



**MVP Health Plan, Inc.
Member Handbook**

Dear MVP Member,

Thank you for selecting MVP as your health care plan.

This Member Handbook will help you understand your benefits as a member of MVP. Please read it carefully and completely. Other plan reference materials include your Subscriber Contract or Certificate of Coverage (“Contract”), Schedule of Benefits and any applicable Riders. These documents further outline in detail coverage, benefits and services available to you.

If you have any questions, please call our Member Services Department toll-free at 1-888-MVP-MBRS (1-888-687-6277) or visit our Internet Web site: www.mvphealthcare.com.

We look forward to serving you as a member of MVP.

Sincerely,

David W. Olikier
President/CEO

INDEX

TOPIC	PAGE
INTRODUCTION AND DEFINITIONS	1
IMPORTANT TELEPHONE NUMBERS	2
THE MVP MEMBER SERVICES DEPARTMENT	3
ENROLLMENT INFORMATION	5
HOW TO USE THE MVP HEALTH PLAN HMO	5
REFERRALS FOR SPECIALTY CARE	9
BEHAVIORAL HEALTH SERVICES	10
EMERGENCY SERVICES	11
UTILIZATION MANAGEMENT	12
RESOLVING PROBLEMS WITH MVP	14
MEMBER FINANCIAL RESPONSIBILITIES	20
PARTICIPATION IN POLICY DEVELOPMENT	21
QUALITY IMPROVEMENT COMMITTEE	21
CONFIDENTIALITY AND PRIVACY POLICIES	22
MEMBER RIGHTS AND RESPONSIBILITIES	25
PROVIDER REIMBURSEMENT	28

INTRODUCTION AND DEFINITIONS

MVP is a health maintenance organization (HMO). MVP pays for Covered Services received from Participating Providers. MVP respects the clinical skills of your doctor and works with you and your doctor to make sure your health care meets high quality standards.

This book is only a guide. You must look at your Contract, Schedule of Benefits and any applicable Riders for your benefits and responsibilities.

Definitions

- A. **Coinsurance** means a dollar amount, expressed as a stated percentage of the Charge. It is the amount that you must pay for Covered Services. You must pay any Coinsurance directly to the provider.
- B. **Copayment** means a fixed dollar amount you must pay for Covered Services. You must pay the Copayment directly to the provider.
- C. **Covered Services** are the services eligible for benefits listed in your Contract.
- D. **Deductible** means a dollar amount that you must pay before we provide benefits under your Contract. You pay any Deductible directly to the provider.
- E. **Member** is a person enrolled with MVP and his or her eligible dependents.
- F. **Non-Participating Provider** means a health care provider who does not have an agreement with MVP to provide Covered Services to Members.
- G. **Participating Provider** means a health care provider who has an agreement with MVP to provide Covered Services to Members.
- H. **Rider** is a MVP document that changes your coverage.

IMPORTANT TELEPHONE NUMBERS

MVP Member Services Department <i>Available 7 days a week from 8:00 a.m. until 10:00 p.m</i>	1-888-MVP-MBRS (1-888-687-6277)
MVP After Hours <i>To speak to a registered nurse on evenings and weekends</i>	1-888-MVP-MBRS (1-888-687-6277)
Healthy Starts Program (8:30 a.m. to 5:00 p.m. Mon.-Fri.) <i>A free service for all expectant mothers</i>	1-888-357-4687
Little Footprints (8:30 a.m. to 5:00 p.m. Mon.-Fri.) <i>A free service for expectant mothers having problems with their pregnancy</i>	1-800-777-4793 Ext. 2042
Asthma Care Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.) <i>A program for members diagnosed with asthma</i>	1-888-357-4687
Diabetes Care Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.) <i>A program for members diagnosed with diabetes</i>	1-888-357-4687
Cardiac Care Program (8:30 a.m. to 5:00 p.m. Mon. - Fri.) <i>A program for members who have had a cardiac event</i>	1-888-357-4687
Back Pain Program (8:30 a.m. to 5:00 p.m. Mon. - Fri.) <i>A program for members with chronic back pain</i>	1-888-357-4687
Stop Fraud (MVP Confidential Investigative Unit). <i>If you suspect fraud, MVP encourages you to report it to MVP's Confidential Investigative Unit.</i>	1-877-TELL-MVP (1-877-835-5687)
Behavioral Health Access Center <i>Available weekdays from 8:30 a.m. until 5:00 p.m.</i>	1-800-568-0458

We Want To Hear From You

We invite members to contact us at the telephone number above, via our Internet web site: www.mvphhealthcare.com, or by writing to:

MVP Health Plan, Inc.
Member Services Department
PO Box 2207
Schenectady, N.Y. 12301-2207

THE MVP MEMBER SERVICES DEPARTMENT

The MVP Member Services Department is here to help you. If you have questions about MVP benefits, services or rules, please call toll-free 1-888-MVP-MBRS (1-888-687-6277) or send an e-mail from our Internet web site: www.mvphealthcare.com. Our Member Services Representatives will do their best to help you.

MVP After Hours Nurse Line

You can speak with a registered nurse Monday through Thursday from 5:00 p.m. to 8:00 a.m. and from Friday through Monday, including holidays, from 5:00 p.m. until 8:00 a.m. After Hours is an additional service for Members, not a required step in getting care. You can call After Hours with routine medical questions.

MVP After Hours Member Services

The After Hours Member Services line is open from 5:00 p.m. until 10:00 p.m. Monday through Friday and from 8:00 a.m. until 10:00 p.m. Saturday and Sunday, excluding holidays. If you have questions about MVP benefits, services or rules, please call toll-free 1-888-MVP-MBRS (1-888-687-6277).

Interpreter/Translation Services

MVP has interpreter services in more than 150 languages. If you need this service, please ask the MVP Representative to contact an interpreter in the language of your choice. Once the interpreter is reached, you will be connected by phone to the MVP Representative and the interpreter.

Services for Hearing-Impaired Members

Hearing-impaired Members should call a relay operator first at 1-800-662-1220. This operator will contact MVP for you and assist in the conversation.

Information Available to Members

All Members of MVP have access to the following information. This describes the information available to you and explains where you can find details.

