2025 Summary of Benefits

MVP Health Plan, Inc.

MVP Medicare Secure Plus® with Part D (HMO-POS)

MVP Medicare Preferred Gold® without Part D (HMO-POS)

H3305: Plan 022 and Plan 020

This is a summary of drug and health services covered by MVP Health Plan January 1, 2025- December 31,2025
MVP Health Plan, Inc. is an HMO-POS/PPO organization with a Medicare contract. Enrollment in 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 Secure Plus® with Part D (HMO-POS)** or **MVP Medicare 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 service area includes the following counties in New York: Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, 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, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington and Westchester.

MVP Medicare Secure Plus® with Part D (HMO-POS) and **MVP Medicare 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% 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).

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MVP® HEALTH CARE

Premiums and Benefits	MVP Medicare Secure Plus® with Part D (HMO-POS)	MVP Medicare Preferred Gold® without Part D (HMO-POS)	What you should know
Monthly Plan Premium	You pay $96.20.	You pay $0.00.	You must continue to pay your Part B premium. ($174.70 in 2024. This amount may change in 2025)
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)*	$6,000 annually.	$7,200 annually.	The most you pay for copayments, coinsurance, and other costs for medical services for the year.
Inpatient Hospital Coverage (Services may require Authorization)	You pay $350 copayment per day for days 1 through 5. You pay $0 copayment per day for days 6 through 90. You pay $0 copayment per day for days 91 and beyond.	You pay $375 copayment per day for days 1 through 5. You pay $0 copayment per day for days 6 through 90. You pay $0 copayment per day for days 91 and beyond.	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)	You pay $300 copayment for Outpatient Hospital surgery. You pay $175 copayment for care in a certified ambulatory surgical center.	You pay $350 copayment for Outpatient Hospital surgery. You pay $250 copayment for care in a certified ambulatory surgical center.	Physician surgery copayment also applies for outpatient hospital or ambulatory surgery.

Premiums and Benefits	MVP Medicare Secure Plus® with Part D (HMO-POS)	MVP Medicare Preferred Gold® without Part D (HMO-POS)	What you should know
Doctor Visits • Primary Care Providers • Specialists (Services may require Authorization)	You pay $0 copayment per visit. You pay $40 copayment per visit.	You pay $0 copayment per visit. You pay $40 copayment per visit.	Cost sharing applies to each service you receive, including multiple services from the same provider.
Preventive Care	You pay $0 copayment.	You pay $0 copayment.	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 $95 copayment per visit.	You pay $110 copayment per visit.	If you are admitted to the hospital within 24 hours, copayment is waived. Emergency care is provided worldwide.
Urgently Needed Services	You pay $30 copayment per visit.	You pay $45 copayment per visit.	Urgently needed services are provided worldwide.

Premiums and Benefits	MVP Medicare Secure Plus® with Part D (HMO-POS)	MVP Medicare Preferred Gold® without Part D (HMO-POS)	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)	You pay $40-$225 copayment. You pay $0 copayment. You pay $10 copayment. You pay $40 copayment.	You pay $50-$200 copayment. You pay $0 copayment. You pay $10 copayment. You pay $50 copayment.	Cost sharing applies to each service you receive, including multiple services from the same provider.
Hearing Services • Diagnostic & Routine Hearing exam • Hearing aid	You pay $0 copayment per hearing exam. You pay $699-$999 Copayment per hearing aid Or up to $600. Toward the cost of two hearing aids every year.	You pay $0 copayment per hearing exam. You pay $699-$999 Copayment per hearing aid or up to $600 toward the cost of two hearing aids every year	Routine hearing exams not covered under POS. Routine hearing exams limited to one per calendar year. Hearing aids must be purchased through TruHearing. Limit 1 hearing aid per ear per calendar year.
Over-the Counter (OTC) Items • OTC Allowance	$75.00 Allowance per quarter	$25.00 Allowance per quarter	Allowance is received quarterly to be used towards over-the-counter medicine and health-related purchases from select pharmacies or by mail order. Allowance amount does not carry over from quarter to quarter

