network: You pay 40% co-insurance.	You pay \$40-\$200 co-pay. You pay \$0 co-pay. You pay \$15 co-pay.	You pay \$30-\$150 co-pay. You pay \$0 co-pay. You pay \$10 co-pay.	Cost sharing applies to each service you receive, including multiple services from the same provider.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
• Outpatient x-rays (Services may require Authorization)	In-Network: You pay \$55 co-pay. Out-of-Network: You pay 40% Coinsurance.	You pay \$40 co-pay.	You pay \$30 co-pay.	
Hearing Services • Diagnostic & Routine Hearing exam	You pay \$0 co-pay per diagnostic hearing exam Out-of-Network: You pay \$60 co-pay. You pay \$0 co-pay per routine hearing exam Out-of-Network: You pay \$60 co-pay.	You pay \$0 co-pay per diagnostic hearing exam. You pay \$0 co-pay per routine hearing exam.	You pay \$0 co-pay per diagnostic hearing exam. You pay \$0 co-pay per routine hearing exam.	Routine hearing exams not covered under POS. Routine hearing exams limited to one per calendar year.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
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	You pay \$699-\$999 copayment per hearing aid or up to \$600 toward the cost of two hearing aids every year.	You pay \$699-\$999 copayment per hearing aid or up to \$600 toward the cost of two hearing aids every year.	Hearing Aids must be ordered through TruHearing. Limit 1 hearing aid per ear per calendar year.
Preventive and Comprehensive Dental Services	Annual Maximum Plan Benefit Coverage Amount: \$750 combined Preventive and Comprehensive services, per calendar year	Annual Maximum Plan Benefit Coverage Amount: \$1,500 combined Preventive and Comprehensive services, per calendar year	Annual Maximum Plan Benefit Coverage Amount: \$1,000 combined Preventive and Comprehensive services, per calendar year.	Allowance is provided on a prepaid debit card that can be used at any dental provider. Once the full allowance is used, you are responsible for 100% of the cost of any preventive or comprehensive dental services. Any unused funds do not rollover to the next calendar year. See the Evidence of Coverage for more information.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
Over-the Counter (OTC) Items • OTC Allowance	\$25.00 Allowance per quarter	\$50.00 Allowance per quarter	\$25.00 Allowance per quarter	Allowance is received quarterly to be used towards 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	Arthritis Post-Joint Replacement Procedure Care Kit is not a covered benefit under this plan.	Customizable care kit	Customizable care kit	Members who 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

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
				kit with items such as, but not limited to, a reacher, shoehorn, non-slip bathmat, alternative shoe laces, laces designed for those with special needs, sock-aid, and long handled shower sponge through our approved contracted vendor.
Vision Services • Diagnostic eye exam • Routine eye exam • Post-cataract surgery eyewear • Eyewear allowance	You pay \$20 co-pay per diagnostic eye exam. You pay \$0 co-pay per routine eye exam. You pay 20% co-insurance. \$150 every year eyewear allowance.	You pay \$40 co-pay per diagnostic eye exam. You pay \$0 co-pay per routine eye exam. You pay 20% co-insurance. \$175 every year eyewear allowance.	You pay \$30 per diagnostic eye exam. You pay \$0 co-pay per routine eye exam. You pay 20% co-insurance. \$150 every year eyewear allowance.	Routine eye exams are limited to one per calendar year. Out-of-Network routine eye exams have a \$70 maximum payable benefit per calendar year.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
Mental Health Services - Inpatient visit - Outpatient group therapy visit - Outpatient individual therapy visit (Services may require Authorization)	In-Network: You pay \$415 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. You pay \$10 per co-pay per group therapy visit. You pay \$10 per co-pay per individual therapy visit. Out-of-Network: You pay 30% co-insurance.	You pay \$375 per day for days 1-5. You pay \$0 co-pay per day for days 6-90. You pay \$0 co-pay per day for days 91 and beyond. You pay \$10 per co-pay per group therapy visit. You pay \$10 per co-pay per individual therapy visit.	You pay \$375 per day for days 1-5. You pay \$0 co-pay per day for days 6-90. You \$0 co-pay per day for days 91 and beyond. You pay \$30 co-pay per group therapy visit. You pay \$30 co-pay per individual therapy visit.	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Mental health services not covered under POS.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
Skilled Nursing Facility (SNF) (Services may require Authorization)	In-Network: You pay \$0 co-pay per day for days 1 through 20. You pay \$218 co-pay per day for days 21 through 100. Out-of-Network: You pay 40% co-insurance.	You pay \$0 co-pay per day for days 1 through 20. You pay \$218 co-pay per day for days 21 through 100.	You pay \$0 co-pay per day for days 1 through 20. You pay \$218 co-pay per day for days 21 through 100.	Our plan covers up to 100 days in a SNF. SNF services not covered under POS.
Physical Therapy (Services may require Authorization)	In-Network: You pay \$35 co-pay per visit. Out-of-Network: You pay 40% co-insurance per visit.	You pay \$20 co-pay per visit.	You pay \$20 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.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
Ambulance (Services may require Authorization)	In-Network/Out-of-Network: You pay \$320 co-pay for ground ambulance. In-Network/Out-of-Network: You pay \$500 co-pay for air ambulance.	You pay \$200 co-pay for ground ambulance. You pay \$400 co-pay for air ambulance.	You pay \$200 co-pay for ground ambulance. 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	Transportation is not a covered benefit under this plan.	You pay \$0 co-pay. 24 one-way rides per year for medical appointments.	You pay \$0 co-pay. 12 one-way rides per year for medical appointments. Additionally, Unlimited rides to a VA facility with a 45 mile max.	Must use plan approved vendor. (30-mile, one-way capitation)

