



2009 Preferred Gold HMO
and GoldAnywhere PPO
Member Handbook



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The information in this handbook is updated based on regulatory guidelines and member suggestions. For more details regarding your coverage, refer to your Preferred Gold HMO or GoldAnywhere PPO Evidence of Coverage (your contract).

If you have suggestions to offer about this handbook, please send them to:
MVP Health Care, Communications Dept., 220 Alexander Street, Rochester, NY 14607.

2009 Preferred Gold HMO & GoldAnywhere PPO Member Handbook

How to use your member handbook

Read this handbook to learn about the many health and wellness programs MVP Health Care offers outside of traditional insurance plans. You will get the most value from your plan if you take advantage of what we have to offer. To be a fully informed consumer, read the entire handbook. While the Evidence of Coverage is your legal agreement with MVP Health Care, this handbook highlights parts of your plan not covered in your Evidence of Coverage booklet.

What does it mean to live well?

At MVP Health Care, living well means taking a more active role in your health and doing everything you can today for a healthy tomorrow. We want you to live well, and we're here to help you do that in a way that fits your style.

You are a central part of your health care team and can do a lot to maintain your good health and to prevent illness and disease. We encourage you to get preventive care services, including immunizations, cancer screenings, and other tests that can help you detect illness early, at its most treatable stage. We also encourage you to take advantage of our health and wellness programs, including the SilverSneakers® Fitness Program.

Even the healthiest people are likely to need health care at some time. When this happens, don't try to diagnose or treat yourself, or rely on the advice of family and friends. When you are not well, call your doctor and seek professional care as described in this handbook.

Rated "Excellent"

Members rated Preferred Gold "Excellent," earning 5 out of 5 stars for overall plan quality, in the 2008 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.

HMOs and PPOs — What's the difference?

The main difference between a Preferred Provider Organization (PPO) health plan (GoldAnywhere) and a Health Maintenance Organization (HMO) health plan (Preferred Gold) is that with a PPO you may receive care for covered services from any provider you choose. With an HMO, you may choose from providers within the health plan's provider network.

If you are a member of GoldAnywhere, you should get most or all of your health services from the doctors, hospitals, and other health care providers that are part of MVP. However, you also may use out-of-network providers to get covered services.

If you are a GoldAnywhere member and use out-of-network providers for care other than emergency or urgently needed care, or renal dialysis, it will cost you more than if the service was performed in-network. That means, if the service is not an emergency, urgently needed care, or renal dialysis you will have to pay a higher percentage of the bill.

What are "plan providers"?

"Providers" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "plan providers" when they participate in Preferred Gold or GoldAnywhere. When we say that plan providers "participate in Preferred Gold or GoldAnywhere," this means that we have arranged with them to coordinate or provide covered services to members of Preferred Gold or GoldAnywhere.

What are "covered services"?

"Covered services" is the general term we use in this booklet to mean all of the health care services and supplies that are covered by Preferred Gold or GoldAnywhere.

Preferred Gold and GoldAnywhere are products of MVP Health Plan, Inc., a not-for-profit HMO/PPO with a Medicare Advantage contract serving Albany, Broome, Cayuga, Chenango, Columbia, Cortland, Dutchess, Fulton, Genesee, Greene, Herkimer, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Rensselaer, Saratoga, Schenectady, Schoharie, Seneca, Steuben, Tioga, Ulster, Warren, Washington, Wayne, Wyoming and Yates counties. Plan availability and premium rates may vary by county.

Health Care Guidelines for Healthy Members Over 65

	WOMEN	MEN
Preventive Health Checkup	Every 1-2 years for healthy adults	Every 1-2 years for healthy adults
Blood Pressure Check	At each visit	At each visit
Breast Self-Examination	Monthly	
Cholesterol Screening	Every 5 years	Every 5 years
Colorectal Screening (fecal occult blood testing)	<ul style="list-style-type: none"> — Annual fecal occult blood testing and flexible sigmoidoscopy every 5 years (starting at age 50), OR — Colonoscopy every 10 years, OR — Double contrast barium enema every 5 years 	<ul style="list-style-type: none"> — Annual fecal occult blood testing and flexible sigmoidoscopy every 5 years (starting at age 50), OR — Colonoscopy every 10 years, OR — Double contrast barium enema every 5 years
Diabetes Screening	Screening recommended every three years only for adults at risk for diabetes—discuss with your doctor	Screening recommended every three years only for adults at risk for diabetes—discuss with your doctor
Eye Exam, including glaucoma screening	Annually	Annually
Flu Shot	Annually	Annually
Mammogram	Annually	
Osteoporosis screening —discuss with your doctor	Routine screening recommended	
Pap Test	Discussion and counseling with your doctor	
Pneumococcal Vaccine	First dose at age 65—second dose 5 years after first	First dose at age 65—second dose 5 years after first
Prostate Cancer Screening (digital rectal exam)		Discussion and counseling with your doctor
Tetanus/Diphtheria Booster	Every 10 years	Every 10 years

These guidelines are recommendations for healthy adults over age 65. It is important to work with your physician to develop a schedule that is appropriate for your health care situation.

Call Member Services for information on health care guidelines for people under age 65.

How to contact us

Contact Member Services

Member Services representatives are ready to answer your questions, explain your benefits and resolve any issues. If you are most comfortable speaking a language other than English, we can arrange to have an interpreter available at no cost to you.

When to contact Member Services

- For the most up-to-date list of doctors, hospitals and other health care professionals in our network.
- To change your primary care physician (members can also do this on the Web—see *Visit the MVP Health Care Web Site* in this section).
- To learn more about your benefits.
- If your address or phone number changes.
- If you receive a bill, other than for copayments, from a physician or other health care professional or facility.
- If you lose your Preferred Gold or GoldAnywhere card or need to update the information on your card.
- When you want to express a concern or make a suggestion about your coverage or treatment.
- For information on allowing a family member, friend, or lawyer to help you with questions about your health care plan.
- For help with an appeal or complaint.
- For more detailed information about physician offices and other health care professionals (for example, to find a doctor's office where another language is spoken).

Contacting Member Services

By phone:

Call (585) 327-2480 or (800) 665-7924

TTY users may call (585) 325-2629 or (800) 252-2452

Representatives are available:

Monday – Friday, 7:00 a.m. – 8:00 p.m. Eastern Time.
From November 15 – March 1, representatives also are available weekends from 8:00 a.m. to 8:00 p.m.

In person:

You may visit our offices at 220 Alexander Street to meet with a Member Services representative. Office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday. Representatives are available to help you on a first come, first served basis. For directions to our office, see *Directions to our office* in this section.

In writing:

You can write Member Services at the following address:

Preferred Gold
Attention: Member Services
220 Alexander Street
Rochester, NY 14607

By fax:

You can send Member Services a fax at (585) 327-2298. Write on the fax: Attention Member Services.

By email:

Send Member Services an email by visiting the Member Services area on our Web site at www.mvphealthcare.com.

Visit the MVP Health Care Web site

You can use MVP Health Care's Web site to help manage your health plan and take charge of your health. These resources and information are available 24 hours a day at www.mvphealthcare.com. You can:

- Search our directory of health care professionals for a provider.
- Look up information in our Health Encyclopedia.
- Look up the definition of a health care term in our Glossary of Terms.
- Email to sign up for a class or to contact Member Services.
- Use the quick links to access forms and publications.
- If you have Medicare Part D coverage through MVP Health Care, you can view our formulary (list of drugs).

If you sign up for *easyLink*sm access, you can:

easyLinksm
members

- View your benefits and copay information.
- View your claims and coverage history.
- Determine your copay for a drug.
- Keep track of your medical expenses.
- Change your Primary Care Physician.
- Request a member ID card or print a temporary ID card.

For pharmacy information

If you are a Preferred Gold or GoldAnywhere member enrolled in our Medicare Part D prescription drug plan, contact Medco Pharmacy Member Services for information at:

(800) 590-6801 for Preferred Gold
(800) 514-8891 for GoldAnywhere
(800) 716-3231 (TTY)

You can call 24 hours a day, 7 days a week, except Thanksgiving and Christmas.

