2025 Summary of Benefits

MVP Health Plan, Inc.

MVP® Medicare WellSelect®with Part D (PPO)

MVP Medicare Patriot Plan® with Part D (PPO)

H9615: Plan 010, Plan 018

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 WellSelect® with Part D (PPO)** or **MVP Medicare Patriot Plan® 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 Hudson Valley service area includes the following counties in New York: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester.

MVP® Medicare WellSelect® with Part D (PPO) and **MVP Medicare Patriot Plan® 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.

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Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan® with Part D (PPO)	What you should know
Monthly Plan Premium	You pay $0.	You pay $44.00	You must continue to pay your Part B premium. ($174.90 in 2024). This amount may change in 2025.
Part B Premium Reduction	$11.80 reduction of the monthly premium you pay to the Social Security Administration	Not Applicable	
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)*	$8,500 In-Network and $12,500 In/Out-of-Network combined annually.	$7,900 In-Network and $12.000 In/Out-of-Network combined annually.	The most you pay for copayments, coinsurance, and other costs for medical services for the year.
Inpatient Hospital Coverage (Services may require Authorization)	In-Network: You pay $435 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. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay $425 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. Out-of-Network: 40% coinsurance.	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)	In-Network: You pay $400 copayment for Outpatient Hospital surgery. You pay $300 copayment for care in a certified	In-Network: You pay $350 copayment for Outpatient Hospital surgery. You pay $250 copayment for care in a	Physician surgery copayment also applies for outpatient hospital or ambulatory surgery.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan® with Part D (PPO)	What you should know
	ambulatory surgical center. Out-of-Network: You pay 40% coinsurance.	certified ambulatory surgical center. Out-of-Network: 40% coinsurance.	
Doctor Visits • Primary Care Providers • Specialists (Services may require Authorization)	In-Network: You pay $0 copayment per PCP visit. Out-of-Network: You pay $5 copayment per PCP visit. In-Network: You pay $55copayment per Specialist visit. Out-of-Network: You pay $60 copayment per Specialist visit.	In-Network: You pay $0 copayment per PCP visit. Out-of-Network: You pay $5 copayment per PCP visit. In-Network: You pay $50 copayment per Specialist visit. Out-of-Network: You pay $60 copayment 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 $0 copayment.	In-Network/Out-of-Network: 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	In-Network/Out-of-Network: You pay $110 copayment per visit.	In-Network/Out-of-Network: You pay $110 copayment per visit.	If you are admitted to the hospital within 24 hours, copayment is waived. Emergency care is provided worldwide.

Premiums and Benefits	MVP® Medicare WellSelect® with Part D	MVP Medicare Patriot Plan® with Part D (PPO)	What you should know
Urgently Needed Services	In-Network/Out-of-Network: You pay $45 copayment per visit.	In-Network/Out-of-Network: You pay $30 copayment per visit.	Urgently needed services are provided worldwide.
Diagnostic Services/Labs/ Imaging			
• Diagnostic radiology service (e.g., MRI)	In-Network: You pay $60-350 copayment. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay $50-$300 copayment. Out-of-Network: You pay 40% coinsurance.	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.
• Lab services	In-Network: You pay $0 copayment. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay $0 copayment. Out-of-Network: You pay 40% coinsurance.	
• Diagnostic tests and procedures	In-Network: You pay $50 copayment. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay $15 copayment. Out-of-Network: You pay 40% coinsurance.	
• Outpatient x-rays (Services may require Authorization)	In-Network/Out-of-Network: You pay $60 copayment.	In-Network: You pay $50 copayment. Out-of-Network: You pay $60 copayment.	

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Hearing Services			
• Diagnostic Hearing exam	In-Network: You pay $0 copayment. Out-of-Network: You pay $60 copayment.	In-Network: You pay $0 copayment. Out-of-Network: You pay $60 copayment.	
• Routine Hearing exam	In-Network: You pay $0 copayment. Out-of-Network: You pay $60 copayment.	In-Network: You pay $0 copayment. Out-of-Network: You pay $60 copayment.	Routine Hearing exam limited to one per calendar year.
• Hearing aid	In-Network $699-$999 per hearing aid or get up to $600 toward the cost of two hearing aids every year. Out-of-Network: Not covered	In-Network $699-$999 per hearing aid or up to $600 toward the cost of two hearing aids every year. Out-of-Network: Not Covered.	Hearing Aids must be ordered through TruHearing. Limit 1 hearing aid per ear per calendar year.
Over-the-Counter (OTC) Items • OTC Allowance	$50.00 Allowance per quarter	$50.00 Allowance per quarter	Allowance is received quarterly to be used towards eligible 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

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• 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: $1,250 combined Preventive and Comprehensive services, per calendar year (services above the allowance are your responsibility).	Annual Maximum Plan Benefit Coverage Amount: $1,500 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.

Vision Services • Diagnostic eye exam	In-Network: You pay $40 copayment. Out-of-Network: You pay $60 copayment.	In-Network: You pay $20 copayment. Out-of-Network: You pay $60 copayment.	
• Routine eye exam	In-Network/Out-of-Network: You pay $0 copayment.	In-Network/Out-of-Network: You pay $0 copayment.	Routine eye exam is limited to one per calendar year.
• Post-cataract surgery eyewear	In-Network: You pay 20% coinsurance. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay 20% coinsurance. Out-of-Network: You pay 40% coinsurance.	
• Eyewear allowance	In-Network/Out-of-Network: $225 every year eyewear allowance.	In-Network/Out-of-Network: $225 every year eyewear allowance.	
Mental Health Services • Inpatient visit	In-Network: You pay $400 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. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay $400 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. Out-of-Network: You pay 40% coinsurance.	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.

