# 2018 Summary of Benefits

## MVP Health Plan, Inc.

### GoldValue with Part D (HMO-POS)

### Preferred Gold with Part D (HMO-POS)

### Preferred Gold without Part D (HMO-POS)

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

**This is a summary of drug and health services covered by MVP Health Plan January 1, 2018 - December 31, 2018.**

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 **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 service area includes the following counties in New York: Albany, Broome, Cayuga, Chenango, Columbia, Cortland, Dutchess, Essex, Fulton, Greene, Montgomery, Orange, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Tompkins, Ulster, Warren, Washington and Westchester.

**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 $2500/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).



Y0051_3399 revised (03/2018)

MVP® HEALTH CARE

| Premiums and Benefits | GoldValue with Part D | Preferred Gold with Part D | Preferred Gold without Part D | What you should know |
|---|---|---|---|---|
| **Monthly Plan Premium** | You pay $108.00 | You pay $172.20 | You pay $59.20 | You must continue to pay your Part B premium ($134 in 2017). |
| **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)* | $6,700 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<br>You pay nothing per day for days 6 through 90<br>You pay nothing per day for days 91 and beyond | $350 co-pay per day for days 1 through 5<br>You pay nothing per day for days 6 through 90<br>You pay nothing per day for days 91 and beyond | $350 co-pay per day for days 1 through 5<br>You pay nothing per day for days 6 through 90<br>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) | • You pay $300 co-pay for Outpatient Hospital surgery.<br>• You pay $150 co-pay for care in a certified ambulatory surgical center. | • You pay $225 co-pay for Outpatient Hospital surgery.<br>• You pay $100 co-pay for care in a certified ambulatory surgical center. | • You pay $225 co-pay for Outpatient Hospital surgery.<br>• You pay $100 co-pay for care in a certified ambulatory surgical center. | Physician surgery co-pay also applies for outpatient hospital or ambulatory surgery. |
| **Doctor Visits**<br>• Primary<br>• Specialists<br>(Services may require Authorization) | • You pay $20 co-pay per visit<br>• You pay $40 co-pay per visit | • You pay $15 co-pay per visit<br>• You pay $30 co-pay per visit | • You pay $15 co-pay per visit<br>• You pay $30 co-pay per visit | Cost sharing applies to each service you receive, including multiple services from the same provider. |

| Premiums and Benefits | GoldValue with Part D | Preferred Gold with Part D | Preferred Gold without Part D | What you should know |
|---|---|---|---|---|
| **Preventive Care** | 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 $80 co-pay per visit | You pay $80 co-pay per visit | You pay $80 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 | Urgently Needed Services are provided worldwide. |
| **Diagnostic Services/ Labs/ Imaging**<br>• Diagnostic radiology service (e.g., MRI)<br>• Lab services<br>• Diagnostic tests and procedures<br>• Outpatient x-rays<br>(Services may require Authorization) | • You pay $100 co-pay<br>• You pay $10 co-pay<br>• You pay $10 co-pay<br>• You pay $40 co-pay | • You pay $60 co-pay<br>• You pay $10 co-pay<br>• You pay $10 co-pay<br>• You pay $30 co-pay | • You pay $60 co-pay<br>• You pay $10 co-pay<br>• You pay $10 co-pay<br>• You pay $30 co-pay | Cost sharing applies to each service you receive, including multiple services from the same provider. |
| **Hearing Services**<br>• Hearing exam<br>• Hearing aid | • You pay $40 co-pay<br>• You pay $699-$999 co-pay | • You pay $30 co-pay<br>• You pay $499-$799 co-pay | • You pay $30 co-pay<br>• You pay $699-$999 co-pay | Hearing Aids must be ordered through TruHearing.<br>Routine hearing exams not covered under POS. |

| Premiums and Benefits | GoldValue with Part D | Preferred Gold with Part D | Preferred Gold without Part D | What you should know |
|---|---|---|---|---|
| **Dental Services**<br>Oral exam & Cleaning | $240 Annual Preventive Dental Allowance | $240 Annual Preventive Dental Allowance | Not covered | Payment limited to Fee Schedule.<br>Dental services not covered under POS. |
| **Premiums and Benefits** | **GoldValue with Part D** | **Preferred Gold with Part D** | **Preferred Gold without Part D** | **What you should know** |
| **Vision Services** | • You pay $40 per Diagnostic Eye exam<br>• You pay $40 per Routine Eye Exam<br>• Post-cataract Surgery Eyewear: You pay 20% of the cost<br>• $75/every two years eyewear allowance | • You pay $30 per Diagnostic Eye exam<br>• You pay $30 per Routine Eye Exam<br>• Post-cataract Surgery Eyewear: You pay 20% of the cost<br>• $125/every two years eyewear allowance | • You pay $30 per Diagnostic Eye exam<br>• You pay $30 per Routine Eye Exam<br>• Post-cataract Surgery Eyewear: You pay 20% of the cost<br>• $100/every two years eyewear allowance | |
| **Mental Health Services**<br>• Inpatient visit<br>• Outpatient group therapy visit<br>• Outpatient individual therapy visit<br>(Services may require Authorization) | • You pay $295/day, days 1-5<br>• You pay nothing per stay for days 91 and beyond<br>• You pay $40 outpatient group/individual therapy visit | • You pay $295/day, days 1-5<br>• You pay nothing per stay for days 91 and beyond<br>• You pay $30 outpatient group/individual therapy visit | • You pay $295/day, days 1-5<br>• You pay nothing per stay for days 91 and beyond<br>• You pay $30 outpatient group/individual therapy visit | Our plan covers up to 190 days in a lifetime for Inpatient Mental Health care in a Psychiatric Hospital.<br>Mental health services not covered under POS. |
| **Skilled Nursing Facility**<br>(Services may require Authorization) | • You pay nothing per day for days 1 through 20<br>• $167 co-pay per day for days 21 through 100 | • You pay nothing per day for days 1 through 20<br>• $167 co-pay per day for days 21 through 100 | • You pay nothing per day for days 1 through 20<br>• $167 co-pay per day for days 21 through 100 | Our plan covers up to 100 days in a SNF.<br>SNF services not covered under POS. |