For behavioral health concerns

For any chemical dependency or mental health issue, call MVP Health Care's confidential Behavioral Health Unit at:

(585) 327-2477 or (800) 836-1430
TTY users may call (585) 325-2629
or (800) 252-2452
Monday - Friday
8:30 a.m. to 5:00 p.m. Eastern Time

To report fraud

Call our confidential hotline to report possible fraud issues. The number is: (877) 835-5687.

Directions to our offices

We are located at 220 Alexander Street in Rochester. Office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday. Representatives are available to help you on a first come, first served basis.

Parking is free in the covered parking garage next to the 220 Alexander St. building. When you enter the garage, take a ticket from the automated machine and bring it with you to the main reception desk or the Wellness Center to be stamped.

Handicapped parking spots are on each level. On the second and third levels, there are several parking spots reserved for our Preferred Gold and GoldAnywhere visitors (look for the GOLD VISITOR PARKING signs). Use these spots whenever you visit MVP Health Care.

To reach MVP Health Care's main reception desk:

From the parking garage: Take the covered walkway on Level 2 of the parking garage. Once inside, continue across the atrium straight ahead to the MVP Health Care reception desk.

From the street: Enter the main atrium of the building. Take the elevators to the second floor and turn left toward the MVP Health Care reception desk.

Special Programs for Preferred Gold and GoldAnywhere members

MVP Health Care *Living Well* programs

Because we're committed to healthier living, we offer a series of health education programs and support services to help you improve or maintain your health and independence. These free educational programs, presented by experts and even some fellow Preferred Gold or GoldAnywhere members, are part of your benefits as a member of Preferred Gold or GoldAnywhere and include:

- Physical activity classes for all levels of ability — from Ta'i Chi for Arthritis and Qi Gong, to Gentle Yoga and our popular Body in Motion class
- Skills for living well with ongoing illnesses, including heart health, diabetes, arthritis and chronic pain conditions
- Skills for daily living — preventing falls and improving balance, protecting your back from injury, and more
- Special programs such as how to protect yourself from identity theft
- Grief support groups
- Managing your weight, stopping the smoking habit, eating healthier

- Fun activities, from journaling to beating the winter blahs

Visit our Web site at www.mvphealthcare.com, check your member newsletter, or call Member Services for a class listing.

The SilverSneakers® Fitness Program*

MVP Health Care is pleased to offer the SilverSneakers® Fitness Program FREE to all Preferred Gold and GoldAnywhere members. With SilverSneakers you have free access to amenities such as treadmills, weights, and fitness classes that are included with a basic fitness center membership. You can take SilverSneakers classes designed specifically for older adults to help you:

- Have more energy
- Improve balance
- Increase flexibility
- Feel good inside and out
- Meet new people
- Have fun!

The SilverSneakers Fitness Program is offered at designated health and fitness centers throughout our service area. Whether you want to take a class or just use the treadmill, we'll help you get started, all in a welcoming and safe environment.

When you travel or go on vacation, SilverSneakers' reciprocity policy allows you to stay in shape at any participating fitness center across the United States. You can continue your SilverSneakers exercise program without taking long breaks! The SilverSneakers network includes more than 3,000 fitness centers nationwide. Go online at www.silversneakers.com to view participating fitness center lists by state.

For more information, call Member Services or use the quick link on our Web site at www.mvphealthcare.com.

HealthDollarssm *

As a Preferred Gold or GoldAnywhere member, you are eligible for \$100 in HealthDollars. You may use your \$100 in HealthDollars for any health, wellness, or fitness class or program. Interested in therapeutic massage or a yoga class? Want to join a bowling league or take golf lessons? The choice is yours, in any of these four areas of wellness:

- Fitness / exercise
- Health education
- Safety
- Well-being

The \$100 HealthDollars benefit is for each Preferred Gold or GoldAnywhere member. (Any unused portion of the HealthDollars benefit cannot carry over into the next calendar year.)

NOTE: The SilverSneakers Fitness Program is a benefit for all Preferred Gold or GoldAnywhere plan members and is not a part of the HealthDollars program.

For more information about HealthDollars or to get a copy of our HealthDollars reimbursement form, go to our Web site at www.mvphealthcare.com, or call Member Services.

**HealthDollars and SilverSneakers are neither offered nor guaranteed under our contract with Medicare. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the MVP Health Care grievance process.*

24/7 Nurse Advice Line

Get answers to your health questions any time. We provide a nurse you can talk to — just a phone call away, seven days a week — for:

- Help with a health problem in the middle of the night.

- Answers to “what do I do if” health questions.
- Finding information and resources about prevention and wellness, treatments, chronic conditions, and other health topics and concerns.

The Nurse Advice Line also features an audio library of more than 400 pre-recorded messages on general health topics.

Get the knowledge and resources you need to make an informed health decision! Call the MVP Health Care Nurse Advice Line at (800) 204-4712.

Care management programs

The Care Management staff at MVP Health Care can help you better manage your chronic illness. An MVP Health Care nurse, therapist, or care manager will work with you and your doctor to manage your health. Your care manager is not your primary care physician (PCP), but rather, another member of your health care team.

We provide Care Management for the following:

- Acute conditions (if you are living with chronic illness)
- Back care
- Behavioral health
- Cancer care
- Depression care
- Diabetes care
- Heart failure
- Kidney care
- Metabolic syndrome
- Respiratory care (asthma/COPD)

Your doctor and our care manager will work together to:

- Find and get the medical care you may need
- Teach you about your illness and the treatments available
- Help you learn how to take the best care of yourself
- Find other useful community programs
- Locate classes and services through our free health and wellness programs

Care management programs give the added support you need to manage your illness and live well. You will get letters and newsletters with the latest information you can use to stay on top of your illness. The programs are voluntary, confidential, and free to you as a Preferred Gold or GoldAnywhere member.

How we provide information to you

***Living Well* newsletter for Preferred Gold and GoldAnywhere members**

Your *Living Well* member newsletter provides information about your benefits and features stories on how to maintain and improve your health, fellow Preferred Gold and GoldAnywhere members, nutrition tips and healthy recipes, and more. Published regularly throughout the year, the newsletter contains the most current information on your plan.

A single copy of *Living Well* is mailed to a household. If you are married, and both you and your spouse are Preferred Gold or GoldAnywhere members, you will receive only one copy of the newsletter.

Required mailings

Because you have a Medicare Advantage plan, MVP Health Care is required by law to mail certain documents to you each year, including:

- Your Evidence of Coverage (your contract) — please read your contract and keep it handy for reference
- Your Member Handbook
- A directory of MVP Health Care's network of health care professionals
- An abridged list of drugs covered by your Medicare Part D prescription drug plan (if you have signed up for Part D coverage with us)
- A letter each fall that outlines your plan benefit changes for the coming year
- Surveys that help us determine who should pay first for your health care services

If you are married, and both you and your spouse are Preferred Gold or GoldAnywhere members, the Centers for Medicare & Medicaid Services requires that we send contracts and other legal or regulatory information to each of you.

Other mailings

We will also send you information that we feel is of benefit to you. For example, we mail a flu shot post card each fall to remind you of the benefits of getting a flu shot.

Your opinion is important to us!

MVP Health Care welcomes regular input and help from its members. Your life experience can be valuable in helping us improve Preferred Gold and GoldAnywhere and the lives of other members. There are several ways to help:

The Member Advisory Committee

This group helps ensure that we offer the programs and services members want most in a way that makes it easy to understand or participate. The group reviews current communications, programs, and services and makes recommendations for potential changes.

Focus groups

At times we randomly select Preferred Gold or GoldAnywhere members and invite them to take part in structured but relaxed focus groups on various topics. There are no right or wrong answers to questions. What we seek is each member's personal opinion. These topic-specific meetings are a one-time occurrence; no ongoing commitment is required.

Surveys

Throughout the year, MVP Health Care writes or calls members to stay in touch and learn what you expect or need, or how satisfied you are with your health plan. We survey a random sample of members to get reliable results while keeping survey costs down. The sample is a good representation of our members. A random sample results in some people being asked once or—in rare circumstances—twice, and others not being asked at all.

