2021 Summary of Benefits

MVP Health Plan, Inc.

MVP® Medicare WellSelect®with Part D (PPO)

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

H9615: Plan 010, Plan 009

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 WellSelect® with Part D (PPO)** or **MVP® Medicare WellSelect® Plus 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 WellSelect® Plus 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 WellSelect® Plus with Part D	What you should know
Monthly Plan Premium	You pay $0.	You pay $125.00.	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.	
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$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.	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: $385 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. Out-of-Network: 40% of the cost.	In-Network: $320 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. Out-of-Network: 40% of the cost.	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: 40% of the cost.	In-Network: You pay $250 co-pay for Outpatient Hospital surgery. You pay $150 co-pay for care in a certified ambulatory surgical center. Out-of-Network: 40% of the cost.	Physician surgery co-pay also applies for outpatient hospital or ambulatory surgery.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP® Medicare WellSelect® Plus with Part D	What you should know
Doctor Visits • Primary Care Providers • Specialists (Services may require Authorization)	In-Network: You pay $0 co-pay per PCP visit. Out-of-Network: You pay $60 co-pay per PCP visit. In-Network: You pay $45 co-pay per Specialist visit. Out-of-Network: You pay $60 co-pay per Specialist visit.	In-Network: You pay $0 co-pay per PCP visit. Out-of-Network: you pay $60 co-pay per PCP visit. In-Network: You pay $50 co-pay per Specialist visit. Out-of-Network: You pay $60 co-pay per Specialist 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 nothing.	In-Network/Out-of-Network: You pay nothing.	Any additional preventive services approved by Medicare during the contract year will be covered. Some items not covered at $0 cost.
Emergency Care	In-Network/Out-of-Network: You pay $90 co-pay per visit.	In-Network/Out-of-Network: 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	In-Network/Out-of-Network: You pay $65 co-pay per visit.	In-Network/Out-of-Network: You pay $50 co-pay per visit.	Urgently needed services are provided worldwide.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP® Medicare WellSelect® Plus with Part D	What you should know
Diagnostic Services/Labs/ Imaging • Diagnostic radiology service (e.g., MRI) • Lab services • Diagnostic tests and procedures • Outpatient x-rays (Services may require Authorization)	In-Network: You pay $135 co-pay. Out-of-Network: You pay 40%. In-Network: You pay $0 co-pay. Out-of-Network: You pay 40% In-Network: You pay $20 co-pay. Out-of-Network: You pay 40% In-Network: You pay $60 co-pay. Out-of-Network: You pay $60 co-pay.	In-Network: You pay $125 co-pay. Out-of-Network: You pay 40%. In-Network: You pay $0 co-pay. Out-of-Network: You pay 40%. In-Network: You pay $10 co-pay. Out-of-Network: You pay 40%. In-Network: You pay $50 co-pay. Out-of-Network: You pay $60 co-pay.	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.
Hearing Services • Hearing exam • Hearing aid	In-Network: You pay $20 co-pay. Out-of-Network: You pay $60 co-pay. In-Network: $699-$999 per hearing aid. Out-of-Network: You pay 100%.	In-Network: You pay $20 co-pay. Out-of-Network: You pay $60 co-pay. In-Network: $499-$799 per hearing aid. Out-of-Network: You pay 100%.	Hearing Aids must be ordered through TruHearing.
Dental Services • Oral exam • Cleaning • X-rays	2 oral exams. 2 routine cleanings. 2 sets of x-rays.	2 oral exams. 2 routine cleanings. 2 sets of x-rays.	Payment limited to established Fee Schedule. MVP® Medicare WellSelect® with Part D and MVP® Medicare WellSelect® Plus with Part D have a max payment of $240 per calendar year.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP® Medicare WellSelect® Plus with Part D	What you should know
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 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).	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 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).	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.
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	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.	
• Post-cataract surgery eyewear	In-Network: You pay 20%. Out-of-Network: You pay 40%.	In-Network: You pay 20%. Out-of-Network: You pay 40%.	

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP® Medicare WellSelect® Plus with Part D	What you should know
Mental Health Services • Inpatient visit • Outpatient group therapy visit/Outpatient individual therapy visit (Services may require Authorization)	In-Network: $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. Out-of-Network: You pay 40%. In-Network: You pay $40 per outpatient group / individual therapy visit. Out-of-Network: You pay $60 co-pay.	In-Network: $320 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. Out-of-Network: You pay 40%. In-Network: You pay $40 per outpatient group / individual therapy visit. Out-of-Network: You pay $60 co-pay.	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.
Skilled Nursing Facility (SNF) (Services may require Authorization)	In-Network: You pay nothing per day for days 1 through 20. You pay $184 co-pay per day for days 21 through 100. Out-of-Network: You pay 40%.	In-Network: You pay nothing per day for days 1 through 20. You pay $184 co-pay per day for days 21 through 100. Out-of-Network: You pay 40%.	Our plan covers up to 100 days in a SNF.
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 $20 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.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP® Medicare WellSelect® Plus with Part D	What you should know
Ambulance (Services may require Authorization)	In-Network: You pay $200 co-pay for ground ambulance. Out-of-Network: You pay $200 co-pay for ground ambulance. In-Network: You pay $500 co-pay for air ambulance. Out-of-Network: You pay $500 co-pay for air ambulance.	In-Network: You pay $175 co-pay for ground ambulance. Out-of-Network: You pay $175 co-pay for ground ambulance. In-Network: You pay $300 co-pay for air ambulance. 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	Not covered.	You pay nothing. 12 one-way rides per year.	Must use plan approved vendor. (30-mile, one-way capitation)
Medicare Part B Drugs (Services may require Authorization)	In-Network: You pay 20%. Out-of-Network: You pay 40%.	In-Network: You pay 20%. Out-of-Network: You pay 40%.	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.)

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP® Medicare WellSelect® Plus with Part D	What you should know
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 $60 co-pay. In-Network: You pay $0 co-pay. Out-of-Network: You pay $60 co-pay.	In-Network: You pay $50 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) • Prosthetics (e.g., braces, artificial limbs) • Diabetes supplies (Services may require Authorization)	In-Network: You pay 20%. Out-of-Network: You pay 40%. In-Network: You pay 20%. Out-of-Network: You pay 40%. In-Network: You pay $5 co-pay for a 30-day supply of OneTouch brand blood glucose test strips and glucometers; you pay $5 co-pay for a 30-day supply of non-preferred strips that have prior authorization. Out-of-Network: You pay 40%.	In-Network: You pay 20%. Out-of-Network: You pay 40%. In-Network: You pay 20%. Out-of-Network: You pay 40%. In-Network: 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. Out-of-Network: You pay 40%.	
Wellness Programs • SilverSneakers® • WellBeing Rewards	No cost to use SilverSneakers® fitness locations. Up to $200 in rewards for completing health and wellness activities.	No cost to use SilverSneakers® fitness locations. Up to $200 in rewards for completing health and wellness activities.	

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP® Medicare WellSelect® Plus with Part D	What you should know
MVP Telemedicine 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 WellSelect® Plus with 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**	You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Deductible	$325 Deductible. Tier 1 and Tier 2 Drugs not subject to Deductible.		No Deductible.		
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 $12. You pay $47. You pay 25%. You pay 27%.	You pay $0. You pay $24. You pay $94. You pay 25%. 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.	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 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)					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.**

This document is available for free in Spanish. Please call our customer service number at **1-800-665-7924** (TTY: 1-800-662-1220), Monday – Friday, 8 am–8 pm Eastern Time. From October 1 – March 31, call seven days a week, 8 am–8 pm.

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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