Premiums and Benefits	MVP Medicare Secure Plus® with Part D (HMO-POS)	MVP Medicare Preferred Gold® without Part D (HMO-POS)	What you should know
• Arthritis Post-Joint Replacement Procedure Care Kit	Customizable care kit	Customizable care kit	Members who have a prior authorization or have undergone a joint replacement within the plan year with a diagnosis of Rheumatoid Arthritis or Osteoarthritis, can receive a customizable care kit with items such as, but not limited to, a reacher, shoehorn, non-slip bathmat, alternative shoe laces, laces designed for those with special needs, sock-aid, and long handled shower sponge through our approved contracted vendor.
Preventive and Comprehensive Dental Services	Annual Maximum Plan Benefit Coverage Amount: $2,000 combined Preventive and Comprehensive services, per calendar year (services above the allowance are your responsibility).	Annual Maximum Plan Benefit Coverage Amount: $1,000 combined Preventive and Comprehensive services, per calendar year (services above the allowance are your responsibility).	Allowance is provided on a prepaid debit card that can be used at any dental provider. Once the full allowance is used, you are responsible for 100% of the cost of any preventive or comprehensive dental services. Any unused funds do not rollover to the next calendar year. See the Evidence of Coverage for more information.

Premiums and Benefits	MVP Medicare Secure Plus® with Part D (HMO-POS)	MVP Medicare Preferred Gold® without Part D (HMO-POS)	What you should know
Vision Services			
• Diagnostic eye exam	You pay $20 per diagnostic eye exam.	You pay $30 per diagnostic eye exam.	
• Routine eye exam	You pay $0 per routine eye exam.	You pay $0 per routine eye exam.	Routine eye exams limited to one per calendar year. Out-of-Network routine eye exams have a $300 maximum payable benefit per calendar year.
• Post-cataract surgery eyewear	You pay 20% coinsurance.	You pay 20% coinsurance.	
• Eyewear allowance	$225 every year eyewear allowance.	$150 every year eyewear allowance.	
Mental Health Services			
• Inpatient visit	You pay $350 per day for days 1-5. You pay $0 copayment per day for days 6-90. You pay $0 copayment per day for days 91 and beyond.	You pay $375 per day for days 1-5. You pay $0 copayment per day for days 6-90. You pay $0 copayment per day for days 91 and beyond.	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.
• Outpatient group therapy visit • Outpatient individual therapy visit (Services may require Authorization)	You pay $10 copayment per outpatient group / individual therapy visit.	You pay $30 copayment per outpatient group / individual therapy visit.	

Skilled Nursing Facility (SNF) (Services may require Authorization)	You pay $0 copayment per day for days 1 through 20. $214 copayment per day for days 21 through 100.	You pay $0 copayment per day for days 1 through 20. $214 copayment per day 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 copayment per visit.	You pay $20 copayment per visit.	Annual dollar limits apply to all outpatient therapy services. Dollar limit also applies to therapy services in a SNF and hospital outpatient departments.
Ambulance (Services may require Authorization)	You pay $175 copayment for ground ambulance. You pay $300 copayment for air ambulance.	You pay $200 copayment for ground ambulance. You pay $400 copayment 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	You pay $0 copayment. 24 one-way rides per year for medical appointments.	You pay $0 copayment. 12 one-way rides per year for medical appointments. Unlimited rides to a VA facility with a 45 mile maximum.	Must use plan-approved vendor. (30-mile, one-way capitation)

Medicare Part B Drugs (Services may require Authorization) • Insulin Drugs	You pay 0%-20% coinsurance. In-Network: You pay 0%-20% coinsurance and your maximum cost share will not exceed $35.	You pay 0%-20% coinsurance. In-Network: You pay 0%-20% coinsurance and your maximum cost share will not exceed $35.	The coinsurance you pay is based on the type of Part B drugs purchased at a pharmacy, administered by a pharmacist, or administered by your doctor. (An office visit copayment may also apply.) Part B drugs not covered under POS. Part B drugs may be subject to Step Therapy requirements.
Foot Care (podiatry services) • Diagnostic foot exams and treatment • Routine foot care (Services may require Authorization)	You pay $40 copayment. You pay $0 copayment.	You pay $40 copayment. You pay $0 copayment.	Routine foot care 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% coinsurance. You pay 0-20% coinsurance. You pay $0 copayment for a 30-day supply of OneTouch, Precision, Freestyle, and Prodigy brand blood glucose test strips and glucometers; you pay $0 copayment for a 30-day supply of non-preferred strips that have prior	You pay 20% coinsurance. You pay 0-20% coinsurance. You pay $0 copayment for a 30-day supply of OneTouch, Precision, Freestyle, and Prodigy brand blood glucose test strips and glucometers; you pay $0 copayment for a 30-day supply of non-preferred strips that have prior authorization.	