There are some surveys we are required by the government or other agencies to send to obtain specific information, such as other types of insurance you might have. The surveys include:

- Our **Member Satisfaction Survey** that asks about your experiences and satisfaction with various aspects of Preferred Gold or GoldAnywhere. We use this information to improve plan benefits and services to you.
- The **Medco Satisfaction Survey** that asks about your experiences and satisfaction with aspects of your Medicare Part D coverage (if you have coverage through MVP Health Care). Our pharmacy benefit manager, Medco, uses your responses to improve benefits and services to you.
- The **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey**, which is required by the National Committee for Quality Assurance and by the Centers for Medicare & Medicaid Services, is sent to MVP Health Care members every year to ask your opinion about your health care experience with your doctors and MVP Health Care.
- The **Member Services Follow-Up Survey** that is sent after you've had contact with Member Services. The information from this survey gives us a satisfaction rating of the service you received from our representatives.
- The **Health Risk Assessment Survey** that is sent to determine if you could benefit from more support from an MVP Health Care nurse care manager who can help you connect with other needed community and medical services.
- The **Medicare Part D Coordination of Benefits Survey** which is required by the Centers for Medicare & Medicaid Services to identify other prescription drug coverage available to Part D plan members.

If you receive a survey from us, please respond promptly. It saves money in mailing costs when we don't need to mail a survey a second time. Make your opinion count—respond to surveys!

Benefit highlights

Acupuncture

Preferred Gold and GoldAnywhere will pay for 50% of the cost for acupuncture office visits, up to 10 visits a year.

Behavioral Health

For any chemical dependency or mental health issue, please call MVP Health Care's Behavioral Health Unit at:

(585) 327-2477 or **(800) 836-1430**

TTY users may call **(585) 325-2629** or **(800) 252-2452**

Clinicians are available 24 hours a day. The phones are staffed Monday - Friday from 8:30 a.m. to 5:00 p.m. All other times, follow the prompts and you will be directed how to seek appropriate service. Every call is **completely confidential**.

Chemical dependency treatment

If your use of alcohol and/or drugs is having a negative effect on your health, family life, volunteer activities, work, or leisure, you may need treatment for alcohol or drug dependency. Even non-prescription medications can be overused. The use of alcohol can have an adverse effect on your medications or have a harmful effect on a medical condition.

If you need help with a drug or alcohol situation, the first step is to get a confidential assessment by calling the MVP Health Care Behavioral Health Unit. A behavioral health clinician will discuss your concerns to determine if you need an assessment.

If you need an assessment, the clinician will help to arrange it for you. The appointment will be at a location that is convenient for you and at the earliest possible date. It will be with a professional who has special training and experience in working with people who are chemically dependent. These professional assessors are certified or licensed by the State of New York.

The assessor sends a confidential written report to the behavioral health clinician who spoke with you. If the report shows that you could benefit from treatment, you will receive specific recommendations either from the location where you were evaluated or from the clinician at MVP Health Care. In addition, they will recommend an appropriate chemical dependency treatment provider from MVP Health Care's network.

Any treatment for chemical dependency that is not coordinated through MVP Health Care will not be covered by your Preferred Gold or GoldAnywhere plan (or Medicare), and you will be responsible for the cost.

Mental health care

MVP Health Care provides coverage for mental health problems. This may include a sudden change in your ability to function which may be related to a specific situation in your life. You might, for example, feel very depressed or experience a change in eating or sleeping habits. If you experience symptoms such as these, contact your primary care physician as a first step.

Your doctor may recommend you seek help from a community resource such as a support group, or that you see a network mental health specialist. To see a mental health specialist your doctor can refer you through MVP Health Care, or you may call MVP Health Care yourself to speak confidentially with a behavioral health clinician at:

(585) 327-2477 or **(800) 836-1430**

TTY users may call **(585) 325-2629** or **(800) 252-2452**

Clinicians are available to answer your questions Monday - Friday from 8:30 a.m. to 5:00 p.m. At all other times, follow the prompts and you will be directed how to seek appropriate services. If you have a medical emergency, get help as quickly as possible. Call 911 for help or go to the nearest emergency room.

Dental

Preferred Gold or GoldAnywhere members who pay MVP Health Care directly are eligible for up to \$300 of dental coverage annually. Check your Evidence of Coverage for your specific plan details. **If your coverage is through your former employer, this benefit may not apply to you.**

You may receive your dental care from any dentist in MVP Health Care's service area. MVP Health Care will reimburse the provider (or reimburse you, if you have already paid the provider) for billed charges up to the maximum allowable benefit for each service. If your dentist charges more than the maximum allowable benefit amount, you may be responsible for the difference. Any unused portion of the dental benefit cannot carry over from one calendar year to the next.

Most dentists will file dental claims on your behalf. It's not necessary, but if you'd like to take a paper copy of the dental claim form to your next dentist visit, you can call Member Services to have one mailed to you. Or, visit us online at www.mvphealthcare.com to print a copy of the form.

Preferred Gold and GoldAnywhere will cover oral surgery in **limited situations** when approved by your primary care physician. Covered emergency dental services are limited to those needed to restore healthy natural teeth within a year of a **traumatic injury**, such as a fall or an auto accident, and do not include prescription medication needed as a result of dental treatment. Your doctor will coordinate the approval of such care for these services:

- Initial X-ray
- Initial filing (not filling) of a broken tooth
- Emergency root canal
- Immediate implantation of a sound natural tooth or teeth

Restoration of injured teeth or cosmetic dental work, such as bridges or caps, is not covered. Prior authorization is needed for dental services.

Exclusions and non-covered services

Preferred Gold does not cover such services as cosmetic surgery, custodial care, non-standard and unevaluated treatments and services provided in conjunction with a non-covered service, among others. Unless expressly indicated in the contract, all non-medically-necessary services are not covered.

Hospice care

Hospice is a special way of caring for a person who is at the end stage of life. It is available under Medicare Hospital Insurance (Part A) to people having a very limited life expectancy. The focus is on comfort care, not treatment or cure. Emphasis is on helping the person make the most of each hour and day of remaining life by providing comfort and relief from pain.

Under Medicare, hospice is primarily a program of care delivered in a person's home or in an inpatient setting by a Medicare-approved hospice.

Reasonable and necessary medical and support services for managing a terminal illness are provided under a plan of care set by the hospice and the patient's attending physician.

If you choose hospice care, you receive non-curative medical and support services for your terminal illness. Home care is provided along with necessary inpatient care, plus other services not otherwise covered by Medicare.

When you choose hospice care, you give up the right to standard Medicare benefits only for treatment of the terminal illness. If you continue as a Preferred Gold or GoldAnywhere member while receiving hospice services, you will continue to receive benefits for the treatment of health problems unrelated to the terminal illness. These services must be provided by MVP Health Care contracted providers.

For more information, call Member Services and you will be put in touch with a nurse care manager. Or, call the National Hospice Organization at (800) 658-8898.

Hospitalization

Your doctor or a specialist will decide if you need treatment in a hospital. This might happen, for example, if you need tests or routine procedures that cannot be performed in a doctor's office or to treat a serious illness or other medical problem. If you do require a hospital stay, your primary care physician will contact MVP Health Care before you are admitted and make all the necessary arrangements. He or she also will explain everything you need to know and answer all your questions.

With very few exceptions, all medically necessary hospital services are covered for as many days as medically necessary in a semi-private room. The length of your stay will be based on medical need, as determined by your primary care physician and any specialist involved in your treatment, together with MVP Health Care's Medical Director.

Your pre-admission testing is a covered service, and the appropriate copayment applies.

There are many medical conditions that cannot be treated on an outpatient basis, but do not require hospitalization. Your doctor may arrange for you to be cared for in a subacute unit at a skilled nursing facility or intermediate care facility, or even through home care. Your doctor has agreed to refer you to the most appropriate setting for your care and may believe that your best care will be in a setting other than a traditional hospital unit. All facilities used by MVP Health Care have met our credentialing standards and are qualified to meet your medical needs.

Mental health care

See the "Behavioral Health" listing at the beginning of this section.

Outpatient observation

When you go to the hospital emergency room, your doctor may want you to stay in the hospital for an observation period. Outpatient observation services are those services that are provided on the hospital's premises, and include the use of a bed and periodic monitoring by nurses or other staff. Your doctor may request these services in order to:

- Evaluate your condition, or
- Determine the need for you to be admitted to the hospital as an inpatient, or
- Monitor your health following a prolonged ambulatory procedure or emergency department evaluation.

