2021 Summary of Benefits

MVP Health Plan, Inc.

MVP Medicare Secure with Part D (HMO-POS)

MVP Medicare Secure Plus with Part D (HMO-POS)

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

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

H3305: Plan 032, Plan 022, Plan 021 and Plan 020

This is a summary of drug and health services covered by MVP Health Plan January 1, 2021 - December 31, 2021.
MVP Health Plan, Inc. is an HMO-POS/PPO/MSA organization with a Medicare contract. Enrollment in the 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 Secure with Part D (HMO-POS), MVP Medicare Secure Plus with Part D (HMO-POS)**, **MVP Medicare Preferred Gold with Part D (HMO-POS), or MVP Medicare Preferred Gold without Part D (HMO-POS)**, 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/Hudson Valley/Central NY/VT service area includes the following counties in New York: Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Orange, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St. Lawrence, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington and Westchester; and Vermont: Addison, Bennington, Caledonia, Chittenden, Essex, Franklin, Grand Isle, Lamoille, Orange, Orleans, Rutland, Washington, Windham, and Windsor.

MVP Medicare Secure with Part D (HMO-POS), MVP Medicare Secure Plus with Part D (HMO-POS), **MVP Medicare Preferred Gold with Part D (HMO-POS), or 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. 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).

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MVP HEALTH CARE

Premiums and Benefits	MVP Medicare Secure with Part D	MVP Medicare Secure Plus with Part D	MVP Medicare Preferred Gold with Part D	MVP Medicare Preferred Gold without Part D	What you should know
Monthly Plan Premium	You pay $40.00.	You pay $90.00.	You pay $140.00.	You pay $62.00.	You must continue to pay your Part B premium. ($144.60 in 2020. This amount may change in 2021.)
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.	This plan does not have a medical deductible.	
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$7,550 annually.	$7,550 annually.	$5,800 annually.	$7,550 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)	$360 co-pay per day for days 1 through 5. You pay nothing per day for days 6 through 90. You pay nothing per day for days 91 and beyond.	$350 co-pay per day for days 1 through 5. You pay nothing per day for days 6 through 90. You pay nothing per day for days 91 and beyond.	$325 co-pay per day for days 1 through 5. You pay nothing per day for days 6 through 90. You pay nothing per day for days 91 and beyond.	$350 co-pay per day for days 1 through 5. You pay nothing per day for days 6 through 90. You pay nothing per day for days 91 and beyond.	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)	You pay $300 co-pay for Outpatient Hospital surgery. You pay $175 co-pay for care in a certified ambulatory surgical center.	You pay $300 co-pay for Outpatient Hospital surgery. You pay $175 co-pay for care in a certified ambulatory surgical center.	You pay $200 co-pay for Outpatient Hospital surgery. You pay $100 co-pay for care in a certified ambulatory surgical center.	You pay $250 co-pay for Outpatient Hospital surgery. You pay $150 co-pay for care in a certified ambulatory surgical center.	Physician surgery co-pay also applies for outpatient hospital or ambulatory surgery.
Doctor Visits • Primary Care Providers • Specialists (Services may require Authorization)	You pay $0 co-pay per visit. You pay $40 co-pay per 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.	You pay $15 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	You pay nothing.	You pay nothing.	You pay nothing.	You pay nothing.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost.

Premiums and Benefits	MVP Medicare Secure with Part D	MVP Medicare Secure Plus with Part D	MVP Medicare Preferred Gold with Part D	MVP Medicare Preferred Gold without Part D	What you should know
Emergency Care	You pay $90 co-pay per visit.	You pay $90 co-pay per visit.	You pay $90 co-pay per visit.	You pay $90 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	You pay $55 co-pay per visit.	You pay $50 co-pay per visit.	You pay $50 co-pay per visit.	You pay $55 co-pay per visit.	Urgently needed services are provided worldwide.
Diagnostic Services/Labs/ Imaging • Diagnostic radiology service (e.g., MRI) • Lab services • Diagnostic tests and procedures • Outpatient x-rays (Services may require Authorization)	You pay $100 co-pay. You pay $0 co-pay. You pay $10 co-pay. You pay $45 co-pay.	You pay $125 co-pay. You pay $0 co-pay. You pay $10 co-pay. You pay $40 co-pay.	You pay $75 co-pay. You pay $0 co-pay. You pay $10 co-pay. You pay $30 co-pay.	You pay $75 co-pay. You pay $0 co-pay. You pay $10 co-pay. You pay $30 co-pay.	Cost sharing applies to each service you receive, including multiple services from the same provider.
Hearing Services • Hearing exam • Hearing aid	You pay $20 per diagnostic hearing exam. You pay $20 per routine hearing exam. You pay $699-$999 per hearing aid.	You pay $20 per diagnostic hearing exam. You pay $20 per routine hearing exam. You pay $699-$999 per hearing aid.	You pay $20 per diagnostic hearing exam. You pay $20 per routine hearing exam. You pay $499-$799 per hearing aid.	You pay $30 per diagnostic hearing exam. You pay $20 per routine hearing exam. You pay $699-$999 per hearing aid.	Routine hearing exams not covered under POS. Hearing aids must be purchased through TruHearing.
Dental Services • Oral exam • Cleaning • X-rays	2 oral exams. 2 cleanings. 2 sets of x-rays.	2 oral exams. 2 cleanings. 2 sets of x-rays.	2 oral exams. 2 cleanings. 2 sets of x-rays.	Not covered.	Payment limited to established Fee Schedule. Maximum coverage is $240 per calendar year, dental services not covered under POS.
Optional Supplemental Dental Rider	Premium: $28 per month This is in addition to the plan premium. Preventive dental services: Included with your plan. No additional coverage needed. Deductible: $100 deductible	Premium: $28 per month This is in addition to the plan premium. Preventive dental services: Included with your plan. No additional coverage needed. Deductible: $100 deductible	Premium: $28 per month This is in addition to the plan premium. Preventive dental services: Included with your plan. No additional coverage needed. Deductible: $100 deductible	Premium: $28 per month This is in addition to the plan premium. Preventive dental services: Included with your plan. No additional coverage needed. Deductible: $100 deductible	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.