You have a right to this information.	You can find this information here.
A list of Participating Providers (physicians and facilities), including name, address and telephone number and, in the case of physicians, board certification (This information is updated annually)	This is in your Provider Directory . MVP will notify you when a new directory is published. This information is also updated monthly on our Internet web site (www.mvphealthcare.com) and new providers are published in Healthy News (The quarterly member magazine).
The rules for selecting, changing, or getting referrals to specialists/providers	This is in your Member Handbook and Contract .
Specific information about your coverage	This is in your Contract and Riders .
Information on preauthorization and the MVP medical management process	This is in your Member Handbook and Contract .
The rules used to determine if care is medically necessary	Call Member Services at 1- 888-MVP-MBRS (1-888-687-6277) to get the clinical criteria for specific care for members in New York.
Information on how providers are paid.	This is in your Member Handbook .

You have a right to this information.	You can find this information here.
Member responsibility to pay premiums, Coinsurance, Copayments, and Deductibles when services are provided by a Participating or Non-Participating Provider	This is in your Member Handbook . Additional information is in your Contract and Riders .
Procedure for complaints and grievances	This is in your Member Handbook and Contract .
External Appeals	This is in your Member Handbook and Contract .
Information on access to member medical records	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277). This information is also in your Member Handbook , or the MVP Privacy Notice .
Information on MVP's quality programs	This is in your Member Handbook .
Information about consumer complaints under Section 210 of the Insurance Law	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) .
Procedures for protecting the confidentiality of medical records and other member information	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) . This information is also in your Member Handbook , or the MVP Privacy Notice .
Written description of the organization and procedures of the Quality Improvement program	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) .
Written application procedures and minimum qualifications for health care providers	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) .
Information about getting medical care in an emergency	This is in your Member handbook and in your Contract .
The addresses and telephone numbers needed to contact MVP	These are in your Member Handbook .
How MVP makes decisions about experimental drugs or treatment	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) .
The names, business addresses and official positions of the membership of the officers, board members of MVP	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) .
Access to Prescription Drug Formulary	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) . The MVP Formulary is also available at (www.mvphealthcare.com).
Access to the most recent certified financial statement of MVP, including balance sheet and summary of receipts and disbursements	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) .
A copy of the most recent individual direct pay subscriber contract	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) .
Individual health provider affiliations with participating hospitals	Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) .

Subscriber Contract or Certificate of Coverage (each referred to as "Contract") and Riders

These explain the specific details of your coverage. Your employer may have purchased riders that add or remove coverage from your Contract. Any riders will be included with your Contract.

Schedule of Benefits

This lists the Copayment, Coinsurance and/or Deductible amounts that you must pay when you receive Covered Services.

Directory of Participating Providers

MVP's comprehensive provider network includes physicians, providers, hospitals, pharmacies and laboratories. Participating Providers are listed in the MVP Provider Directory. Participating Providers in your area are listed in the Welcome to MVP booklet. If you are unsure if a particular physician or health care provider participates with MVP, please call Member Services at 1-888-MVP-MBRS (1-888-687-6277) or visit MVP's Internet Web site www.mvphealthcare.com.

Healthy News member magazine

You will be mailed the MVP magazine, Healthy News, four times each year. Healthy News tells you about changes to the provider network and to the health plan that may affect your coverage. It may also include health and wellness articles, information about various programs, and much more.

ENROLLMENT INFORMATION

Membership in MVP is limited to active employees and eligible dependents of employees in participating employer groups. Your employer will determine when you will be allowed to enroll. Typically, employers allow you to do so once a year during an open enrollment period determined by the employer.

Enrollment is open throughout the year to new employees, those newly eligible for benefits and, if you have family coverage, to new family members such as spouses or newborns.

Continuation of Benefits

If the coverage under your plan ends, you and your covered dependents may be able to continue coverage and/or purchase an individual insurance policy. Please see Section Seventeen of your Contract for details, types of coverage and time limitations for qualification or contact the Member Services Department at 1-888-MVP-MBRS (1-888-687-6277) for assistance.

Changes to your Enrollment Information

If you or a covered dependent changes your name, your address your family status, or if you need to add a newborn to your policy or change your employment class or status, please notify both your employer's Human Resources Department and MVP. Then MVP can keep your records accurate so you and your dependents get the proper coverage.

HOW TO USE THE MVP HEALTH PLAN HMO

Your Primary Care Physician (PCP)

When you join MVP, you and every covered dependent must choose a PCP, from those in the MVP provider network. You must tell MVP the PCP you selected.

Your PCP is responsible for coordinating and overseeing your health care and referring you to specialists. In some cases, your PCP must get preauthorization from MVP before you can get some referrals and treatments.

There are some cases where you can self-refer to get care from a provider other than your PCP.

- Emergency Services
- A woman does not need a referral from her PCP to get care from a participating gynecologist or a participating obstetrician (OB/GYN), except for the treatment of infertility.
- Members with certain serious conditions
- Routine eye examination from a Participating Provider once every two calendar years.

Finding a Primary Care Physician

To find a PCP, look in the MVP Provider Directory, call your doctor to confirm their participation, contact the Member Services Department at 1-888-MVP-MBRS (1-888-687-6277), or visit our Internet web site: www.mvphealthcare.com.

Family Practitioners, General Practitioners, Internists, Pediatricians and Obstetricians/Gynecologists can be PCPs.

It is strongly recommended that you schedule an initial appointment with your PCP if you have not seen him or her in the past. Most physicians like to see new patients as soon as possible, rather than meeting them for the first time in an urgent or emergency situation.

Changing your Primary Care Physician

You may change your PCP at any time. Call Member Services at 1-888-MVP-MBRS (1-888-687-6277) or you can make the change yourself from our Internet Web site: www.mvphealthcare.com.

Hospitals and Labs

If you need hospital care or lab tests, you must see a Participating hospital and lab. Remind your physician that you are a MVP member if lab work or hospital care is ordered. MVP will not pay for care given by Non-Participating Providers, except for emergencies and services that MVP has prior approved.

Services Provided by a Limited Network of Providers

Bariatric Surgery. We will provide benefits for bariatric surgery only when such surgery is performed at a Hospital participating in MVP's Bariatric Surgery Network. You may obtain a description of this Network by calling the MVP Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

Transplant Services. We will provide Benefits for covered transplant services only when such services are approved by MVP and obtained through MVP's Network of

Participating Transplant Providers. For a description of this Network, contact MVP's Member Services department at 1-888-MVP-MBRS (1-888-687-6277).

Services Provided by Non-Participating Providers (Out of Plan Services)

Participating Providers Not Available

If you are enrolled in the MVP HMO Plan:

If your health care needs cannot be met by a Participating Provider, MVP may pay for the services from a Non-Participating Provider. Your PCP must submit a pre-service claim to MVP for prior approval. You will get a written explanation of the approval or denial from MVP. If MVP approves, you will pay the same for the service as you would for services from a Participating Provider.