Observation services can last from 8 to 72 hours. If your doctor requests an extension of the observation period, the medical staff at MVP Health Care will consider the medical appropriateness of extending the observation stay and provide the doctor with a determination.

Observation stays are not an admission to a hospital. Your emergency room copay will apply and observation stays do not count toward the three-day required hospital stay for skilled nursing.

Physical exams

MVP Health Care wants to help you stay fit and healthy. We recommend you have a physical examination by your primary care physician every year. In this way, your doctor can update your medical history and assess your overall health. To make the most of your visit:

- Ask your most important questions first
- Make a list of any changes in your health, eating, sleeping or moods and discuss them with your doctor
- Tell your doctor of any major life changes, such as a family death or change of residence
- Show your doctor all of the medications and supplements you are taking, including those prescribed by your specialist and over-the-counter medicines, vitamins and herbal supplements
- Seek medical approval for any diet or exercise program you wish to begin

For new members we recommend and cover a physical exam. This exam includes measurement of height, weight and blood pressure; an EKG; education, counseling and recommendations for covered screening and preventive services.

We also cover blood screening tests for the early detection of heart disease (or abnormalities associated with an elevated risk of heart disease), including tests for cholesterol and other lipid or triglyceride levels.

Professionally administered medications

For prescription medications **given by medical personnel** in a doctor's office, end-stage renal disease treatment facility, or outpatient center: A copay will be charged for the administration of a drug, such as chemotherapy and vitamin B-12 shots. This is in addition to any other copay charged on that day, such as an office visit copay. This copay **does not apply** to allergy shots, flu and pneumonia immunizations, or any injections given to a patient who is confined in a hospital or who is in a home health care setting. Only one drug copay will be charged per doctor per day. So, for example, if your doctor gives you two injections in one day, Preferred Gold will only charge one drug copay.

Rehabilitation therapies

Some illnesses, injuries, or diseases require rehabilitation therapy, such as speech, physical, or occupational therapy. The goal of therapy is to help you return to the best possible degree of functioning. Maintenance therapy is not covered.

Your doctor must coordinate rehabilitation therapy. He or she will determine, often in consultation with a specialist, if your condition meets the criteria for medically necessary treatment. If treatment is required, your doctor will contact MVP Health Care and arrange your treatment with a network provider.

Second opinions

In some cases, more than one type of care may be equally effective for treatment of a certain illness or disease, and different doctors may recommend different approaches. That is why, after a consultation with a specialist, you may want to see another specialist for a second opinion. Your specialist copay would apply to this visit.

Skilled nursing facility care

A skilled nursing facility is:

- Specifically qualified to provide inpatient medical and nursing care
- Recognized and certified as such by Medicare
- Falls within the definition of a skilled nursing facility under Title XVIII of the Social Security Act.

In most cases, a three-day inpatient hospital stay is required before being admitted to a skilled nursing facility. If you do not need to be hospitalized but need skilled nursing care that cannot be provided at home, your doctor may recommend care in a skilled nursing facility on a short-term basis.

If your doctor recommends care in a skilled nursing facility and you meet certain Medicare criteria, Preferred Gold or GoldAnywhere will cover a semi-private room as medically necessary. Refer to your contract for the number of days covered. This benefit does not cover custodial care or permanent residence in a nursing home.

MVP Health Care managers, together with your doctors, determine the level of care you need. If it is determined that you are at a custodial level of care, MVP Health Care will not cover the service.

Custodial care is non-skilled, personal care, such as help with activities of daily living:

- Bathing
- Dressing
- Eating
- Getting in and out of bed or chair
- Moving around
- Using the bathroom

Custodial care also may include care that most people do themselves, like using eye drops. Medicare does not pay for custodial care.

About your prescription coverage

This section provides some basic information about how to fill your prescriptions with Preferred Gold and GoldAnywhere. To get a complete description of your prescription coverage, including how to fill your prescriptions, please review your Evidence of Coverage (your contract).

Using a network pharmacy

A network pharmacy is a pharmacy with which MVP Health Care has made arrangements to provide prescription drugs to plan members. In most cases, your prescriptions are covered under Preferred Gold or GoldAnywhere only if they are filled at a network pharmacy or through our mail order pharmacy service. Once you go to one pharmacy, you are not required to continue going to the same pharmacy to fill your prescription. You can go to any of our network pharmacies. We will cover prescriptions at non-network pharmacies under certain circumstances as described later.

Finding an MVP Health Care Medicare Advantage network pharmacy in your area

You can use the 2009 MVP Health Care Medicare Advantage Pharmacy Directory to look for a network pharmacy near you.

You can also visit our Web site at www.mvphealthcare.com or call Member Services to help you find a network pharmacy.

Changes to the list of network pharmacies

MVP Health Care may add or remove pharmacies from our pharmacy directory.

To get current information about MVP Health Care network pharmacies in your area, please visit our Web site at www.mvphealthcare.com or call Member Services using the information provided on the back cover of this handbook.

Filling a prescription at a network pharmacy

To fill your prescription at a network pharmacy, you must show your Medco prescription ID card. Most prescription drugs can be dispensed for a 90-day supply at a network pharmacy. There is a small list of medications that may be limited to a 30-day supply. Please refer to the 2009 MVP Health Care Medicare Advantage Part D Covered Drugs and Pharmacy Directory for specifics.

If you do not have your ID card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your co-payment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a paper claim. To obtain a paper claim form, please visit our Web site at www.mvphealthcare.com or call Member Services. All paper claim forms must be completely filled out and submitted to Medco along with your pharmacy receipts. To find out how to submit a paper claim, please refer to the paper claims process described later.

Paper claims will be paid at our network rate minus your co-payment. Our network rates for prescriptions are usually less than a pharmacy's price, so it is best to always use your pharmacy card and pay your co-payment when picking up prescriptions.

Filling a prescription through MVP Health Care's mail order pharmacy service

To get order forms and information about filling your prescriptions by mail, please visit our Web site at www.mvphealthcare.com or call Member Services using the information provided on the back cover of this handbook. Please note that you must use the Medco mail order service. Prescription drugs that you get through any other mail order service are not covered.

You may begin using the Medco mail order service in one of the following ways:

By mail:

1. Ask your doctor to write a new prescription for a 90-day supply of medication, plus refills (as appropriate). Your mail order copays are based on a 90-day supply, so make sure all of your mail order prescriptions are for 90 days.
2. Choose a convenient payment method. You may pay by check, money order, or major credit card. If you prefer to pay by credit card, you may also want to join Medco's automatic payment program by simply keeping your credit card information on file with them.
3. Mail the new prescription(s) in the return envelope provided with your Member Handbook, along with a completed mail order form and the appropriate payment.

By fax:

1. Ask your doctor to write a new prescription for a 90-day supply of medication, plus refills (as appropriate). Give your doctor your Member ID number, which is on your Member ID card (It will begin with the letter A).
2. Ask your doctor to call the "Prescription phone number," provided on the back cover of this handbook, for instructions on faxing your prescription to Medco. Please note that Medco only accepts **faxed** prescriptions from doctors.

Refills:

You can find your refill date on the prescription label and on the refill slip that comes with every order, or by visiting the Medco Web site. You can obtain refills in one of three ways: by mailing the order to Medco, by visiting Medco's Web site, or by calling Medco Member Services using the information provided on the back cover of this handbook.

To ensure that you don't run out of your medications, try to reorder at least 3 weeks before your prescription runs out. If you don't have enough medication to last until your next supply comes in the mail, ask your doctor to give you a second prescription for a 30-day supply and call MVP Health Care for authorization to fill it at a retail network pharmacy while you wait for your mail-order supply to arrive. If your mail order shipment is delayed, please call Member Services using the information provided on the back cover of this handbook. We'll make sure you are able to obtain your medication when you need it.

Filling prescriptions outside the network

Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy.

Before you fill your prescription in these situations, call Member Services using the information provided on the back cover of this handbook to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription.

You can ask us to reimburse you for our share of the cost by submitting a paper claim form to Medco. However, even after we reimburse you for our share of the cost, you may pay more for a drug purchased at an out-of-network pharmacy because the out-of-network

pharmacy's price is usually higher than what a network pharmacy would have charged. To learn how to submit a paper claim, please refer to the paper claims process described later.