Premiums and Benefits	MVP Medicare Secure with Part D	MVP Medicare Secure Plus with Part D	MVP Medicare Preferred Gold with Part D	MVP Medicare Preferred Gold without Part D	What you should know
	before coverage begins, per calendar year for in and out of network benefits. Annual Maximum Plan Benefit Coverage Amount: $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	before coverage begins, per calendar year for in and out of network benefits. Annual Maximum Plan Benefit Coverage Amount: $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	before coverage begins, per calendar year for in and out of network benefits. Annual Maximum Plan Benefit Coverage Amount: $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	before coverage begins, per calendar year for in and out of network benefits. Annual Maximum Plan Benefit Coverage Amount: $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	
Vision Services • Diagnostic eye exam • Routine eye exam • Post-cataract surgery eyewear • Eyewear allowance	You pay $20 per diagnostic eye exam. You pay $0 per routine eye exam. You pay 20% of the cost. $125 every year eyewear allowance.	You pay $20 per diagnostic eye exam. You pay $0 per routine eye exam. You pay 20% of the cost. $125 every year eyewear allowance.	You pay $20 per diagnostic eye exam. You pay $0 per routine eye exam. You pay 20% of the cost. $175 every year eyewear allowance.	You pay $30 per diagnostic eye exam. You pay $0 per routine eye exam. You pay 20% of the cost. $150 every year eyewear allowance.	
Mental Health Services • Inpatient visit • Outpatient group therapy visit • Outpatient individual therapy visit (Services may require Authorization)	You pay $350/day, days 1-5. You pay nothing per stay for days 6-90. You pay nothing per stay for days 91 and beyond. You pay $40 per outpatient group / individual therapy visit.	You pay $350/day, days 1-5. You pay nothing per stay for days 6-90. You pay nothing per stay for days 91 and beyond. You pay $40 per outpatient group / individual therapy visit.	You pay $305/day, days 1-5. You pay nothing per stay for days 6-90. You pay nothing per stay for days 91 and beyond. You pay $30 per outpatient group / individual therapy visit.	You pay $350/day, days 1-5. You pay nothing per stay for days 6-90. You pay nothing per stay for days 91 and beyond. You pay $30 per outpatient group / 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.
Skilled Nursing Facility (SNF) (Services may require Authorization)	You pay nothing per day for days 1 through 20. $184 co-pay per day for days 21 through 100.	You pay nothing per day for days 1 through 20. $184 co-pay per day for days 21 through 100.	You pay nothing per day for days 1 through 20. $184 co-pay per day for days 21 through 100.	You pay nothing per day for days 1 through 20. $184 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)	You pay $20 co-pay per visit.	You pay $20 co-pay 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 SNF and hospital outpatient departments.

