

2020 Summary of Benefits

MVP Health Plan, Inc.

MVP GoldSecure with Part D (HMO-POS)

MVP GoldValue with Part D (HMO-POS)

MVP Preferred Gold with Part D (HMO-POS)

MVP 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, 2020 - December 31, 2020.

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 **GoldSecure with Part D (HMO-POS)**, **GoldValue with Part D (HMO-POS)**, **Preferred Gold with Part D (HMO-POS)**, or **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, Broome, Cayuga, 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.

GoldSecure with Part D (HMO-POS), **GoldValue with Part D (HMO-POS)**, **Preferred Gold with Part D (HMO-POS)**, and **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).

Premiums and Benefits	MVP GoldValue with Part D	MVP Preferred Gold with Part D	MVP Preferred Gold without Part D	MVP GoldSecure with Part D	What you should know	
Monthly Plan Premium	You pay \$89.00	You pay \$139.00	You pay \$62.00	You pay \$39	You must continue to pay your Part B premium (\$135.50 in 2019. This amount may change in 2020.)	
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 <i>(does not include prescription drugs)</i>	\$6,700 annually	\$4,800 annually	\$6,700 annually	\$6,700 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)	\$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	\$305 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	\$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	Our plan covers an unlimited number of days for an inpatient hospital stay. Copayment is applied to each new inpatient hospital stay. Medicare benefit periods do not apply.	
Outpatient Hospital Coverage (Services may require Authorization)	<ul style="list-style-type: none"> You pay \$250 co-pay for Outpatient Hospital surgery. You pay \$175 co-pay for care in a certified ambulatory surgical center. 	<ul style="list-style-type: none"> You pay \$175 co-pay for Outpatient Hospital surgery. You pay \$75 co-pay for care in a certified ambulatory surgical center. 	<ul style="list-style-type: none"> You pay \$250 co-pay for Outpatient Hospital surgery. You pay \$150 co-pay for care in a certified ambulatory surgical center. 	<ul style="list-style-type: none"> You pay \$300 co-pay for Outpatient Hospital surgery. You pay \$175 co-pay for care in a certified ambulatory surgical center. 	Physician surgery co-pay also applies for outpatient hospital or ambulatory surgery.	
Doctor Visits	<ul style="list-style-type: none"> Primary Care Providers Specialists (Services may require Authorization) 	<ul style="list-style-type: none"> You pay \$0 co-pay per visit You pay \$40 co-pay per visit 	<ul style="list-style-type: none"> You pay \$0 co-pay per visit You pay \$30 co-pay per visit 	<ul style="list-style-type: none"> You pay \$15 co-pay per visit You pay \$30 co-pay per visit 	<ul style="list-style-type: none"> You pay \$0 co-pay per visit You pay \$45 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.	
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.	
Urgently Needed Services	You pay \$50 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.	

Premiums and Benefits	MVP GoldValue with Part D	MVP Preferred Gold with Part D	MVP Preferred Gold without Part D	MVP GoldSecure with Part D	What you should know
Diagnostic Services / Labs / Imaging <ul style="list-style-type: none"> Diagnostic radiology service (e.g., MRI) Lab services Diagnostic tests and procedures Outpatient x-rays (Services may require Authorization) 	<ul style="list-style-type: none"> You pay \$100 co-pay You pay \$0 co-pay You pay \$10 co-pay You pay \$40 co-pay 	<ul style="list-style-type: none"> You pay \$60 co-pay You pay \$0 co-pay You pay \$10 co-pay You pay \$30 co-pay 	<ul style="list-style-type: none"> You pay \$60 co-pay You pay \$10 co-pay You pay \$10 co-pay You pay \$30 co-pay 	<ul style="list-style-type: none"> You pay \$100 co-pay You pay \$0 co-pay You pay \$10 co-pay <p>You pay \$45 co-pay</p>	Cost sharing applies to each service you receive, including multiple services from the same provider.
Hearing Services <ul style="list-style-type: none"> Hearing exam Hearing aid 	<ul style="list-style-type: none"> You pay \$20 per Diagnostic Hearing exam You pay \$20 per Routine Hearing exam You pay \$699-\$999 per hearing aid 	<ul style="list-style-type: none"> You pay \$20 per Diagnostic Hearing exam You pay \$20 per Routine Hearing exam You pay \$499-\$799 per hearing aid 	<ul style="list-style-type: none"> You pay \$30 per Diagnostic Hearing exam You pay \$20 per Routine Hearing exam You pay \$699-\$999 per hearing aid 	<ul style="list-style-type: none"> You pay \$20 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	\$240 Annual Preventive Dental Allowance	\$300 Annual Dental Allowance for any service	Not covered	\$240 Annual Preventive Dental Allowance	Payment limited to Fee Schedule. Dental services not covered under POS.
Vision Services	<ul style="list-style-type: none"> You pay \$20 per Diagnostic Eye exam You pay \$20 per Routine Eye Exam Post-cataract Surgery Eyewear: You pay 20% of the cost \$125 every year eyewear allowance 	<ul style="list-style-type: none"> You pay \$20 per Diagnostic Eye exam You pay \$20 per Routine Eye Exam Post-cataract Surgery Eyewear: You pay 20% of the cost \$175 every year eyewear allowance 	<ul style="list-style-type: none"> You pay \$30 per Diagnostic Eye exam You pay \$20 per Routine Eye Exam Post-cataract Surgery Eyewear: You pay 20% of the cost \$150 every year eyewear allowance 	<ul style="list-style-type: none"> You pay \$20 per Diagnostic Eye exam You pay \$20 per Routine Eye Exam Post-cataract Surgery Eyewear: You pay 20% of the cost \$125 every year eyewear allowance 	
Mental Health Services <ul style="list-style-type: none"> Inpatient visit Outpatient group therapy visit Outpatient individual therapy visit (Services may require Authorization) 	<ul style="list-style-type: none"> You pay \$350/day, days 1-5. You pay nothing per stay for days 91 and beyond You pay \$40 outpatient group/individual therapy visit 	<ul style="list-style-type: none"> You pay \$305/day, days 1-5. You pay nothing per stay for days 91 and beyond You pay \$30 outpatient group/individual therapy visit 	<ul style="list-style-type: none"> You pay \$350/day, days 1-5. You pay nothing per stay for days 91 and beyond You pay \$30 outpatient group/individual therapy visit 	<ul style="list-style-type: none"> You pay \$350/day, days 1-5. You pay nothing per stay for days 91 and beyond You pay \$40 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.