The following are a few exceptions when we will pay for a prescription filled at a pharmacy outside of our network.

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service
- We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgent care
- If you are traveling within the United States or its territories and become ill or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high-cost and unique drugs)
- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B and some covered drugs that are administered in your doctor's office

Please note: We cannot pay for any prescriptions that are filled by pharmacies outside of the United States and its territories, even for a medical emergency.

Before you fill your prescription in any of these situations, call Member Services using the information provided on the back cover of this handbook to see if there is a network pharmacy in your area where you can fill your prescription.

If you do go to an out-of-network pharmacy for the reasons previously listed, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form to Medco. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. To learn how to submit a paper claim, please refer to the paper claims process described next.

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy will not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

To submit a paper claim, you must refer to your pharmacy receipt to fill in all required information on the paper claim form. Once it is completely filled in, attach your pharmacy receipt and mail to the paper claim mailing address on the back cover of this handbook. Please note that the included pharmacy receipt must be the paper receipt from the pharmacy computer, not the transaction receipt from the cash register. Upon receipt, we will make an initial coverage determination on the claim. Please refer to your Evidence of Coverage (your contract) for more information on initial coverage determinations or call Member Services using the information provided on the back cover of this handbook.

For more information

For more detailed information about your Preferred Gold or GoldAnywhere prescription drug coverage, please review your Evidence of Coverage and your MVP Health Care Medicare Advantage Part D Covered Drugs and Pharmacy Directory.

Meeting your primary health care needs

Getting medical care when your doctor's office is closed

In an emergency, you should get care immediately. You do not have to contact your doctor or get permission in an emergency. You can dial 911 for immediate help by phone or go directly to the nearest emergency room, hospital, or urgent care center.

No referral needed for specialists

If you are a Preferred Gold member, you will not need to call your primary care doctor for a referral to see a specialist, such as a podiatrist, rheumatologist, dermatologist, or cardiologist. You may call directly to make your appointment. The specialist must be part of the MVP Health Care network. To check to see if a specialist is a part of our network, visit www.mvphealthcare.com or call Member Services.

If you are a GoldAnywhere member, you can see any doctor, anywhere, any time.

If your health care professional leaves MVP Health Care

A health care professional may leave the MVP Health Care network. This may happen because your doctor:

- May retire
- May move out of the service area
- Is not meeting the MVP Health Care standards for quality care
- May choose not to participate in the MVP Health Care network

If your doctor leaves our network, we can help you find a new one and make sure you get the care you need. This is called "continuation of care."

Continuation of care for existing members

If your current health care professional leaves the MVP Health Care network, you may keep seeing this professional up to ninety (90) days after your provider's contract has ended with MVP Health Care. The following conditions apply:

- The provider did not leave the network because of the quality of care given to patients
- The provider was giving you treatment for an acute medical condition
- The provider was giving you treatment for an acute episode of a chronic illness

Health care providers must agree to:

- Accept the MVP Health Care reimbursement as payment in full (minus any copays or deductibles)
- Maintain our quality assurance requirements
- Share medical information with MVP Health Care
- Follow our policies and procedures for prior authorization of services

To ask for this type of continuation of care, have your doctor call the MVP Health Care Professional Relations team at (585) 325-3114 or (800) 999-3920. If you need help in choosing a new doctor, call Member Services.

Transitional care for new members

If you are a new member and your doctor from your previous plan is not part of the MVP Health Care network, you may ask to continue seeing your former doctor for up to 60 days after you become a member if you are living with a life-threatening, deteriorating or disabling condition or disease. The doctor must:

- Agree to accept MVP Health Care's reimbursement as payment in full (minus any copays or deductibles)

- Maintain our quality assurance requirements
- Share medical information with MVP Health Care
- Follow our policies and procedures for prior authorization of services

To ask for this type of transitional care or help with choosing a new doctor, call Member Services.

Specialized medical care over a prolonged period of time

If you have a very serious degenerative or disabling condition or disease that requires specialized care over a prolonged period of time (for example, cancer) you may request that your specialist becomes your primary care physician. You also may request care at a specialty care center, if appropriate, for the same reason. All requests for this type of specialty care must be made through your primary care physician to MVP Health Care's Utilization Management Department. We will inform you of the decision made on your request.

To have the most effective relationship with your doctor:

- **Be on time for appointments.** If you are unable to keep your appointment, call to cancel at least 24 hours before the scheduled time.
- **Pay all copayments** at the time you receive services.
- **Take an active role** in your health care.
- **Make a list of questions** to ask the doctor and ask them in order of importance.
- **Don't be afraid to ask questions.** Any time you are uncertain about a medical procedure or don't understand the treatment your physician recommends, ask questions. If you feel you have received duplicative tests or unnecessary services, talk to your doctor or call us. To help remember what the doctor says, take notes or ask the doctor if you

may use a tape recorder. You may want to have a family member or friend with you—to take part in the discussion, to take notes, or to just listen.

- **Share information.** Give your doctor or health care provider an honest assessment of your symptoms, effects of medication, or results of treatments.
- Contact your primary care physician **before receiving services** from a specialist.

You can expect your doctor to:

- Provide treatment in a timely manner.
- Inform you of your health condition and the full range of treatment options regardless of cost or benefit coverage.
- Obtain your consent, or the consent of someone you authorize, for all treatment.
- Maintain confidentiality about your care.
- Be accessible 24 hours a day, 365 days a year and have a designated backup (or on-call) physician.

Credentialing and recredentialing of providers

All MVP Health Care network physicians are carefully evaluated—both when they become part of the MVP Health Care panel, and every three years thereafter. This is to ensure that they meet our standards for training and professional certification and that they demonstrate skill in treating patients. They must:

- Demonstrate that they are involved in continuing medical education.
- Provide references from at least three other physicians who have had the opportunity to evaluate the quality of care they deliver.
- Receive approval through our Credentialing Committee (members of the committee include providers in the community).

All network professionals have agreed to provide care to our members at negotiated prices.

Your network physician will not balance bill you or charge you any extra fees for covered services.

You are responsible for your copayments. If you are a Preferred Gold member, you should receive your care from MVP Health Care network providers (except for emergency and urgently needed care outside of the service area), or it will not be covered by MVP Health Care.

Provider reimbursement

MVP Health Care is committed to providing our members with quality, affordable health care. We partner with more than 10,500 local health care providers to ensure access to this care, and contract with them using a variety of reimbursement methods.

MVP Health Care reimburses major physician organizations using “capitation,” an amount paid per person each month. In return, the physicians who belong to these organizations provide or arrange health care services for MVP Health Care members. When services are received by members, physicians may bill MVP Health Care. Services are paid according to an agreed upon amount, based on the type of procedure.

The physician organizations withhold a percentage of the amount they pay each physician. The withhold percentage—or “withhold” as it is commonly called—is agreed upon in advance by MVP Health Care and its physicians. At the end of the year, if the physician organizations meet or exceed their budgeted goal, the withhold is returned to the physicians. If the organizations do not meet their budgeted goal, some or none of the withhold amount is returned to the physicians.

MVP Health Care also contracts with other providers (for example, hospitals, labs, visiting nurses) using capitation and other types of reimbursement methods, such as discounted fee-for-service. With this type of reimbursement, the provider is simply paid a predetermined agreed-upon discounted amount for each service provided. MVP Health Care’s provider reimbursement methodologies are intended to ensure that members receive the right care.

Business matters

MVP's privacy notice — How we protect and keep your personal health information confidential

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

MVP respects the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, provide you with this notice of our privacy practices and legal duties and to abide by the terms of this notice.

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and New York State laws and regulations regarding the confidentiality of health information, MVP provides this notice to explain how we may use and disclose your health information to carry out payment and health care operations and for other purposes permitted or required by law. "Health information" is defined as enrollment, eligibility, benefit, claim, and any other information that relates to your past, present or future physical or mental health

MVP's duties regarding your health information

MVP is required by law to:

- Maintain the privacy of information about your health in all forms including oral, written, and electronic;
- Provide you with this notice of our legal duties and health information privacy rules; and
- Abide by the terms of this notice.

We reserve the right to change the terms of this notice at any time, consistent with applicable law, and to make those changes effective for health information we already have about you. Once revised, we will provide the new notice to you by mail and post it on our Web site www.mvphealthcare.com.