• Outpatient group therapy visit/Outpatient individual therapy visit (Services may require Authorization)	In-Network: You pay $10 copayment per outpatient group/individual therapy visit. Out-of-Network: You pay $50 copayment.	In-Network: You pay $10 per outpatient group / individual therapy visit. Out-of-Network: You pay $50 copayment.	
Skilled Nursing Facility (SNF) (Services may require Authorization)	In-Network: You pay $0 copayment per day for days 1 through 20. You pay $214 copayment per day for days 21 through 100. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay $0 copayment per day for days 1 through 20. You pay $214 copayment per day for days 21 through 100. Out-of-Network: You pay 40% coinsurance.	Our plan covers up to 100 days in a SNF.
Physical Therapy (Services may require Authorization)	In-Network: You pay $35 copayment per visit. Out-of-Network: You pay $60 copayment per visit.	In-Network: You pay $35 copayment per visit. Out-of-Network: You pay $60 copayment per visit.	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)	In-Network/Out-of-Network: $300 copayment for ground ambulance. In-Network/Out-of-Network: $500 copayment for air ambulance.	In-Network/Out-of-Network: You pay $250 copayment for ground ambulance. In-Network/Out-of-Network: You pay $350 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. 12 one-way rides per year for medical appointments.	You pay $0 copayment. 12 one-way rides per year for medical appointments non-VA providers (30-mile, one-way capitation per trip) and unlimited rides to VA facility (45-mile one-way capitation per trip)	Must use plan approved vendor. (30-mile, one-way capitation)
Medicare Part B Drugs (Services may require Authorization) • Insulin Drugs	In-Network: You pay 20% coinsurance. Out-of-Network: You pay 40% coinsurance. In-Network: You pay 0%-20% coinsurance and your maximum cost share will not exceed $35. Out-of-Network: You pay 40% coinsurance	In-Network: You pay 20% coinsurance. Out-of-Network: You pay 40% coinsurance. In-Network: You pay 0%-20% coinsurance and your maximum cost share will not exceed $35. Out-of-Network: You pay 40% coinsurance.	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 may be subject to Step Therapy requirements
Foot Care (podiatry services) • Diagnostic Foot exams and treatment • Routine foot care (Services may require Authorization)	In-Network: You pay $55 copayment. Out-of-Network: You pay $60 copayment. In-Network: You pay $0 copayment.	In-Network: You pay $50 copayment. Out-of-Network: You pay $60 copayment. In-Network: You pay $0 copayment.	Routine foot exams and treatment only if you have diabetes-related nerve damage and/or meet certain conditions.

• Routine foot care (continued)	Out-of-Network: You pay $60 copayment	Out-of-Network: You pay $60 copayment.	
Medical Equipment/ Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen)	In-Network: You pay 20% coinsurance. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay 20% coinsurance. Out-of-Network: You pay 40% coinsurance.	
• Prosthetics (e.g., braces, artificial limbs)	In-Network: You pay 0-20% coinsurance. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay 0-20% coinsurance. Out-of-Network: You pay 40% coinsurance.	
• Diabetes supplies (Services may require Authorization)	In-Network: You pay $0 copayment for a 30-day supply of Freestyle, OneTouch, Precision 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. Out-of-Network: You pay 40% coinsurance.	In-Network: You pay $0 copayment for a 30-day supply of OneTouch, Precision, Freestyle, 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. Out-of-Network: You pay 40% coinsurance.	

• Blood Pressure Cuff	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 through 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	In-Network/Out-of-Network: You pay $0 copayment per visit using remote access technology.	In-Network/Out-of-Network: 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.

Outpatient Prescription Drugs			
Benefits	**MVP® Medicare WellSelect® with Part D**	**MVP Medicare Patriot Plan® with Part D (PPO)**	**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*.

Outpatient Prescription Drugs					
Benefits	**MVP® Medicare WellSelect® with Part D**		**MVP Medicare Patriot Plan® with Part D (PPO)**		**What you should know**
	Retail Rx 30-day supply	**Mail Order up to 90-day supply, except Tier 1 which is 100-day supply**	**Retail Rx 30-day supply**	**Mail Order up to 90-day supply, except Tier 1 which is 100-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	$500 Deductible. Tier 1, Tier 2, and Plan-covered Insulin drugs are not subject to the deductible.		$350 Deductible. Tier 1, Tier 2 and Select Insulin Drugs are not subject to deductible		
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	 You pay $0. You pay $15. You pay $47. You pay 25%. You pay 26%. You pay up to $35.	 You pay $0. You pay $30. You pay $94. You pay 25%. Not available. You Pay up to $70.	 You pay $0. You pay $15. You pay $47. You pay 26%. You pay 28%. You pay up to $35.	 You pay $0. You pay $30. You pay $94. You pay 26%. Not available. You pay up to $70.	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					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.com**.
Toll-free **1-800-324-3899**, TTY users should call 711.
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. MVP virtual care services through Gia are available at no cost-share for most members. In-person visits and referrals are subject to 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).