Premiums and Benefits	MVP Medicare Secure with Part D	MVP Medicare Secure Plus with Part D	MVP Medicare Preferred Gold with Part D	MVP Medicare Preferred Gold without Part D	What you should know
Ambulance (Services may require Authorization)	You pay $200 co-pay for ground ambulance. You pay $350 co-pay for air ambulance.	You pay $175 co-pay for ground ambulance. You pay $300 co-pay for air ambulance.	You pay $100 co-pay for ground ambulance. You pay $200 co-pay for air ambulance.	You pay $100 co-pay for ground ambulance. You pay $200 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	Not covered.	Not covered.	You pay nothing. 12 one-way rides per year.	Not covered.	Must use plan-approved vendor. (30-mile, one-way capitation)
Medicare Part B Drugs (Services may require Authorization)	You pay 20% of the cost.	You pay 20% of the cost.	You pay 20% of the cost.	You pay 20% of the cost.	You pay a 20% co-insurance for 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 not covered under POS.
Foot Care (podiatry services) • Diagnostic foot exams and treatment • Routine foot care (Services may require Authorization)	You pay $40 co-pay. You pay $0 co-pay.	You pay $40 co-pay. You pay $0 co-pay.	You pay $30 co-pay. You pay $0 co-pay.	You pay $30 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 (Services may require Authorization)	You pay 20% of the cost. You pay 20% of the cost. You pay $0 co-pay for a 30-day supply of OneTouch 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.	You pay 20% of the cost. You pay 20% of the cost. You pay $0 co-pay for a 30-day supply of OneTouch 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.	You pay 20% of the cost. You pay 20% of the cost. You pay $0 co-pay for a 30-day supply of OneTouch 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.	You pay 20% of the cost. You pay 20% of the cost. You pay $0 co-pay for a 30-day supply of OneTouch 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.	

Premiums and Benefits	MVP Medicare Secure with Part D	MVP Medicare Secure Plus with Part D	MVP Medicare Preferred Gold with Part D	MVP Medicare Preferred Gold without Part D	What you should know
Wellness Programs • SilverSneakers®	No cost to use SilverSneakers® fitness locations.	No cost to use SilverSneakers® fitness locations.	No cost to use SilverSneakers® fitness locations.	No cost to use SilverSneakers® fitness locations.	
• WellBeing Rewards	Up to $200 in rewards for completing health and wellness activities.	Up to $200 in rewards for completing health and wellness activities.	Up to $200 in rewards for completing health and wellness activities.	Up to $200 in rewards for completing health and wellness activities.	
MVP Telemedicine Services	You pay $0 co-pay per visit using remote access technology.	You pay $0 co-pay per visit using remote access technology.	You pay $0 co-pay per visit using remote access technology.	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. Not covered under POS.

Benefits	Outpatient Prescription Drugs							
	MVP Medicare Secure with Part D		MVP Medicare Secure Plus with Part D		MVP Medicare Preferred Gold with Part D		MVP Medicare Preferred Gold without Part D	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**	**Retail Rx 30-day supply**	**Mail Order up to 90-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 Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drugs Tier 5: Specialty Tier	$150 deductible. You pay $0 (no deductible). You pay$10 (no deductible). You pay the full cost of drugs in Tiers 3 through 5 until you have reached the yearly deductible.		No deductible.		No 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	You pay $0. You pay $10. You pay $47. You pay 26%. You pay 30%.	You pay $0. You pay $20. You pay $94. You pay 26%. Not available.	You pay $0. You pay $15. You pay $45. You pay 27%. You pay 33%.	You pay $0. You pay $30. You pay $90. You pay 27%. Not available.	You pay $0. You pay $10. You pay $35. You pay 27%. You pay 33%.	You pay $0. You pay $20 You pay $70. You pay 27%. Not available.	Not covered.	You pay this amount for each prescription until your yearly drug costs reach $4,130. If you reside in a long-term care facility, only 30-day supply is available, and you pay the same as at a retail pharmacy.
Coverage Gap								
Tier 1: Preferred Generic Other Generic Drugs (Tiers 2-5) Brand Name Drugs (Tiers 2-5)	You pay 25%. You pay 25%. You pay 25%.	You pay 25%. You pay 25%. You pay 25%.	You pay $0. You pay 25%. You pay 25%.	You pay $0. You pay 25%. You pay 25%.	You pay $0. You pay 25%. You pay 25%.	You pay $0. You pay 25%. You pay 25%.	Not covered.	You pay this amount for each prescription until your yearly out-of-pocket costs reach $6,550.
Catastrophic Coverage								
Tiers 1- 5: You pay the greater of 5% of the cost or $3.70 (generic)/$9.20 (brand name).							Not covered.	You pay this amount after your yearly out-of-pocket costs reach $6,550.

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 1-800-662-1220.
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 our website at **www.mvphealthcare.com/members/medicare/find-a-doctor**.

You can see our plan’s pharmacy directory at our website at **www.mvphealthcare.com/members/medicare/find-a-doctor.**

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **www.mvphealthcare.com/members/medicare/prescription-drug-coverage.**

MVP Health Plan, Inc. is an HMO-POS/PPO/MSA organization with a Medicare contract. Enrollment in the 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. Telemedicine services from MVP Health Care are powered by Amwell and UCM Digital Health. Regulatory restrictions may apply.

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. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-946-8010 (TTY: 1-800-662-1220). 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: 1-800-662-1220).

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