How we use or disclose your health information

As a member, you agree to let MVP share information about you for treatment, payment, and health care operations. The following are ways we may use or disclose your health information:

For Treatment: We may share your health information with a physician or other health care provider in order for them to provide you with treatment.

For Payment: We may use and disclose your health information to collect premium payments, determine benefit coverage, or to provide payment to health care providers who render treatment on your behalf.

For Health Care Operations: We may use or disclose your health information for health care operations that are necessary to enable us to arrange for the provision of health benefits, the payment of health claims, and to ensure that our members receive quality service. For example, we may use and disclose your health information to conduct quality assessment and improvement activities, case management and care coordination, licensing, credentialing, underwriting, premium rating, fraud and abuse detection, medical review and legal services.

Appointment Reminders: We may use or disclose your health information to send you a reminder that you have an appointment with your doctor for treatment or medical care.

Health-Related Benefits and Services: We may use or disclose your health information to tell you about alternative medical treatments and programs or about health-related products and services that may be of interest to you.

Disclosures to a Business Associate: We may disclose your health information to other companies that perform certain functions on our behalf. These companies are called “Business Associates.” These Business Associates must agree in writing to protect your privacy and follow the same rules we do.

Disclosures to a Plan Sponsor: We may disclose your health information to the plan sponsor of your group health plan (usually your employer) so that the plan sponsor may obtain premium bids, modify, amend or terminate your group health plan and perform enrollment functions on your behalf. If we obtain assurances as required by law from your plan sponsor, including an assurance that it will not use your health information for any employment-related decisions, we may also disclose your health information to your plan sponsor so that it can carry out other administrative functions on behalf of your group health plan related to your treatment, payment of your claims and the health care operations of your group health plan.

Disclosures to a Third Party Representative: We may disclose to a Third Party Representative (family member, relative, friend, etc.) health information that is directly relevant to that person’s involvement with your care or payment for care if we can reasonably infer that the person is involved in your care or payment for care and that you would not object.

Disclosures Authorized by You: We can accept an Authorization to Disclose Information Form if you would like us to share your health information with someone for a reason we have not stated above. Using this form, you can designate who you would like us to share information with, what information you would like us to share, and how long you want us to be able to share your information with that individual. A copy of this form is available by calling Member Services at the phone numbers on the back of your member ID card, or logging on to the MVP Web site at www.mvphealthcare.com. You must complete this form and send it to the address or fax it to the fax number on the form. You can cancel this Authorization at any time in writing and per the requirements on the form.

Special use and disclosure situations

Under certain circumstances, as required by law, MVP would be required to share your information without your permission. Some circumstances include:

Uses and Disclosures required by law: We may use and disclose health information about you when we are required to do so by federal, state or local law.

Public Health: We may disclose your health information for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births or deaths; or reporting reactions to medications or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight: We may disclose your health information to a health oversight agency that monitors the health care system and government programs for designated oversight activities.

Legal Proceedings: We may disclose your health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and, in certain situations, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your health information, so long as applicable legal requirements are met, for law enforcement purposes.

Abuse or Neglect: We may disclose your health information to a public health authority, or other government authority authorized by law to receive reports of child abuse, neglect or domestic violence consistent with the requirements of applicable federal and state laws.

Coroners, Funeral Directors and Organ Donation:

We may disclose your health information to a coroner or medical examiner to identify a deceased person, determine a cause of death or as authorized by law. We may also disclose your health information to funeral directors as necessary to carry out their duties. If you are an organ donor, we may release your health information for procurement, banking or transplantation.

Research Purposes: In certain circumstances, we may use and disclose your health information for research purposes.

Criminal Activity: We may disclose your health information when necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Military Activity: We may disclose your health information to authorized federal officials if you are a member of the military (or a veteran of the military).

National Security: We may disclose your health information to authorized federal officials for national security, intelligence activities and to enable them to provide protective services for the President and others.

Workers' Compensation: We may disclose your health information as authorized to comply with workers' compensation laws and other similar legally established programs.

What are your rights?

The following are your rights with respect to your health information. Requests for restrictions, confidential communications, accounting of disclosures, amendments to your health information or to inspect or copy your health information, can be made by contacting us at:

**Preferred Gold
Member Services
220 Alexander Street
Rochester, NY 14607**

Or call Member Services at the phone numbers on the back of your member ID card.

Right to Request Restrictions: You have the right to request a restriction or limitation on your health information we disclose for payment or health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment for your care, like a family member, relative, or friend. While we will try to honor your request, we are not legally required to agree to restrictions or limitations. If we agree, we will comply with your request or limitations except in emergency situations.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information in a certain way or at a certain location if the disclosure of information could endanger you. We will require the reason for the request and will accommodate all reasonable requests.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us other than those necessary to carry out treatment, payment, and health care operations, disclosures made to you or authorized by you, or in certain other situations.

Right to Inspect and Obtain Copies of Your Health Information: You have the right to inspect and obtain a copy of certain health information that we maintain. In limited circumstances, we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing of the reason for the denial and if applicable the right to have the denial reviewed.

Right to Amend: If you feel that the health information we maintain about you is incomplete or inaccurate, you may ask us to amend the information. In certain circumstances we may deny your request. If we deny the request, we will explain your right to file a written statement of disagreement. If we approve your request, we will include the change in your health information and tell others that need to know about your changes.

Right to a Copy of the Notice of Privacy Practices: You have the right to obtain a copy of this notice at any time.

Exercising your rights

Unless you provide us with a written authorization, we will not use or disclose your health information in any manner not covered by this notice. If you authorize us in writing to use or disclose your health information in a manner other than described in this notice, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your authorization; however, we will not reverse any uses or disclosures already made in reliance on your authorization before it was revoked. You have a right to receive a paper copy of this notice at any time. You can also view this notice on our Web site at www.mvphealthcare.com. If you have any questions about this notice, please contact us at:

**Preferred Gold
Member Services
220 Alexander Street
Rochester, NY 14607**

Or call Member Services at the phone numbers on the back of your member ID card.

If you believe your privacy rights have been violated, you may file a written complaint by contacting us at:

**MVP Health Care
Complaints Coordinator
P.O. Box 2207
625 State Street
Schenectady, NY 12301**

Or call Member Services at the phone numbers on the back of your member ID card.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must:

1. be in writing;
2. contain the name of the entity against which the complaint is lodged;
3. describe the relevant problems; and
4. be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request.

We will not take any action against you for filing a complaint.

We will not retaliate in any way if you choose to file a complaint in good faith with us or with the U.S. Department of Health and Human Services. We support your right to the privacy of your medical information.

Your rights and responsibilities

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan, and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048, or visit www.medicare.gov on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "find a Medicare Publication." If you have any questions whether our Plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with our plan, you have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

MVP members have the right to be treated with dignity, respect, and fairness at all times.

Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or your local Office for Civil Rights.

You have the right to the privacy of your medical records and personal health information.

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The Plan will release your information, including your prescription drug event data to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services. The Plan will release your information, including your prescription drug event data to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

You have the right to see network providers, get covered services, and get your prescriptions filled within a reasonable period of time.

You will get most or all of your care from network providers; that is, from doctors and other health providers who are part of our Plan. You have the right to choose a network provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. You have the right to timely access to your prescriptions at any network pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time.

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

You have the right to use advance directives (such as a living will or a power of attorney).

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the New York State Department of Health at (800) 206-8125.

You have the right to make complaints.

You have the right to make a complaint if you have concerns or problems related to your coverage or care.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

You have the right to get information about our Plan, network providers, drugs, health care coverage, and costs.

You have the right to an explanation from us about any bills you may get for services not covered by our Plan. We must tell you in writing why we will not pay for or approve a service, and how you can file an appeal to ask us to change this decision.

You also have the right to get information from us about our Plan. This includes information about our financial condition, about our Plan health care

providers and their qualifications; as well as information on our network pharmacies, and how our Plan compares to other health plans. You have the right to find out from us how we pay our doctors. You have the right to get information from us about our network pharmacies, providers and their qualifications and how we pay our doctors. To get this information, call Member Services.