• Blood Pressure Cuff	authorization. One basic blood pressure cuff per year at no cost.	One basic blood pressure cuff per year at no cost.	Must have diagnoses of Hypertension. One approved basic blood pressure cuff from our contracted vendor will be covered per year
• Home and Bathroom Safety Devices and Modifications	$250 allowance per year in total for select items from our contracted vendor.	$250 allowance per year in total for select items from our contracted vendor.	Must have diagnoses related to Stroke. Bathroom safety items on a selected list from our contracted vendor including, but not limited to shower seats, raised toilet seats, bathtub seats, and grab bars. Only the approved items will be covered and only through our approved contracted vendor.
Meal Benefit	14 Meals post inpatient hospital discharge	14 Meals post inpatient hospital discharge	Post-Hospitalization meals are covered through contracted vendor and set-up thru Care Management program. 14 meals / 7 days benefit. No limit to number of times benefit can be accessed in a calendar year so long as it is preceded by a hospitalization.

Wellness Programs • SilverSneakers®	No cost for SilverSneakers® membership and to use SilverSneakers® fitness locations and virtual resources. Plus, you get access to GetSetUp, with thousands of live online classes to ignite your interests in topics like cooking, technology, and art.	No cost for SilverSneakers® membership and to use SilverSneakers® fitness locations and virtual resources. Plus, you get access to GetSetUp, with thousands of live online classes to ignite your interests in topics like cooking, technology, and art.	
• ***Be Well*** Rewards Program	With the MVP ***Be Well*** Rewards Program, Medicare members are rewarded with 100 points once they complete an annual wellness visit. Then members can redeem their reward points for a $100 gift card.	With the MVP ***Be Well*** Rewards Program, Medicare members are rewarded with 100 points once they complete an annual wellness visit. Then members can redeem their reward points for a $100 gift card.	
MVP Virtual Care Services	You pay $0 copayment per visit using remote access technology.	You pay $0 copayment per visit using remote access technology.	Must use plan-approved vendor(s). Using your smartphone, tablet or laptop, you can access doctors via video. Not covered under POS.

Outpatient Prescription Drugs			
Benefits	**MVP Medicare Secure Plus® with Part D (HMO-POS)**	**MVP Medicare Preferred Gold® without Part D (HMO-POS)**	**What you should know**
Beginning in 2025; • There are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit. • The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs. • The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December).			For specific information about your costs look at Chapter 6 in your *Evidence of Coverage*.

	Retail Rx 30-day supply	**Mail Order up to 90-day supply, except Tier 1 which is 100 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 Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drugs Tier 5: Specialty Tier Plan-covered Insulin Drugs	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 Plan-covered Insulin Drugs	 You pay $0. You pay $15. You pay $45. You pay 25%. You pay 33%. You pay up to $35.	 You pay $0. You pay $30. You pay $90. You pay 25%. Not available. You pay up to $70.	Not covered.	You pay this amount for each prescription until your yearly drug costs reach $2,000. If you reside in a long-term care facility, only 31-day supply is available, and you pay the same as at a retail pharmacy.
Catastrophic Coverage Tiers 1- 5: You pay $0 co-payment for all drug tiers.			Not covered.	You pay this amount after your yearly out-of-pocket costs reach $2,000.

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 **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 **mvphealthcare.com**

You can see our plan's pharmacy directory at **mvphealthcare.com/partD**

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions at **mvphealthcare.com/partD**

MVP Health Plan, Inc. is an HMO-POS/PPO organization with a Medicare contract. Enrollment in 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. Virtual care services from MVP Health Care are provided by UCM Digital Health, Amwell, and at no cost-share for members. (Plan exceptions may apply.) Members' direct or digital provider visits may be subject to copayment/cost-share per plan.

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 (including sexual orientation and gender identity).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-946-8010 (TTY: 711). 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: 711).