2017 Summary of Benefits

MVP Health Plan, Inc.

2017

GoldValue with Part D (HMO-POS)

Preferred Gold without Part D (HMO-POS)

H3305: Plan 015, Plan 007

This is a summary of drug and health services covered by MVP Health Plan January 1, 2017 - December 31, 2017.

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) 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 Rochester/Buffalo service area includes the following counties in New York: Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates.

GoldValue 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% coinsurance. 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_3162 (08/2016)

Premiums and Benefits	GoldValue with Part D	Preferred Gold without Part D	What you should know
Monthly Plan Premium	You pay $192.80	You pay $99.90	You must continue to pay your Part B premium ($121.80 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 annually	$5,500 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage (Services may require Authorization)	$400 copay per day for days 1 through 4 You pay nothing per day for days 5 through 90 You pay nothing per day for days 91 and beyond	$295 copay 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.
Doctor Visits • Primary • Specialists (Services may require Authorization)	• You pay $15 copay per visit • You pay $40 copay per visit	• You pay $15 copay per visit • You pay $30 copay per visit	
Preventive Care	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 $75 copay per visit	You pay $75 copay per visit	If you are admitted to the hospital within 24 hours, copay is waived.
Urgently Needed Services	You pay $40 copay per visit	You pay $30 copay 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 copay • You pay $10 copay • You pay $10 copay • You pay $40 copay	• You pay $60 copay • You pay $10 copay • You pay $10 copay • You pay $30 copay	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.
Hearing Services • Hearing exam • Hearing aid	• You pay $40 copay • You pay $699-$999 copay	• You pay $30 copay • You pay $699-$999 copay	Hearing Aids must be ordered through TruHearing. Routine hearing exams not covered under POS.
Dental Services • Oral exam & Cleaning (Services may require Authorization)	$240 Annual Preventive Dental Allowance	Not covered	Payment limited to Fee Schedule. Dental services not covered under POS.
Vision Services	• You pay $40 per Diagnostic Eye exam • You pay $40 per Routine Eye Exam • Post-cataract Surgery Eyewear: You pay 20% of the cost • $75/every two years eyewear allowance.	• You pay $30 per Diagnostic Eye exam • You pay $30 per Routine Eye Exam • Post-cataract Surgery Eyewear: You pay 20% of the cost • $100/every two years eyewear allowance.	
Mental Health Services • Inpatient visit • Outpatient group therapy visit • Outpatient individual therapy visit (Services may require Authorization)	• You pay $295/day, days 1-5 • You pay nothing per stay for days 91 and beyond • You pay $40 outpatient group/individual therapy visit	• You pay $295/day, days 1-5 • You pay nothing per stay for days 91 and beyond • 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. Mental health services not covered under POS.

Benefits	GoldValue with Part D	Preferred Gold without Part D	What you should know
Skilled Nursing Facility	• You pay nothing per day for days 1 through 20 • $160 copay per day for days 21 through 100	• You pay nothing per day for days 1 through 20 • $160 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. SNF services not covered under POS.
Rehabilitation Services • Occupational therapy visit • Physical therapy and speech and language therapy visit (Services may require Authorization)	• You pay $40 copay • You pay $40 copay	• You pay $30 copay • You pay $30 copay	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 $150 copay	You pay $75 copay	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)	• You pay $40 copay • You pay $40 copay	• You pay $30 copay • You pay $30 copay	Foot exams and treatment 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 10% of the cost	• You pay 20% of the cost • You pay 20% of the cost • You pay 10% of the cost	
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)	You pay 20% of the cost	You pay 20% of the cost	You pay a 20% coinsurance for Part B drugs purchased at a pharmacy, administered by a pharmacist, or administered by your doctor. (An office visit copay may also apply.) Part B drugs not covered under POS.
Electronic Doctor Visits	You pay $15-$40 copay per visit using remote access technology	You pay $15-$30 copay 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 without Part D**	**What you should know**
	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		Not covered	
Initial Coverage				
Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drugs Tier 5: Specialty Tier Tier 6: Vaccines	You pay $0 You pay $10 You pay $40 You pay 50% You pay 33% You pay $0	You pay $0 You pay $20 You pay $80 You pay 50% Not available Not available	Not covered	You pay this amount for each prescription until your yearly drug costs reach $3,700. 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 Tier 6: Vaccines Other Generic Drugs Brand Name Drugs	You pay $0 You pay $0 You pay 51% You pay 40%	You pay $0 Not available You pay 51% You pay 40%	Not covered	You pay this amount for each prescription until your yearly out-of-pocket costs reach $4,950.
Catastrophic Coverage				
You pay the greater of 5% of the cost or $3.30 (generic)/$8.25 (brand name)			Not covered	You pay this amount after your yearly out-of-pocket costs reach $4,950.

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.**

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