You have the right to an explanation from us about any prescription drugs or Part C medical care or service not covered by our Plan. We must tell you in writing why we will not pay for or approve a prescription drug or Part C medical care or service, and how you can file an appeal to ask us to change this decision. You also have the right to this explanation even if you obtain the prescription drug or Part C medical care or service from a pharmacy and/or provider not affiliated with our organization. You also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to your plan. Please review our formulary Web site or call Member Services for more information.

You have the right to receive information about your member rights and responsibilities.

Additionally, you have the right to make recommendations regarding the member rights and responsibilities policy.

You have the right to get information in other formats.

You have the right to get your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486- 2048.

If you think you have been treated unfairly or your rights are not being respected

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.

If you have any other kind of concern or problem related to your Medicare rights and protections described, you can also get help from HIICAP/SHIP at 1-800-701-0501.

Your right to make recommendations

You have a right to member rights and responsibilities and to make recommendations to MVP Health Care about our members' rights and responsibilities policies. You may do so by:

- Calling Member Services.
- Visiting www.mvphealthcare.com on the Web and clicking on "Member Services."
- Contacting us at *Living Well* (your member newsletter) by email at livingwell@mvphealthcare.com, or by writing to MVP Health Care, 220 Alexander St., Rochester, NY 14607.

The following are your responsibilities as a member of our Plan:

1. Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services if you have any questions.
2. Using all of your insurance coverage. If you have additional health insurance coverage or prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care or prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the health or drug benefits that are available to you.
3. You are required to tell our Plan if you have additional health insurance or drug coverage. Call Member Services.
4. Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan enrollment card to the provider.
5. Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
6. Understanding your health problems and taking part in developing mutually agreed upon treatment goals to the extent possible.
7. Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
8. Paying your plan premiums and your co-payments/coinsurance for your covered services. You must pay for services that aren't covered.
9. Notifying us if you move. If you move within our service area, we need to keep your membership records up-to-date. If you move outside our service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
10. Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

Evaluating medical technology

MVP Health Care medical policies are developed and reviewed annually and as needed when medical technology changes. If appropriate, new policies are established as new medical technologies arise.

Requests may come from different sources, including providers, members, and regulatory agencies. Careful consideration and research go into each request for consideration of a new technology as a covered benefit. Decisions are made based on the most recent evidence-based medical literature and research available.

MVP Health Care medical directors, community physicians on MVP Health Care's specialty health care teams, medical services departments, claims administration, and product management make up the team that reviews each request. For more explanation of this process, call Member Services.

Physician incentive program regulation

As Medicare Advantage health plans, Preferred Gold and GoldAnywhere must provide you with the following information if you request it:

- Whether we use a physician incentive plan that affects the use of referral services
- The type of incentive arrangement
- Whether stop-loss protection is provided

Fraud

Fraud is stealing. Fraudulent health insurance claims increase health care costs. Who pays for this costly crime? We all do. Common forms of fraud include accepting:

- Payments made for services not rendered
- Payments made for services previously covered by another insurance carrier
- Payments made to or for someone who was not an eligible subscriber or dependent

All of these situations are serious crimes — punishable by law.

Report suspected insurance fraud

At MVP Health Care, we're tough on insurance fraud. We work closely with our health care providers and other insurance companies to identify potential fraud. We rely on you to help us fight insurance fraud by reporting any suspicious activity similar to the situations described above.

If you suspect fraud in the health care system, please call our confidential Special Investigations Unit fraud hotline at **(877) 835-5687**.

Your Explanation of Benefits (EOB)

Whether you receive care from an in-network or out-of-network provider, we may send you an "Explanation of Benefits." This form cites all the care for which we have been billed on your behalf. It is not a bill. We ask that you review any Explanation of Benefits you receive to be sure we are being billed only for the services you actually received. If you see any errors, please call Member Services right away.

Quality Improvement Program

MVP Health Care's Quality Improvement Program is committed to increasing clinical quality, making the most of safe clinical practices, and continually improving service to you.

Ensuring you are satisfied with MVP Health Care and our network of providers is part of our quality plan. You may request more information about MVP Health Care's Quality Improvement initiatives, programs, and a report of the organization's progress in meeting its goals by calling Member Services Monday – Friday from 7:00 a.m. – 8:00 p.m. Eastern Time at (585) 327-2480 or (800) 665-7924. TTY users may call (585) 325-2629 or (800) 252-2452. Or visit **www.mvphealthcare.com** on the Web.

Utilization management

Utilization management is a process that MVP Health Care uses to review the health care services you receive. The process makes sure you get the right care for your health needs—effective care that you are able to get in a timely manner and at a place that best meets your specific health care needs.

MVP Health Care asks certain questions when reviewing a service or making coverage decisions, such as:

- What is the quality of the care like?
- Do the benefits of getting this care outweigh its risks?
- Is this care appropriate for your specific medical condition?
- Is this the only service that is available or are there other more cost-effective treatments?
- Does your health plan cover this type of care?

Not all the care you get will be reviewed by MVP Health Care. Types of care that may be reviewed include services that are high cost (such as gastric bypass surgery) or if the service is often considered not medically necessary (such as cosmetic surgery).

It's important for you to know that MVP Health Care wants to make sure you know that individuals make decisions based only on appropriateness of care and services and the benefit coverage available to you. Doctors, specialists, and other health care professionals are not encouraged to deny care or coverage for care to our members. MVP Health Care does not reward or offer incentives to employees or health care professionals to deny health care services to you.

MVP Health Care will generally speak to your provider if there are questions about your care.

Your doctor has the right to ask MVP Health Care to reconsider its coverage decision if he or she does not agree with that decision. MVP Health Care will reconsider the request and provide a response within one business day after the request is received. This timeline does not apply if you have already received the care.

You and your doctor will make all final decisions on your health care. MVP Health Care cannot stop you from getting medical care. These utilization management policies are used to determine if, and to what degree, your care will be covered by your MVP Health Care health plan.

There are three basic types of review:

Pre-service review (before treatment)

A “pre-service review” is a review that takes place before you get care. Your doctor will contact MVP Health Care to request approval for coverage of care. We will review your request before you get the treatment. We will contact your primary care physician and the doctor treating you with the result of the review, and will let you know whether your care will be covered under your health plan.

Types of services that may be reviewed before you get care include elective hospital admissions. An elective admission is a planned admission to the hospital — such as knee replacement surgery. This type of care is not an urgent or emergency admission. Your health will not be at risk if you do not get immediate care.

MVP Health Care will review elective admission requests and other pre-service requests within two business days after the request is received. You and your doctor will be informed of the decision within three business days of the request.

You will be informed of the MVP Health Care decision in writing. If you have chosen a person to represent you (member designee), that person will also be notified. MVP Health Care also uses this review to find out if you may benefit from our care management programs. You also may get help with planning once you are ready to leave the hospital.

Concurrent review (during treatment)

A “concurrent review” is a review that takes place while you are getting care. This happens when your doctor asks for additional services while you are going through a course of treatment. Examples include ongoing physical therapy and care received while you are in the hospital.

A decision on this type of review will be made within one business day after the request is received. You and your doctor will be informed of the MVP Health Care decision about whether this care will be covered under your health plan — by phone and in writing. If you have chosen a person to represent you (“member designee”), that person will also be notified.

Examples of services reviewed during treatment include mental health care, rehabilitation care, and chemical dependency care.

MVP Health Care also uses this review to find out if you may benefit from care management programs. You may also get help with planning once you are ready to leave the hospital.

Post-service review (after treatment)

A “post-service review” takes place *after* you receive care. This type of review includes things such as the reason for an inpatient admission, member complaints, appeals, and claims review.

MVP Health Care will make a decision and provide a written notice to you and your doctor on this type of review within 30 calendar days after the request is received. The decision will include information about whether this care will be covered under your health plan. If you have chosen a person to represent you, that person will also be notified.

MVP Health Care has a medical team — nurses, medical directors, pharmacists, psychologists, social workers, physical therapists, and a chiropractor — on staff. This medical team will help answer questions you may have about your care.

Call Member Services if you have questions about a review of your medical care. You will be put in contact with someone on our medical team who can answer your questions.

Utilization management for prescription drugs

There are certain prescription drugs that require MVP Health Care’s review and authorization. This review needs to take place before the prescription can be filled in order for the prescription to be covered under your health plan.