In the pre-service claim, your PCP must include your diagnosis and other relevant medical information about your condition, a medical opinion as to why your care cannot be obtained in-plan, and the name of the provider to whom you are being referred.

If you are enrolled in the MVP Direct Access HMO Plan:

You will have a Direct Access Rider attached to your Certificate of Coverage. If you have Direct Access coverage, you may receive services from MVP Participating Providers without a referral from your PCP. Your PCP or other MVP provider must submit a pre-service claim to MVP for prior approval. You will get a written explanation of the approval or denial from MVP. If MVP approves, you will pay the same for the service as you would for services from a Participating Provider.

In the pre-service claim, your PCP must include your diagnosis and other relevant medical information about your condition, a medical opinion as to why your care cannot be obtained in-plan, and the name of the provider to whom you are being referred.

If you are enrolled in the MVP POS Plan:

If you are enrolled in an MVP Point of Service (POS) plan, benefits are available for certain services provided by Non-Participating Providers (out-of-plan). Benefits that are available are described below:

The POS plan has been designed to offer a Non-Participating Provider option to some of the covered services available to you under the HMO Certificate, subject to different benefits and cost sharing. For example, if you have a POS plan you may access covered health care services described within your Certificate of Coverage from Non-Participating Providers not affiliated with MVP. You are subject to the rules and benefit limitations within your Certificate of Coverage, Schedule of Benefits including any applicable riders. Your PCP or other provider must submit a pre-service claim to MVP for prior approval from MVP before you can get some services.

Generally, you can go to any Non-Participating Provider or hospital – for covered services with no referrals required. You are typically responsible for paying a Deductible

and Coinsurance and subject to benefit limitations, reasonable and customary charges and any non-covered services. See your coverage materials for the cost sharing information.

If you are enrolled in the MVP Direct Access POS Plan:

If you are enrolled in the MVP Direct Access Point of Service (POS) plan, you will have a Direct Access Rider and a Point of Service Rider attached to your Certificate of Coverage. With Direct Access coverage, you may receive services from MVP Participating Providers without a referral from your PCP. With POS coverage you may access covered health care services described within your Certificate of Coverage from providers not affiliated with MVP. You are subject to the rules and benefit limitations within your Certificate of Coverage, Schedule of Benefits including any applicable riders. Your PCP or other provider must submit a pre-service claim to MVP for prior approval before you can get some services. Non-Participating Provider benefits are available and are described as follows:

The POS plan has been designed to offer a Non-Participating Provider option to some of the covered services available to you under the HMO Certificate of Coverage, subject to different benefits and cost sharing. For example, if you have a Direct Access POS plan you may access covered health care services described within your HMO Certificate of Coverage from Non-Participating Providers not affiliated with the MVP. You are subject to the rules and benefit limitations within your HMO Certificate of Coverage, Schedule of Benefits including any applicable riders.

Generally, you can go to any Non-Participating Provider or hospital – for covered services with no referrals required. You are typically responsible for paying a Deductible and Coinsurance and subject to benefit limitations, reasonable and customary charges and any non-covered services. See your coverage materials for the cost sharing information.

College Students

Your group may have purchased a rider that covers full-time students attending a college or university outside of MVP's service area. The student must fill out a student waiver form. Then the student's coverage will include sick care from Non-Participating Providers up to a certain dollar amount. Coverage does not include preventive care services or elective inpatient hospital services. You can access the form on MVP's Internet web site www.mvphealthcare.com (the form may be completed and submitted on-line) or by calling Member Services at 1-888-MVP-MBRS (1-888-687-6277).

Transitional Services

Transitional Services for Members Whose Providers Leave MVP

If your Participating Provider leaves MVP, MVP will send you a letter. You may be able to continue seeing that provider for Covered Services for up to 90 days from the effective date of the provider's termination. You cannot do this if the provider leaves or was made to leave the MVP network for the following reasons:

- imminent harm to patient care,
- a determination of fraud, or

- a final disciplinary action by a state licensing board that impairs the provider's ability to practice.

Transitional Services for New Members

If you are seeing a Non-Participating Provider when you join MVP, you must switch to a Participating Provider. If you have a life threatening condition or disease or a disabling and degenerative condition or disease, you may continue to see a Non-Participating Provider for 60 days from the date you join MVP. You must notify MVP and MVP must approve it.

If you are in the second or third trimester of pregnancy when you join MVP, you can continue to see a Non-Participating Obstetrician. You can get care from this provider through your delivery and for post-partum care directly related to your pregnancy.

MVP will only approve Transitional Services for both of the situations listed above if the provider agrees to:

- accept MVP's reimbursement as payment in full,
- provide MVP with medical information related to your care, and
- adhere to MVP's policies and procedures.

You must obtain prior approval from MVP in order to receive benefits for transitional services. Call Member Services at 1-888-MVP-MBRS (1-888-687-6277), if you feel that you are entitled to transitional services.

REFERRALS FOR SPECIALTY CARE

If you need to see a specialist, your PCP will refer you to a specialist who is a Participating Provider. If your PCP feels it is Medically Necessary for you to see a Non-Participating Specialist Provider, your PCP must submit a pre-service request to MVP for prior approval. If you are referred in this manner, you will have no financial liability other than your applicable Copayment, Coinsurance and Deductible.

Your PCP will alert MVP of the referral (you may also receive a copy). MVP will then forward a copy of the referral to your specialist for their records. When you see the specialist for the first time, he or she may ask you for this form.

Changing Specialists

Call your PCP if you want to change the specialist you are seeing. He or she can help you select another MVP specialist from the MVP network.

Standing Referrals

MVP may approve "standing referrals" for members with certain diseases or conditions. MVP must approve a standing referral. You and your PCP will be notified of MVP's decision in writing. If approved, the standing referral lets you see the specialist for a certain time or number of visits.

Specialist as PCP

If you have a life threatening or degenerative and disabling condition or disease, you can have your participating specialist or participating specialty care center act as your PCP. The specialist or specialty care center will coordinate your primary care services. They will also authorize visits for specialty care, lab work, hospitalizations and all other health services.

MVP must approve this arrangement. Have your PCP write to MVP. You and your PCP will be notified of MVP's decision in writing. You may contact a Member Services Representative for assistance with this process at 1-888-MVP-MBRS (1-888-687-6277).

Self Referral

If you are enrolled in the MVP HMO Plan:

You should contact your PCP for medical care except as described within the Emergency Services Section of this Handbook. You will be responsible for paying all charges if you self-refer to a provider other than your PCP, except as described on page 5 in this Handbook and further described in your Contract.

