2018 Summary of Benefits

MVP Health Plan, Inc.

BasiCare with Part D (PPO)

Gold PPO with Part D (PPO)

H9615: Plan 008, Plan 007

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 **BasiCare with Part D (PPO)** or **Gold PPO 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 Capital District/Southern Tier/Central NY/Western VT service area includes the following counties in New York: Albany, Broome, Cayuga, Chenango, Columbia, Cortland, Essex, Fulton, Greene, Herkimer, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Tompkins, Warren and Washington; and Vermont: Addison, Bennington, Chittenden, Lamoille, Rutland and Washington.

BasiCare with Part D (PPO) and **Gold PPO 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.

Y0051_3403 Accepted (08/2017)

MVP HEALTH CARE

Premiums and Benefits	BasiCare with Part D	Gold PPO with Part D	What you should know
Monthly Plan Premium	You pay $0	You pay $155.00	You must continue to pay your Part B premium ($134.00 in 2016).
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 In-Network and $10,000 In/Out-of-Network combined annually	$6,700 In-Network and $10,000 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: $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: 40% of the cost	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: 40% of the cost	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.
Doctor Visits · Primary · Specialists (Services may require Authorization)	· In-Network: you pay $15 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	· In-Network: you pay $15 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. There are some items not covered at $0 cost.

Premiums and Benefits	BasiCare with Part D	Gold PPO with Part D	What you should know
Emergency Care	In-Network/Out-of-Network: You pay $80 co-pay per visit	In-Network/Out-of-Network: You pay $80 co-pay per visit	If you are admitted to the hospital within 24 hours, co-pay is waived.
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.
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 $150 co-pay Out-of-Network: You pay 40% · In-Network: You pay $15 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 $100 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 $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 $50 co-pay Out-of-Network: You pay $60 co-pay · In-Network: $699-$999 co-pay Out-of-Network: You pay 100%	· In-Network: You pay $50 co-pay Out-of-Network: You pay $60 co-pay · In-Network: $499-$799 co-pay Out-of-Network: You pay 100%	Hearing Aids must be ordered through TruHearing.
Dental Services · Oral exam & Cleaning	· Not covered	· $240 Annual Preventive Dental Allowance	Payment limited to Fee Schedule. Dental services not covered under POS.
Vision Services · Eye Exam · Post-cataract Surgery Eyewear	· In-Network: You pay $50 co-pay Out-of-Network: You pay $60 co-pay · In-Network: You pay 20% Out-of-Network: You pay 40%	In-Network: You pay $50 co-pay Out-of-Network: You pay $60 co-pay · In-Network: You pay 20% Out-of-Network: You pay 40%	

Premiums and Benefits	BasiCare with Part D	Gold PPO with Part D	What you should know
Benefits	**BasiCare with Part D**	**Gold PPO 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: $315 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 outpatient group/individual therapy visit Out-of-Network: You pay $60 co-pay	· In-Network: $295 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 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	In-Network: You pay nothing per day for days 1 through 20. You pay $167 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 $167 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.
Rehabilitation Services · Occupational therapy visit · Physical therapy and speech and language therapy visit (Services may require Authorization)	· In-Network: You pay $30 co-pay Out-of-Network: You pay $60 co-pay · In-Network: You pay $30 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 · In-Network: You pay $20 co-pay Out-of-Network: You pay $60 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.

Premiums and Benefits	BasiCare with Part D	Gold PPO with Part D	What you should know
Ambulance (Services may require Authorization)	In-Network: You pay $250 co-pay Out-of-Network: You pay $250 co-pay	In-Network: You pay $150 co-pay Out-of-Network: You pay $150 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	
Foot Care (podiatry services) · Foot exams and treatment · Routine foot care (Services may require Authorization)	· In-Network: You pay $50 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 $50 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	Foot exams and treatment only if you have diabetes-related nerve damage and/or meet certain conditions.

Premiums and Benefits	BasiCare with Part D	Gold PPO with Part D	What you should know
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 20% 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 10% Out-of-Network: You pay 40%	
Benefits	**BasiCare with Part D**	**Gold PPO with Part D**	**What you should know**
Wellness Programs: · SilverSneakers · Wellness Rewards	· No cost to use SilverSneakers fitness locations · $75 gift card after you get your Annual Wellness Visit and two preventive screening services	· No cost to use SilverSneakers fitness locations · $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.
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.)
Electronic Doctor Visits	In-Network/Out-of-Network: You pay $15-$40 co-pay per visit using remote access technology	In-Network/Out-of-Network: You pay $15-$40 co-pay per visit using remote access technology	Using your smartphone, tablet or laptop, you can access doctors via video.

Outpatient Prescription Drugs					
Benefits	**BasiCare with Part D**		**Gold PPO 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	$400 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 $2 You pay $11 You pay $47 You pay 36% You pay 25%	You pay $4 You pay $22 You pay $94 You pay 36% Not available	You pay $0 You pay $10 You pay $35 You pay 36% You pay 33%	You pay $0 You pay $20 You pay $70 You pay 36% Not available	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 Other Generic Drugs Brand Name Drugs	You pay 44% You pay 44% You pay 35%	You pay 44% You pay 44% You pay 35%	You pay $0 You pay 44% You pay 35%	You pay $0 You pay 44% You pay 35%	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)					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 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. Out-of-network/non-contracted providers are under no obligation to treat MVP Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

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