If you have Medicare Part D prescription drug coverage through Preferred Gold or GoldAnywhere, please check your Evidence of Coverage booklet for more information. You also may go to www.mvphealthcare.com for a list of medications that may require prior authorization under your Part D coverage. Or call Member Services for answers to your questions.

Health care decisions

MVP Health Care wants you to know that you have the right to make informed decisions about your health care. If you choose to fill out any of the following advance directives, give a copy to your agent, doctor, and any other family members or close friends. Keep it with other important papers and take a copy with you when you travel. Appointing someone to speak on your behalf is a serious decision; discuss it with your doctor, family, or close friends.

A. Health Care Proxy

Under New York State law, you have the right to establish a Health Care Proxy. The proxy allows you to choose a representative (agent) to carry out your plan for medical treatment only when you are unable to speak for yourself. In the proxy, you can give your agent as little, or as much, authority as you wish. You can allow your agent to make decisions about all your health care needs or only about certain treatments. Your agent will have the authority to decide how your wishes apply as your medical condition changes. A copy of the health care proxy form is in this handbook.

B. Living Will

A Living Will lets you state your wishes about specific treatment should you develop an irreversible condition that prevents you from making your own decisions. It is generally used to declare your wish to refuse life-sustaining treatment under certain circumstances. Understand that general instructions about refusing treatment, even if written down, may not be effective. Your instructions must clearly cover the treatment decisions that must be made. State the kind of treatment that you do not want, such as a respirator or chemotherapy, and describe the medical condition for which you would refuse the treatment, such as when you are terminally ill or permanently unconscious with no hope of recovering.

C. Do-Not-Resuscitate Order

Your right to decide about treatment includes the right to decide about cardiopulmonary resuscitation (CPR). CPR is emergency treatment to restart the heart and lungs when your breathing or circulation stops. A do-not-resuscitate (DNR) order tells medical professionals not to perform CPR. During hospitalization, an adult patient may consent to a DNR order orally or in writing, if two witnesses are present. When your consent is given orally, one of the witnesses must be a physician affiliated with the hospital. Prior to hospitalization, consent must be in writing in the presence of two adult witnesses. The Health Care Proxy Law allows you to appoint someone you trust to make decisions about CPR and other treatments if you are unable to decide for yourself.

D. Authorization to Disclose Information

Maintaining member confidentiality is very important to us at MVP Health Care. If you would like to allow a family member (including spouse, child, or relative), friend, lawyer, or someone else you trust to assist you with questions about your health care plan or claims, you must fill out an Authorization to Disclose Information form and send it to Member Services. This form will remain on file with MVP Health Care. A copy of this form is in this handbook.

Health care proxy form instructions

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: **I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.**

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments:

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain

individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death, or any other legally authorized person.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

After completing this form, keep the original document and make two copies—one for your health care proxy and one for your primary care physician.

(1) I, _____
hereby appoint _____

(name, home address, and telephone number of your proxy)
as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent,
I hereby appoint _____

(name, home address, and telephone number of your proxy) as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.)

This proxy shall expire (specify date or conditions):

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section.

(5) Your Identification (please print)

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

Any needed organs and/or tissues

The following organs and/or tissues: _____

Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.) I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____

Name of Witness 1 (print) _____

Signature _____

Address _____

Date _____

Name of Witness 2 (print) _____

Signature _____

Address _____

MVP Health Care Authorization to Disclose Information

Protecting your confidentiality is important to MVP Health Care and its subsidiaries (collectively, "MVP"). If you would like MVP to share your health information with another party, you must first give your permission to do so.

By filling out and signing this form, you give that permission. MVP may then share your health information with the people you have authorized. PLEASE READ THIS FORM CAREFULLY.

There are five (5) Sections on this form:

SECTION 1 — Fill in your Name, MVP Member ID#, and Date of Birth identifying you as the Member.

This Section may also be used if you are giving MVP permission to share health information on a minor for whom you are the parent or legal guardian.

SECTION 2 — Fill in the Name(s), Address(es), and Phone Number(s) of the person(s) you are authorizing MVP to share your health information with.

Be sure to write the contact's full name and address. MVP will only share information if the contact correctly verifies the name and address you have written.

SECTION 3 — Select the health information you are authorizing MVP to share. There are 3 options:

The **first** option gives MVP permission to share all of your health information, except for information involving HIV/AIDS, psychiatric and substance abuse, family planning and pregnancy, or sexually transmitted diseases. You must specifically authorize MVP to share this information with another party.

The **second** option gives MVP permission to share information about HIV/AIDS, psychiatric and substance abuse, family planning and pregnancy, or sexually transmitted diseases, and is explained more fully below. **MVP will not share this information if you have not specifically authorized us to do so.** Please read the special notice from the NYS Department of Health on page 43.

The **third** option gives MVP permission to share only the information you specify, such as eligibility information only, information specific to a particular service, or claims information for a specific provider.

SECTION 4 — Read and make sure you understand your rights under this authorization.

You may use this section to specify an expiration date on this form, otherwise it will remain in effect indefinitely, or until you request it to be revoked.

SECTION 5 — Sign and date the form and print your name underneath your signature.

You can use this form if you are giving MVP permission to share health information on a minor for whom you are the parent or legal guardian. If so, make sure to write in your relationship to that member.

When completed, please mail or fax the completed Authorization to Disclose Information form to the address or fax number on the bottom of the form.

Your Rights Related to Authorization to Disclose Information

- 1) You may authorize someone to appeal an issue on your behalf (with the exception of Medicare members, additional information is required). By doing so you are exercising your right to appeal and will not be permitted to appeal the same issue yourself.
- 2) MVP shall not condition treatment, payment, enrollment or eligibility for benefits under its insured plans on receipt of this authorization.
- 3) Information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- 4) If information is disclosed from alcohol and drug abuse records protected by federal confidentiality rules (42 CFR Part 2), these federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Your Rights Relating to the Release of Confidential HIV* Related Information

Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, confidential HIV related information can only be given to people you allow to have it by signing a written release, or to people who need to know your HIV status in order to provide medical care and services, including: medical care providers; persons involved with foster care or adoption; parents and guardians who consent to care of minors; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals, other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive. State law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as

necessary to pay for care and treatment. Under State law, anyone who illegally discloses HIV related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of such information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at **1-800-962-5065**.

By signing and initialing where indicated on page 45 of this form, HIV related information can be given to the people listed on the form, and for the reason(s) you may list on the form. You do not have to sign the form, and you can change your mind at any time by indicating your change in writing.

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or **1-212-480-2493** or the New York City Commission of Human Rights at **1-212-306-5070**. These agencies are responsible for protecting your rights.

* Human Immunodeficiency Virus that causes AIDS.

MVP Health Care Authorization to Disclose Information

By completing this form you are allowing MVP to disclose health care information to the individuals you identify.

Section 1 — Indicate the Member Whose Information is to be Released:

Name _____ Member ID# _____ DOB ____/____/____

Section 2 — I Authorize MVP to Disclose Health Information to:

(Print the Name(s), Address(es) and Telephone Number(s) of the person(s) you would like to appoint):

Section 3 — Indicate the Health Information to be Released:

All Health Information (except the health information listed below)

The following items must be specifically indicated for MVP to discuss these types of health information with the person(s) you have appointed:

HIV/AIDS related information and/or records

Mental health information and/or records

Drug/alcohol diagnosis and treatment information

Pregnancy, family planning, abortion information

Sexually transmitted disease information

Other (specify the information you are authorizing MVP to disclose)

Section 4 — Read and Understand Your Rights:

This authorization shall be in force and effect until such time as MVP no longer maintains the health information, or until revoked by the undersigned in the manner described below or until (insert applicable date or event) _____.

I understand that I have the right to revoke this authorization, at any time by sending written notification to the address indicated below.

The revocation should clearly state your intent to revoke this authorization and the date such revocation is to take effect.

Section 5 — Sign and Date this Form:

Signature _____

Print Name _____

Date (DD/MM/YY) ____/____/____ Relationship to Member _____

Rochester & Buffalo Regions, send this form to: MVP Member Services Department / 220 Alexander Street / Rochester, New York 14607 or fax it toll free to: 1-585-327-2227

All Other Regions, send this form to: MVP Member Services Department / PO Box 2207 / Schenectady, New York 12301-2207 or fax it toll-free to 1-800-765-3808