If you are enrolled in the Direct Access HMO Plan:

This plan allows self-referrals to participating specialists without having to contact your PCP, however, you must receive "Primary Care Services" from your PCP. "Primary Care Services" are defined in your Contract. See your Contract and any applicable Riders for details and some exceptions.

If you are enrolled in the MVP POS Plan:

If you choose to see a Non-Participating Provider, you may self-refer. However, you are responsible for the payment of Deductibles and Coinsurance and are subject to reasonable and customary charges, benefit limitations and any non-covered services. See your coverage materials for the cost sharing information.

If you are enrolled in the Direct Access POS Plan:

This plan allows self-referrals to participating specialists without having to contact your PCP, however, you must receive "Primary Care Services" from your PCP. Examples of "Primary Care Services" include routine well care, preventive care and basic health screening services. Other than participating specialists, if you choose to see a Non-Participating Provider outside the MVP Network or Service Area, you are responsible for the payment of Deductibles and Coinsurance and are subject to reasonable and customary charges, benefit limitations and any non-covered services. See your coverage materials for the cost sharing information.

BEHAVIORAL HEALTH (Mental Health and Substance Abuse) SERVICES

You do not need a referral from your PCP to get these services, but you must get prior approval from MVP. You must see a Participating Provider. To ask for prior approval for Mental Health and Substance Abuse Services, you must call the Behavioral Health Access Center, Monday through Friday, 8:30 a.m. to 5:00 p.m. at 1-800-568-0458 prior

to treatment to obtain the prior approval. If you do not know which provider to choose, MVP has specially trained clinical intake specialists who can assist in helping you locate a behavioral health provider. MVP has an extensive profile of the behavioral health providers in its network and can match you with providers that will best meet your needs. Profiled data include information such as access availability, provider education, location, phone numbers, specialty skills, hours of availability, alternative languages and ethnic or culture specialties. Once you choose your provider you need to register the care with the Behavioral Health Access Center prior to your visit.

Letters are sent to both you and the behavioral health provider with an initial authorization of visits. Your Behavioral Health Provider will request prior approval of additional visits.

EMERGENCY SERVICES

An emergency medical condition refers to a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- 1) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or
- 2) Serious impairment to such person's bodily functions; or
- 3) Serious dysfunction of any bodily organ or part of such person; or
- 4) Serious disfigurement of such person.

Emergencies Within the Service Area

If you are unsure if your condition is an emergency, call your PCP for guidance before getting emergency medical care. Your PCP or a physician covering for your PCP is required to be on call twenty-four (24) hours a day, including weekends and holidays. If you believe your condition is an Emergency, as outlined above, go to the nearest hospital emergency room or call 911.

You do not need your PCP or MVP to approve emergency services, but if you receive emergency services that do not meet the above standards, MVP will not pay for them.

Each time you visit the emergency room, you will have to pay the designated amount listed on your Schedule of Benefits.

Call your PCP within 48 hours of getting emergency services so he or she can coordinate follow-up care.

Out-Of-Area Emergencies

If an emergency happens while you are outside of MVP's Service Area, go to the nearest hospital emergency room for treatment. Services will be covered in full (minus your emergency room Copayment) if your condition met the definition of emergency outlined above. If you are asked to pay for services at the time of treatment, request an itemized

bill. Send the bill, with your name and ID number to MVP at the following address for reimbursement you for the emergency services.

MVP Health Plan, Inc.
Attention: Subscriber Claims
P.O. Box 2207
Schenectady, N.Y. 12301-2207

Please notify MVP within 48 hours, or as soon thereafter as possible, of the emergency, so we can arrange for any follow-up care that may be necessary. Follow-up care must be provided or directed by your PCP.

UTILIZATION MANAGEMENT

MVP reviews services to determine whether they are Covered Services and if so, whether they are Medically Necessary, provided in a cost-effective manner and eligible for benefits under your Contract. The MVP staff who review health care are trained and licensed health care professionals such as medical doctors, pharmacists and where appropriate other licensed health care practitioners.

They use specific clinical review criteria. These criteria include clinical protocols, practice guidelines and written policies and procedures. You and your doctor can get these criteria by contacting the MVP Member Services Department.

If we deny your request for services, we will tell you and/or your provider in writing. The letter will tell the reasons. Your provider can talk to the doctor who decided your case. If you disagree, you may request that we change the decision. This is called making an appeal. You and your doctor are the two people who know the most about your medical condition. When your doctor submits information about your case to MVP, make sure that the information he or she gives MVP is as complete as possible.

MVP does not provide incentives to staff

MVP does not use incentives of any kind to reward staff or providers for discouraging the use of Medically Necessary services.

Determinations of Medical Necessity

Licensed Professionals compare requests for treatment with nationally accepted clinical protocols, practice guidelines and written policies and procedures. If the proposed treatment matches these criteria, the nurses approve the treatment.

If the proposed treatment does not match these criteria, then a physician medical director at MVP reviews the request. He or she may request additional medical information to determine coverage. The request goes to you and your doctor. You get to see the information your doctor has given to MVP.

If the MVP physician medical director does not believe the proposed treatment meets the criteria then MVP cannot approve the treatment. If the physician medical director believes the treatment does meet the criteria, then MVP can approve the treatment.

Time Frames for UM Decisions

Urgent Care Decisions

For urgently needed care and Emergencies, MVP will tell you and your Provider, by telephone, what we decided within 72 hours from when we get the request as long as MVP gets all information needed to decide the request. If we do not get all the information we need to decide the request, we will tell you what is missing within 24 hours from when we got the request. You will then have 48 hours to give us the missing information. In such cases we will make a decision within forty-eight (48) hours after: (i) our receipt of the missing information or (ii) the expiration of time to provide us with the missing information, whichever is earlier. We will notify you of our decision either orally or in writing within the timeframe, set forth above. If oral notification is used, we will also notify you in writing within the earlier of three (3) days after the oral notification or three (3) business days of receipt of all necessary information.

Non-Urgent Pre-Service Decisions

When MVP must look at services before you get them, MVP will decide as follows. If MVP gets all needed information when we get the request, MVP will decide within 3 business days from when we get the request. If not, MVP will tell you what is missing within 15 days after we get the request. You will then have 45 days to give us the missing information. We will then notify you of our decision (a) within 3 working days after we get the missing information; or (b) 15 days after the end of your time to give us the missing information, whichever is first. We will notify you and your health care provider of our decision both orally and in writing within the timeframe, set forth above.