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Medicare Part B Drugs (Services may require Authorization) Insulin Drugs	In-Network: You pay 20% co-insurance. Out-of-Network: You pay 40% In-Network: You pay 0%-20% co-insurance and your maximum cost share will not exceed \$35.	You pay 20% co-insurance. In-Network: You pay 0%-20% co-insurance and your maximum cost share will not exceed \$35.	You pay 20% 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 by your doctor. (An office visit co-pay may also apply.) Part B drugs are not covered under POS. Part B drugs may be subject to Step Therapy requirements.
Foot Care (podiatry services) Diagnostic Foot exams and treatment	In-Network: You pay \$55 co-pay. Out-of-Network: You pay 40% co-insurance	You pay \$40 co-pay.	You pay \$30 co-pay.	

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Routine foot care (Services may require Authorization)	In-Network: You pay \$0 co-pay. Out-of-Network: You pay 40% co-insurance	You pay \$0 co-pay.	You pay \$0 co-pay.	Routine foot care if you have diabetes-related nerve damage and/or meet certain conditions.
Medical Equipment/Supplies - Durable Medical Equipment (e.g., wheelchairs, oxygen) - Prosthetics (e.g., braces, artificial limbs) - Diabetes supplies	In-Network: You pay 20% co-insurance. Out-of-Network: You pay 40% co-insurance. In-Network: You pay 0-20% co-insurance. Out-of-Network: You pay 40% co-insurance.	You pay 20% co-insurance. You pay 0-20% co-insurance.	You pay 20% co-insurance. You pay 0-20% co-insurance.	

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
(Services may require Authorization) • Blood Pressure Cuff	In-Network: You pay \$10 co-pay for a 30-day supply of Freestyle, Prodigy , and Accu-check blood glucose test strips and glucometers You pay \$10 co-pay for a 30-day supply of non-preferred strips that have prior authorization. Out-of-Network: You pay 40% co-insurance. One basic blood pressure cuff per year at no cost.	You pay \$0 co-pay for a 30-day supply of Freestyle, Prodigy, and Accu-check 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. One basic blood pressure cuff per year at no cost.	You pay \$0 co-pay for a 30-day supply of Freestyle, Prodigy, and Accu-check 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. One basic blood pressure cuff per year at no cost.	Must have diagnoses of Hypertension. One approved basic blood pressure cuff from our contracted vendor will be covered per year

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
Home and Bathroom Safety Devices and Modifications	Not a Covered Benefit under this plan.	\$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, raised toilet seats, bathtub seats, and grab bars. Only the approved items will be covered and only through our approved contracted vendor.