Premiums and Benefits	MVP GoldValue with Part D	MVP Preferred Gold with Part D	MVP Preferred Gold without Part D	MVP GoldSecure with Part D	What you should know
Skilled Nursing Facility (Services may require Authorization)	<ul style="list-style-type: none"> You pay nothing per day for days 1 through 20 \$178 co-pay per day for days 21 through 100 	<ul style="list-style-type: none"> You pay nothing per day for days 1 through 20 \$178 co-pay per day for days 21 through 100 	<ul style="list-style-type: none"> You pay nothing per day for days 1 through 20 \$178 co-pay per day for days 21 through 100 	<ul style="list-style-type: none"> You pay nothing per day for days 1 through 20 \$178 co-pay 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	You pay \$20 co-pay	You pay \$20 co-pay	You pay \$20 co-pay	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)	You pay \$175 co-pay	You pay \$100 co-pay	You pay \$100 co-pay	You pay \$200 co-pay	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	Not covered	Not covered	
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.

Premiums and Benefits	MVP GoldValue with Part D	MVP Preferred Gold with Part D	MVP Preferred Gold without Part D	MVP GoldSecure with Part D	What you should know
Foot Care (podiatry services) <ul style="list-style-type: none"> • Foot exams and treatment • Routine foot care (Services may require Authorization) 	<ul style="list-style-type: none"> • You pay \$40 co-pay • You pay \$40 co-pay 	<ul style="list-style-type: none"> • You pay \$30 co-pay • You pay \$30 co-pay 	<ul style="list-style-type: none"> • You pay \$30 co-pay • You pay \$30 co-pay 	<ul style="list-style-type: none"> • You pay \$45 co-pay • You pay \$45 co-pay 	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.
Medical Equipment/Supplies <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetes supplies (Services may require Authorization) 	<ul style="list-style-type: none"> • You pay 20% of the cost • You pay 20% of the cost • You pay 10% of the cost for OneTouch brand blood glucose test strips and glucometers; you pay a 20% co-insurance for non-preferred strips that have prior authorization. 	<ul style="list-style-type: none"> • You pay 20% of the cost • You pay 20% of the cost • You pay 10% of the cost for OneTouch brand blood glucose test strips and glucometers; you pay a 20% co-insurance for non-preferred strips that have prior authorization. 	<ul style="list-style-type: none"> • You pay 20% of the cost • You pay 20% of the cost • You pay 10% of the cost for OneTouch brand blood glucose test strips and glucometers; you pay a 20% co-insurance for non-preferred strips that have prior authorization. 	<ul style="list-style-type: none"> • You pay 20% of the cost • You pay 20% of the cost • You pay 10% of the cost for OneTouch brand blood glucose test strips and glucometers; you pay a 20% co-insurance for non-preferred strips that have prior authorization. 	
Wellness Programs <ul style="list-style-type: none"> • SilverSneakers • WellBeingRewards 	<ul style="list-style-type: none"> • No cost to use SilverSneakers fitness locations • \$100 rewards card for completing health and wellness activities 	<ul style="list-style-type: none"> • No cost to use SilverSneakers fitness locations • \$100 rewards card for completing health and wellness activities • 	<ul style="list-style-type: none"> • No cost to use SilverSneakers fitness locations • \$100 rewards card for completing health and wellness activities • 	<ul style="list-style-type: none"> • No cost to use SilverSneakers fitness locations • \$100 rewards card for completing health and wellness activities • 	
myVisitNow® – 24/7 Online Doctor Visits	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	Using your smartphone, tablet or laptop, you can access doctors via video. Not covered under POS.

Outpatient Prescription Drugs

Benefits	MVP GoldSecure with Part D		MVP GoldValue with Part D		MVP Preferred Gold with Part D		MVP 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	
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	You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.
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 \$4,020. 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 \$6,350.
Catastrophic Coverage								
Tiers 1- 5: You pay the greater of 5% of the cost or \$3.60 (generic)/\$8.95 (brand name)							Not covered	You pay this amount after your yearly out-of-pocket costs reach \$6,350

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 Monday – Friday 8 am – 6 pm, and Saturdays 8 am – 12 pm Eastern Time.

From April 1 – September 30, you can call us Monday – Friday from 8 am – 6 pm Eastern Time.

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

You can see our plan's pharmacy directory at our website at www.mvphealthcare.com/medicare/PartD/partd_index.html.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.mvphealthcare.com/medicare/PartD/partd_index.html.

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.