Concurrent Care Claims

Concurrent Care Claims involve our review of continued or extended health care services, or additional services when you are undergoing a course of continued treatment prescribed by your health care provider. MVP will make all UM determinations relating to Concurrent Care Claims within the following timeframes:

- i. Any UM Determination related to an extended course of treatment that involves an Urgent Care matter, shall be made within twenty-four (24) hours after receipt of the Concurrent Care Claim. If the Concurrent Care Claim does not involve Urgent Care matter, then UM Determination shall be made within one (1) business day after receipt of all necessary information or within the timeframe to make a Pre-Service UM Determination, whichever is earlier.
- ii. Any Adverse Determination that results in a reduction or denial of a course of treatment before the end of the period of time or number of treatments that have been previously approved, shall be made at a time sufficiently in advance of such reduction or denial to allow you to commence an Expedited Level One Appeal (see "Expedited Level One

Appeals" below) and to obtain a determination from such promptly commenced Expedited Level One Appeal before such benefit is reduced or denied.

- iii. We will notify you and your health care provider of our decision both orally and in writing within the timeframe, set forth above.

Post Service Claims

This involves determinations relating to services, which have already been provided. MVP will make UM determinations relating to Post-Service Claims as follows. If we have all necessary information at the time the Post Service Claim is received, MVP will make a decision within thirty (30) days after receipt of the Claim. If we do not have all necessary information at the time the Post Service Claim is received, we will notify you within fifteen (15) days of receiving the Post Service Claim of any missing information that is needed to make a determination. You will then have forty-five (45) days after receipt of this notice to provide us with the missing information. In such cases, we will make a decision: (a) within fifteen (15) days of our receipt of the missing information; or, if missing information is not provided, (b) within fifteen (15) days of the expiration of the time to provide such missing information. We will notify you in writing of our decision within the timeframe set forth above.

RESOLVING PROBLEMS WITH MVP

MVP wants to solve any problems you may have with us fairly and in a friendly manner. We want you to get quality care and excellent service. Call Member Services at 1-888-MVP-MBRS (1-888-687-6277) if you have a problem with MVP. A Member Services Representative can often resolve your problem on the spot.

Filing a Complaint or an Appeal

If the Member Services Representative cannot resolve your problem, you or your representative can file your complaint or appeal.

Complaint

A member complaint is a written or verbal expression of dissatisfaction with MVP. You may file your complaint verbally or in writing. It will be investigated thoroughly, and you will be sent a response within 30 working days. Examples of complaints are problems scheduling appointments with providers, or timeliness of claims payment problems. You can file a complaint by calling Member Services, or you may file your complaint in writing directed to:

MVP Health Plan, Inc.
Member Appeals Unit
PO Box 2207
Schenectady, NY 12301

Your complaint will be investigated thoroughly and MVP will send you a letter with our decision, the reasons for our decision, the medical basis for the decision if applicable and procedures for appealing our decision, if any apply. For all complaints related to quality

of care, access to care and billing, you may initiate an internal appeal. You should follow the internal appeals process set forth directly below.

Internal Appeals

An "internal appeal" is an appeal submitted directly to MVP. You or a designee appointed by you may submit an Internal Appeal of any Adverse UM Determination.

In all cases, you have the right to designate a representative for the purpose of initiating an Internal Appeal. To appoint a designee, you should contact MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277) and follow the instructions provided.

You shall be afforded the opportunity to submit written comments, documents, records, and other information relating to your Internal Appeal. Moreover, upon request and free of charge you shall be allowed reasonable access to, and copies of all documents, records and other information relevant to your Internal Appeal.

Internal Appeals that pertain to clinical matters shall be reviewed by an appropriate licensed health care practitioner with appropriate training and experience in the field of medicine involved in your Internal Appeal.

Internal Appeals shall be reviewed by persons who were not involved in the UM determination process and who are not subordinate to those who made the prior UM determination. No deference shall be given to the determination made at the prior level of review.

Any written Adverse Determination Notice sent to you shall be deemed delivered as of the date it is sent by mail to you by MVP at the address provided on your Enrollment Application or at the last address provided to MVP pursuant to our policies and procedures. A Level One Adverse Determination Notice shall include the following:

- A written detailed explanation and reasons for the determination resulting from the investigation; and
- The clinical rationale for the determination with a clinical basis when the determination has a clinical basis, without releasing protected peer review information; or
- Or a written statement that insufficient information was presented or available to reach a determination.

A Level Two Adverse Determination Notice shall include the following:

- A written detailed explanation and reasons for the determination resulting from the investigation; and
- The clinical rationale for the determination with a clinical basis when the determination has a clinical basis, without releasing protected peer review information; and

- Additional appeal rights, if any.

You may submit your request for an Internal Appeal orally or in writing by either calling MVP at 1-888-MVP-MBRS (1-888-687-6277) or writing to MVP Health Plan, Inc., at 625 State Street, Schenectady, New York 12305.

There are two (2) levels of Internal Appeal.

A. Level One Appeals - Mandatory Internal Appeals. Level One Appeals are "mandatory appeals." This means that you must commence and complete a Level One Internal Appeal (unless jointly waived in writing by you and MVP) before you may seek any other internal or external remedy, including External Review by the State of New York or civil action. A request to waive MVP's internal appeal process should be made to MVP in writing and directed to MVP's Member Appeals Unit. If MVP agrees to waive the internal appeal process, MVP will provide you with written confirmation within ten (10) days of MVP's receipt of the written request.

MVP has two types of Level One Appeals:

- i. Expedited Level One Appeals. You may request an Expedited Level One Appeal if you are appealing an Adverse UM Determination related to Urgent Care or Concurrent Care Claims. You must submit your request for an Expedited Level One Appeal within one-hundred and eighty (180) days after your receipt of the Adverse Determination Notice.
 - (a) MVP will make a decision within forty-eight (48) hours after receipt of the Expedited Level One Appeal.
 - (b) We will notify you of our decision orally and in writing within the timeframe set forth above. If MVP fails to notify you within the above timeframe, then this may be considered satisfaction of your Mandatory Internal Appeal requirements. Additionally, if MVP fails to notify you within the above timeframe, we will reverse any Adverse UM Determination that was based upon Medical Necessity and/or because a service is deemed Experimental or Investigational.
 - (c) Receipt of an Adverse Determination Notice from an Expedited Level One Appeal or expiration of MVP's time to make a decision regarding a properly commenced Expedited Level One Appeal shall satisfy your Mandatory Internal Appeal requirements.
 - (d) In the event you receive an Adverse Determination Notice following your Expedited Level One Appeal, you may, in addition to any other legal remedy available to you:

- (i) Commence a MVP Standard Level One Appeal. In this case, if you timely commence a Standard Level One Appeal, the time to file a NYS External Appeal shall be stayed until you receive a Final Adverse Determination Notice from your Standard Level One Appeal; or
 - (ii) Proceed directly to New York State External Review, if the Adverse Determination Notice is based upon Medical Necessity and/or because a service is Experimental or Investigational. In this case, the Adverse Determination Notice from MVP's Expedited Level One Appeal shall be deemed the Final Adverse Determination Notice for the purpose of initiating a NYS External Appeal; and/or
 - (iii) Commence a "voluntary" Expedited Level Two Appeal. Please be advised that commencing an Expedited Level Two Appeal does not stay your time to file a NYS External Appeal. In this case, the time to file a NYS External Appeal would run from your receipt of a Final Adverse Determination Notice from the Expedited Level One Appeal.
- ii. Standard Level One Appeals. You may request a Standard Level One Appeal if you are appealing an Adverse UM Determination related to Pre-Service or Post Service Claims. Additionally, you may elect to commence a Standard Level One Appeal following an Adverse Determination from an Expedited Level One Appeal. You must request a Standard Level One Appeal within one hundred and eighty (180) days after your receipt of a written Adverse UM Determination Notice or a written Adverse Determination Notice from an Expedited Level One Appeal.
- (a) MVP will make a decision regarding a Standard Level One Appeal within fifteen (15) days after receipt of the Appeal.
 - (b) We will notify you of our decision in writing within the timeframe set forth above. If MVP fails to notify you within the above timeframe, then this may be considered satisfaction of your Mandatory Internal Appeal requirements. Additionally, if MVP fails to notify you within the above timeframe, we will reverse any Adverse UM Determination that was based upon Medical Necessity and/or because a service is deemed Experimental or Investigational.
 - (c) In the event you receive an Adverse Determination Notice following your Standard Level One Appeal, you may, **in addition to any other legal remedy available to you:**
 - (i) Proceed directly to New York State External Review, if the Adverse Determination Notice (denial) is based upon Medical Necessity and/or because a service is Experimental or Investigational. In this case, the Adverse Determination Notice from MVP's Standard Level One

Appeal shall be deemed the Final Adverse Determination Notice for the purpose of initiating a NYS External Appeal; and/or

- (ii) Commence a "voluntary" Standard Level Two Appeal. Please be advised that commencing a Standard Level Two Appeal does not stay your time to file a NYS External Appeal. In this case, the time to file a NYS External Appeal would run from your receipt of a "Final Adverse Determination" Notice from the Standard Level One Appeal.

B. Level Two Appeals are "voluntary appeals." This means that you are not required to commence a Level Two Appeal in order to pursue any other external remedy that may be available to you. Notwithstanding, if you are dissatisfied with the results of the Level One Appeal, MVP provides for a voluntary second level of Internal Appeal. Level Two Appeals are reviewed by persons who are not subordinate to persons who conducted the Level One Appeal. You may submit your request for a Level Two Appeal in the same manner as a Level One Appeal.

MVP has two (2) types of Level Two Appeals:

- i. Expedited Level Two Appeals. Expedited Level Two Appeals are only available if you have received an Adverse Determination from an Expedited Level One Appeal. You must submit your request for an Expedited Level One Appeal within one-hundred and eighty (180) days after your receipt of a written Adverse Determination Notice from Expedited Level One Appeal. MVP will review and respond to Expedited Level Two Appeals within the following timeframes:
 - (a) MVP will make a decision regarding the Expedited Level Two Appeal within forty-eight (48) hours after its receipt.
 - (b) We will notify you of our decision in writing within the timeframe set forth above.
- ii. Standard Level Two Appeals. Standard Level Two Appeals are only available following an Adverse Determination from Standard Level One Appeal. You must submit your request for a Standard Level Two Appeal within one-hundred and eighty (180) days after your receipt of a written Adverse Determination from Standard Level One Appeal. MVP will respond to Standard Level Two Appeals within the following timeframes:
 - (a) MVP will make a decision regarding the Standard Level Two Appeal within fifteen (15) days after its receipt.
 - (b) We will notify you of our decision in writing within the timeframe set forth above.

At any time during the appeal process you may request a review by the New York State Department of Health and/or the State of New York Insurance Department. MVP recommends that you wait for the decision of the MVP appeals process before doing so. These agencies may be reached at:

State of New York Insurance Department
Consumer Services Bureau
Agency Building One
Empire State Plaza
Albany, NY 12257
(800) 342-3736

New York State Department of Health
Office of Managed Care
Corning Tower - Room 1911
Empire State Plaza
Albany, NY 12257
(800) 206-8125 (for medical issues only)
(518) 474-4156 (for all other issues)

External Appeals Process

If MVP denies coverage for a service on the basis that it is not Medically Necessary or Experimental or Investigational, you can ask New York State for an appeal. This is called an “External Appeal” because reviewers who do not work for MVP decide it. These reviewers are qualified people approved by New York State. You do not have to pay for an External Appeal if you meet MVP’s financial hardship criteria.

To appeal, you must complete MVP’s first level appeal process. You have up to forty five (45) days after you receive MVP’s final decision from your first level appeal to file an External Appeal. If you and MVP agree, in writing, to skip MVP’s appeal process, you must ask for the External Appeal within forty five (45) days of the date of that agreement.

You will lose your right to an External Appeal if you do not file an application for an External Appeal within forty five (45) days from your receipt of MVP’s denial notice from your first level appeal.

To ask for an External Appeal, fill out an application and send it to the State Insurance Department. You and your doctors will have to give information about your medical problem. Here are some ways to get an application:

- Call the NYS Department of Insurance at 1-800-400-8882 or go to their Internet web site: www.ins.state.ny.us.
- Call MVP’s Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

The External Appeal application will instruct you to send it to the NYS Department of Insurance. You and your doctors must release all pertinent medical information concerning your medical condition and request for services. An independent external appeal agent approved by the state will review your request to determine if the denied services are medically necessary and should be covered by MVP. All external appeals are conducted by clinical peer reviewers. The agent's decision is final and binding on both you and MVP.

Your appeal will be decided in thirty (30) workdays. More time (up to five (5) workdays) may be needed if the External Appeal reviewer asks for more information.