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
Meal Benefit	Not a Covered Benefit under this plan.	14 Meals post inpatient hospital discharge	14 Meals post inpatient hospital discharge	Post-Hospitalization meals are covered through contracted vendor and set-up thru 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.
Wellness Programs • SilverSneakers [®]	No cost for SilverSneakers [®] membership and to use SilverSneakers [®] fitness locations and virtual resources.	No cost for SilverSneakers [®] membership and to use SilverSneakers [®] fitness locations and virtual resources.	No cost for SilverSneakers [®] membership and to use SilverSneakers [®] fitness locations and virtual resources.	

Premiums and Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
• 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.	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	You pay \$0 co-pay per visit.	You pay \$0 co-pay per visit.	You pay \$0 co-pay per visit.	MVP virtual care services provided by Amwell, Galileo, and UCM through Gia are available at no cost-share. Other virtual care services through Gia are subject to the applicable cost-share. Using your smartphone, tablet or laptop, you can access doctors via video. Not covered under POS.

Outpatient Prescription Drugs				
Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December)			Part D prescription drugs not covered.	For specific information about your costs look at Chapter 6 in your <i>Evidence of Coverage</i> .

Outpatient Prescription Drugs						
Benefits	MVP Medicare WellSelect [®] with Part D (PPO)		MVP Medicare Preferred Gold [®] with Part D (HMO-POS)		MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
	Retail Rx 30-day supply	Mail Order up to 90-day supply, except Tier 1 which is 100-day supply	Retail Rx 30-day supply	Mail Order up to 90-day supply except Tier 1 which is 100-day supply	Part D prescription drugs not covered.	You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Deductible	\$615 Deductible. Tier 1 and Plan-covered Insulin Drugs are not subject to deductible.		\$300 Deductible. Tier 1 and Plan-covered Insulin Drugs are not subject to deductible.		Not covered.	
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 Drugs	You pay \$0. You pay \$2 You pay 16% You pay 25%. You pay 25%. You pay up to \$35.	You pay \$0. You pay \$4 You pay 16% You pay 25%. Not available. You pay up to \$70.	You pay \$0. You pay \$2. You pay 16% You pay 25%. You pay 25%. You pay up to \$35.	You pay \$0. You pay \$4. You pay 16% You pay 25%. Not available. You pay up to \$70.	Not covered.	You pay this amount for each prescription until your yearly drug costs reach \$2,100. 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.

Outpatient Prescription Drugs				
Benefits	MVP Medicare WellSelect [®] with Part D (PPO)	MVP Medicare Preferred Gold [®] with Part D (HMO-POS)	MVP Medicare Preferred Gold [®] without Part D (HMO-POS)	What you should know
Catastrophic Coverage Tiers 1- 5: You pay \$0 co-payment for all drug tiers.			Not covered.	You pay this amount after your yearly out-of-pocket costs reach \$2,100.

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. Virtual care services from MVP Health Care are provided by UCM Digital Health, Amwell, and at no cost-share for members. (Plan exceptions may apply.) Members' direct or digital provider visits may be subject to co-pay/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).

Language Assistance

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call **1-844-946-8010 (TTY 711).**

English

ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou.
Rele **1-844-946-8010** (TTY 711).

**Kreyòl Ayisyen
(French Creole)**

אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט **1-844-946-8010** (TTY 711).

**אידיש
(Yiddish)**

ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis.
Llame al **1-844-946-8010** (TTY 711).

**Español
(Spanish)**

UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: **1-844-946-8010** (TTY 711).

**Polski
(Polish)**

请注意: 您可以免费获得语言协助服务和其他辅助服务。请致电 **1-844-946-8010** (TTY 711)。

**繁體中文
(Chinese)**

ATANSYON: Available ang mga serbisong tulong sa wika at iba pang tulong nang libre.
Tumawag sa **1-844-946-8010** (TTY 711).

**Tagalog
(Tagalog-Filipino)**

ملاحظة **1-844-946-8010**:
خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم (TTY 711).

**لعرية
(Arabic)**

주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다
1-844-946-8010 (TTY 711). 번으로 연락해 주십시오.

**한국어
(Korean)**

ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру **1-844-946-8010** (TTY 711).

**Русский
(Russian)**

ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti.
Chiamare il **1-844-946-8010** (TTY 711).

**Italiano
(Italian)**

ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο **1-844-946-8010** (TTY 711).

**Ελληνικά
(Greek)**

ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le **1-844-946-8010** (TTY 711).

**Français
(French)**

توجه فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں **1-844-946-8010** (TTY 711) کریں

**اردو
(Urdu)**