| Premiums and Benefits | GoldValue with Part D | Preferred Gold with Part D | Preferred Gold without Part D | What you should know |
|---|---|---|---|---|
| **Rehabilitation Services**<br>• Occupational therapy visit<br>• Physical therapy and speech and language therapy visit<br>(Services may require Authorization) | • You pay $20 co-pay<br>• You pay $20 co-pay | • You pay $20 co-pay<br>• You pay $20 co-pay | • You pay $20 co-pay<br>• 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**<br>(Services may require Authorization) | You pay $150 co-pay | You pay $75 co-pay | You pay $75 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 | |

| Premiums and Benefits | GoldValue with Part D | Preferred Gold with Part D | Preferred Gold without Part D | What you should know |
|---|---|---|---|---|
| **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 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.)<br>Part B drugs not covered under POS. |
| **Foot Care** (podiatry services)<br>• Foot exams and treatment<br>• Routine foot care (Services may require Authorization) | • You pay $40 co-pay<br>• You pay $40 co-pay | • You pay $30 co-pay<br>• You pay $30 co-pay | • You pay $30 co-pay<br>• You pay $30 co-pay | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. |
| **Medical Equipment/Supplies**<br>• Durable Medical Equipment (e.g., wheelchairs, oxygen)<br>• Prosthetics (e.g., braces, artificial limbs)<br>• Diabetes supplies (Services may require Authorization) | • You pay 20% of the cost<br>• You pay 20% of the cost<br>• You pay 10% of the cost | • You pay 20% of the cost<br>• You pay 20% of the cost<br>• You pay 10% of the cost | • You pay 20% of the cost<br>• You pay 20% of the cost<br>• You pay 10% of the cost | |

| Premiums and Benefits | GoldValue with Part D | Preferred Gold with Part D | Preferred Gold without Part D | What you should know |
|---|---|---|---|---|
| **Wellness Programs**<br>• SilverSneakers<br>• Wellness Rewards | • No cost to use SilverSneakers fitness locations<br>• $75 gift card after you get your Annual Wellness Visit and two preventive screening services | • No cost to use SilverSneakers fitness locations<br>• $75 gift card after you get your Annual Wellness Visit and two preventive screening services | • No cost to use SilverSneakers fitness locations<br>• $75 gift card after you get your Annual Wellness Visit and two preventive screening services | • Your PCP must sign a form certifying you received the services to receive Wellness Rewards. |
| **Electronic Doctor Visits** (MyVisitNow) | You pay $20-$40 co-pay per visit using remote access technology | You pay $15-$30 co-pay per visit using remote access technology | You pay $15-$30 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** | **GoldValue with Part D** | | **Preferred Gold with Part D** | | **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** | 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** | No Deductible | | No Deductible | | Not covered | |
| **Initial Coverage** | | | | | | |
| Tier 1: Preferred Generic<br>Tier 2: Generic<br>Tier 3: Preferred Brand<br>Tier 4: Non-Preferred Drugs<br>Tier 5: Specialty Tier | You pay $0<br>You pay $15<br>You pay $45<br>You pay 36%<br>You pay 33% | You pay $0<br>You pay $30<br>You pay $90<br>You pay 36%<br>Not available | You pay $0<br>You pay $10<br>You pay $35<br>You pay 36%<br>You pay 33% | You pay $0<br>You pay $20<br>You pay $70<br>You pay 36%<br>Not available | Not covered | You pay this amount for each prescription until your yearly drug costs reach $3,750. 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<br>Other Generic Drugs<br>Brand Name Drugs | You pay $0<br>You pay 44%<br>You pay 35% | You pay $0<br>You pay 44%<br>You pay 35% | You pay $0<br>You pay 44%<br>You pay 35% | You pay $0<br>You pay 44%<br>You pay 35% | Not covered | You pay this amount for each prescription until your yearly out-of-pocket costs reach $5,000. |
| **Catastrophic Coverage** | | | | | | |
| You pay the greater of 5% of the cost or $3.35 (generic)/$8.35 (brand name) | | | | | Not covered | You pay this amount after your yearly out-of-pocket costs reach $5,000. |

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 **www.mvphealthcare.com.**

Toll-free **1-800-324-3899**, TTY users should call **1-800-662-1220**.

From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern Time.

From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time.

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

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

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

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.**

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 Oct. 1 – Feb. 14, call seven days a week, 8 am – 8 pm.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia linguística. Llame al **1-800-665-7924** (TTY: **1-800-662-1220**).

This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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