You and MVP will be told the final decision within two (2) days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an “expedited appeal”. The external appeal reviewer will decide an expedited appeal in three days or less. The reviewer will tell you and MVP the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

MEMBER FINANCIAL RESPONSIBILITIES

When you receive Covered Services from Participating Providers, you must pay the designated amounts for these services listed on your Contract, Schedule of Benefits or any applicable Riders.

Other than designated amounts described in the documents noted above, you should not have to pay for Covered Services received from Participating Providers. In the rare instances where this may occur, please send the claim (itemized bill) to MVP. Include your name, address, MVP ID number, provider, date of service and diagnosis. Send it to:

MVP Health Plan, Inc.
Attention: Subscriber Claims
P.O. Box 2207
Schenectady, N.Y. 12301-2207

Please keep a copy of the claim for your records.

Services Not Covered

If you receive services that are not included as covered benefits in the Contract or applicable Riders, you will be responsible for payment whether received from Participating or Non-Participating Providers. Refer to your Contract and applicable Riders for coverage information. You will be responsible for payment of all charges if, for example:

- you get services that are not Covered Services; or
- you get services that are excluded under your Contract; or
- you get services from a Non-Participating Provider without prior approval from MVP; or
- you get services from a provider after getting an adverse determination from MVP; or
- you do not get services from your PCP; or
- you do not get a PCP referral when necessary; or
- you do not get MVP’s prior approval where it is needed; or
- you receive services that were not Medically Necessary.

Emergency Care

You will be responsible for payment if you receive care at an emergency room that does not meet the standard set forth in the Emergency Services Section of this Handbook and as set forth in your Contract.

Reimbursement for Approved Services from a Non-Participating Provider

If you have received prior written approval/authorization from MVP to receive services from a Non-Participating Provider, you are responsible for your regular designated Copayment, Deductible and/or Coinsurance amounts for such services as described in your Schedule of Benefits. There may be times when you pay for the service when it is provided. If this happens, please send the claim (itemized bill) to MVP. Include your name, address, MVP ID number, provider, date of service and diagnosis. Send it to:

MVP Health Plan, Inc.
Attention: Subscriber Claims
P.O. Box 2207
Schenectady, N.Y. 12301-2207

Please keep a copy of the claim for your records.

PARTICIPATION IN POLICY DEVELOPMENT

We want the Members of MVP Health Plan to participate in the policy development of the organization. We welcome ideas and suggestions from Members.

Board of Directors

We reserve 33 percent of the seats on the MVP Health Plan Board of Directors, the primary policy-making body of the health plan, for MVP Members.

How to Make Suggestions

To make suggestions, send a letter to the President of MVP Health Plan, Inc., P.O. Box 2207, Schenectady, NY 12301-2207. If you prefer, you may call a Member Services Representative and give us your suggestion by phone. MVP Senior Management will review all suggestions received.

Technology Assessment

MVP draws upon the knowledge of its Medical Directors, participating physicians and allied health professionals, evidenced based medical literature and nationally recognized criteria to research new technologies, behavioral health treatments, medical products and pharmaceuticals for consideration as a Covered Service by MVP.

QUALITY IMPROVEMENT COMMITTEE

A Quality Improvement Committee made up of doctors representing many specialties oversees and helps to implement our ongoing Quality Improvement Program. The MVP Chief Medical Officer leads this Committee.

The main goals of the MVP Quality Improvement Program are:

- To measure member satisfaction with MVP and our providers.
- To make sure our providers meet our standards for education, licensure, professional standing and standards of care and service.
- To initiate programs which improve member health.
- To set and monitor goals for access to care, the availability of providers and outcomes of care.

CONFIDENTIALITY AND PRIVACY POLICIES

MVP and all of the practitioners who provide care and services to MVP Members share the responsibility and the challenge of protecting personal health information. MVP has re-examined how and by whom, Member health information is handled to be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Privacy and Security rules.

Protection of Verbal, Written and Electronic PHI

All MVP employees receive training in appropriate use and disclosure of members' protected health information (PHI) and sign a corporate confidentiality statement annually in order to uphold MVP's standard of protecting oral, written and electronic PHI. Access to our physical facility and information systems is limited to the minimum necessary required to provide services. MVP has established physical, electronic and procedural safeguards that comply with federal and state regulations to guard PHI. In addition, all MVP provider, practitioner and vendor agreements include language regarding the confidential handling of Members' medical information.

Please see the Privacy Notice (below) that MVP provides to all its Members for details about MVP's use and disclosure of Member medical information:

MVP's Privacy Notice

At MVP, we respect 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.

This notice explains how we may use and disclose your health information to carry out payment and health care operations and for other purposes that are permitted or required by law. When we talk about "health information" in this notice we mean claim information and any other information that relates to your past, present or future physical or behavioral health.

How We Use or Disclose Your Health Information

The following are ways we may use or disclose your health information:

- For Payment. We may use and disclose your health information 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, and the payment of health claims and to ensure that MVP 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 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 decision, 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.

Special Use and Disclosure Situations:

- **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 the Member Services department MVP Health Plan, 625 State Street, Schenectady, NY 12305 or call 1-888-MVP-MBRS (1-888-687-6277).

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. 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 disclosure of information could endanger you. We will accommodate your reasonable request.

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

Right to Inspect and Copy: You have the right to inspect and obtain a copy of certain health information that we maintain to make decisions about you.

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. 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.

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. Please contact us. You can also view a copy of this notice on our Internet web site at www.mvphealthcare.com.

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 Internet web site.

If you have any questions about this notice, please contact Member Services at MVP Health Plan, 625 State Street, Schenectady, NY 12305 or call 1-888-MVP-MBRS (1-888-687-6277).

If you believe your privacy rights have been violated, you may file a written complaint with the Complaints Coordinator at MVP Health Plan, 625 State Street, Schenectady, NY 12305 or you may contact us at 1-888-MVP-MBRS (1-888-687-6277). You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.**

MEMBER RIGHTS AND RESPONSIBILITIES

MVP Member Rights

1. Right to be treated with dignity

You have the right to get quality medical care in a professional and polite way. Your race, sex, religion, age, or sexual orientation does not matter.

2. Right to confidentiality

Your medical history and enrollment information is confidential. MVP will not release any information about you without your written okay, except when law permits or requires it.

3. Right to obtain information

You have the right to get complete current information on your diagnosis, treatment and prognosis from your doctor or other provider. This must be given in terms you can understand. You need this information so you can take part in and agree to decisions about treatment or care your doctor proposes. If you cannot make medical decisions, this information must be available to the person who is acting on your behalf.

4. Right to make decisions

You have the right to make decisions about your medical care. This includes the right to accept or refuse treatment. You should ask your provider for his or her policies about refusal of treatment. You also can write down your wishes about treatment in advance. State laws may apply. MVP does not give you medical care directly, so it cannot guarantee that your wishes about treatment will be respected.

You have the right to appoint someone you trust (such as a family member or close friend) to make decisions for you if you cannot do so yourself. This person is called your health care “proxy.” You decide how much or how little power your “proxy” has. This should be written down, signed and dated. You can get proxy forms from your health care providers. You should give your providers copies of your signed health care proxy form. They will keep copies in your records.

You have the right to make a Terminal Care Document. This says that no heroic measures should be used to prolong your life if you are terminally ill or injured.

You also have the right to a durable power of attorney. This gives someone else power to make your decisions if you cannot do so yourself.

5. Right to know treatment options

You have the right to get complete information about all available or necessary courses of treatment for your condition. This must be in terms you can understand. You also have the right to talk to your doctor about all possible treatment plans no matter what the cost or MVP coverage status of the treatment.

6. Right to request out of plan care

You may feel that a provider with an appropriate specialty is not available within the MVP plan. You have the right to ask for out-of-plan care. Your Primary Care Physician must request all out-of-plan care. MVP must also okay it before you see the Non-Participating Provider.

7. Right to refuse treatment

You have the right to refuse treatment that your doctor or other provider recommends, as allowed by law. You must be told what will happen if you refuse treatment.

8. Right to voice a complaint or appeal

You may not be satisfied with MVP's service. You have the right to a thorough investigation of your complaint or appeal by qualified and impartial people.

9. Right to information

You may request information about MVP's policies and procedures, Covered Services and the names and professional status of MVP's health care providers. You may also make recommendations about MVP's Rights and Responsibilities policy.

MVP Member Responsibilities

Members must follow certain procedures. Read your Contract for complete details of your benefits. Read this Member Handbook for general information about MVP. If you have questions, call Member Service toll-free at 1-888-MVP-MBRS (1-888-687-6277).

1. Choose an MVP Primary Care Physician (PCP)

Choose a PCP for yourself and each of your dependents. Your PCP will oversee your medical care.

2. Give your doctor complete information

Provide complete information to your doctor including an accurate medical history, drugs you take and general health and safety habits. Also tell your doctor about any other medical services you get through work, school or state programs. Examples would be mammograms and immunizations.

3. Take an active role in your health care

Develop good relationships with your doctors and providers. Learn about your health concerns and work with your doctors to develop goals to manage them. Follow your doctors' advice about your treatment.

4. Keep all scheduled appointments with your providers

If you need to cancel, please do so at least 24 hours before the appointment. Plan to pay your Copayment at the time you get services.

5. Keep MVP informed

Contact your employer and MVP when you change your name, address or marital status, or if you wish to add dependents to your coverage. Call us with any other changes that affect your coverage or that of your dependents.

6. Carry your MVP ID card at all times

Your ID card belongs to you. Never let anyone else use it.

7. Call MVP as soon as you can...

...after you (or your dependent) get emergency medical treatment. Call Member Services toll-free at 1-888-MVP-MBRS (1-888-687-6277) within 48 hours if you (or your dependent) are hospitalized in an out-of-area hospital for a medical emergency.

8. Get the referrals you need

Make sure you have a referral before going to see a specialist, when required. Always get MVP's okay in writing before going to a Non-Participating Provider. Always use labs and hospitals that are Participating Providers. Remind your doctors that you are an MVP member when lab work is ordered.

9. Pay your Copayment, Deductible and/or Coinsurance

Refer to your MVP Contract and Schedule of Benefits for information about your plan's designated Copayments, Deductible and/or Coinsurance amounts.

10. Call MVP's Behavioral Health Access Center to obtain prior approval before receiving mental health or substance abuse services.

PROVIDER REIMBURSEMENT

MVP uses a variety of methods to pay providers for the Covered Services you receive. These methods are described below.

Physician and Practitioner Services

Fee-For-Service Reimbursement

When you receive services from a Participating Provider, the provider bills MVP for those services using a pre-determined fee schedule. MVP pays the provider directly. You pay the designated amount for the service(s) listed in your Contract or Schedule of Benefits. MVP subtracts any Member responsibility (Copayments, Deductible and/or Coinsurance) that you owe when making this payment. You may receive a bill or statement of account from the provider for any applicable amount due (Copayments, Deductible and/or Coinsurance).

Withhold Arrangements

Like many HMOs, MVP has withhold arrangements in place with many Participating Providers. During the course of the year, MVP withholds a certain percentage of providers' fees from each provider's payment. At year's end, if medical costs have not exceeded the amount budgeted, all or part of this withhold is returned to the providers.

Capitation

MVP has capitation arrangements in place with some providers. This means MVP pays the provider a fixed dollar amount on a regular basis (usually monthly). The amount we pay is based on the number of MVP members the provider serves.

Hospital and Facility Reimbursement

When you receive Covered Services at Participating hospitals/facilities, the hospital/facility bills MVP directly for Covered Services based upon MVP's fee

agreement with the hospital/facility. MVP subtracts any member responsibility (Copayment, Deductible and/or Coinsurance) that you owe when making this payment. You must pay for the appropriate Member responsibility amount, as designated for the service in your contract or Schedule of Benefits.

Out-of-Plan Provider Reimbursement

If you properly receive Covered Services from a Non-Participating Provider, with prior approval/authorization from MVP, in most cases that provider will bill MVP, and MVP will reimburse the provider directly. Non-Participating Providers are reimbursed on a fee for service basis. You should only receive a bill from the Non-Participating Provider for the portion of the bill (Copayments, Deductible, and/or Coinsurance) that is your responsibility. Providers may send you a statement of account outlining that MVP has been billed. If you receive a bill for services covered by MVP, forward it to MVP for processing at the following address:

MVP Health Plan, Inc.
Attention: Subscriber Claims
P.O. Box 2207
Schenectady, NY 12301-2207

Please keep a copy of the claim for your records.

If you are enrolled in the MVP POS Plan or MVP Direct Access POS Plan:

If you choose to see a Non-Participating doctor or specialist, you are typically responsible for Deductible, Coinsurance, limitations, and any non-Covered Services. See your coverage materials for the cost sharing information. In addition, you are responsible for submitting the claim to MVP for processing. This may not be necessary if the Non-Participating Provider agrees to submit for you. Benefits for Non-Participating Providers are subject to “usual and customary rates” also known as “reasonable and customary rates” and charges in excess of these rates are your responsibility.