



Welcome to MVP Health Plan, Inc.

Please read this book and the materials described below. They will help you learn about your benefits and duties.

Your Subscriber Contract/Certificate of Coverage and Riders

These tell about your benefits and duties.

Directory of Participating Providers

The directory lists the providers who give services to Members. Local providers are in the Welcome to MVP book. They are also on our web site.

Copayment Schedule

This lists your Copayments, Coinsurance and Deductibles. You must pay these when you get services.

Healthy News

MVP sends this four times a year. Healthy News tells about Participating Providers. It tells about your coverage. It also has health stories.

Identification Cards

MVP gives ID cards to Members. The card lists:

- (1) your name;
- (2) your ID number;
- (3) your group's number;
- (4) the date you enrolled;
- (5) some Copayments;
- (6) MVP addresses; and
- (7) MVP telephone numbers.

Interpreter/Translation Services

MVP has these services. Call Member Services for help.

We invite you to call us. Call toll-free at 1-800-318-8575. Send email from our web site (www.mvphealthcare.com).

Write to us at:

MVP Health Plan, Inc.

Member Services Department

P.O. Box 2207

Schenectady, N.Y. 12301-2207

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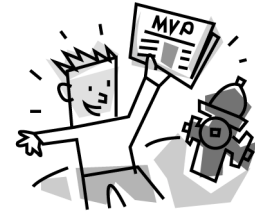
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I. INTRODUCTION

MVP is an HMO. We pay for Covered Services. You must get Covered Services from Participating Providers.

This book is only a guide. You must look at your coverage document for your benefits and duties.



II. DEFINITIONS

- A. Coinsurance is a part of a provider's bill that you must pay.
- B. Copayment is a set amount that you must pay.
- C. Covered Services are the services listed in your coverage.
- D. Deductible is an amount that you must pay before we pay.
- E. Emergency is a sudden and surprising condition, with such bad symptoms that not getting help right away would:
 - 1) Place your health in serious danger; or
 - 2) Cause serious limits; or
 - 3) Cause serious dysfunction.
 Emergency Services or Care means Covered Services needed for an Emergency.
- F. Medically Necessary means that a Covered Service is:
 - 1) Proper for you; and
 - 2) Goes with standard practice; and
 - 3) One which:
 - i. Helps fix or keep your health; or
 - ii. Stops you from getting worse; or
 - iii. Stops or finds a problem.
- G. Member is a person enrolled with MVP.
- H. Non-Participating Provider is a health care provider who does not have a contract with MVP.
- I. Participating Provider is a health care provider who has a contract with MVP.
- J. Rider is a MVP document that changes your coverage.

- K. Urgently Needed Care means Covered Services which, if not given to you within a day, would seriously hurt you. If given by a Non-Participating Provider it means Covered Services to screen and stabilize you, so you can get to a Participating Provider. You must have been unable to get services from a Participating Provider.

III. ACCESS TO PROVIDERS

When you become a Member, you and your family must each pick a PCP. You must tell MVP who you picked. Call Member Services at 1-800-318-8575. You can send e-mail from our web site. You must get all services:

- (1) from your PCP;
- (2) from a Participating Provider after getting a PCP referral. This is not true for:
 - (1) Emergency Services and Urgently Needed Care.
 - (2) Some GYN and OB services.
 - (3) Mental health services.
 - (4) Members with certain serious conditions.
 - (5) Some pregnant Members.
 - (6) Services not available from a Participating Provider.
 - (7) Members with Point of Service Riders.

Sometimes, MVP must give prior approval before you get covered services.

Finding a PCP

Look in the directory. Participating Providers are also on our web site.

Changing your Primary Care Physician

You may do this any time. Tell MVP before you see the new PCP. Call or write Member Services. You can send e-mail from our web site.

Referrals for Specialty Care

Call your PCP. If you need a specialist, your PCP will send you to a Participating Provider. Your PCP will:

- (1) give you a form; or
- (2) send the form to the specialist.

The specialist's office must get the form before you get any services.

The form lists:

- (1) the reason for the referral;
- (2) a certain number of visits.

You need a new form if:

- (1) the reason changes; or
- (2) you need more visits.



Hospitals and Labs

You must see Participating Providers. MVP will not pay for Non-Participating Providers.

Standing Referrals for Specialty Care

If you need a lot of care from a specialist, you may get a “standing referral.”

It lets you see that specialist for:

- (1) a certain time; or
- (2) number of visits.

The services must be based on a plan. Sometimes, MVP must give prior approval.

Changing Specialists

Call your PCP.

Specialist as PCP

If you need special care for a long time, your specialist can be your PCP.

MVP must prior approve this.

After Hours PCP Services

PCPs must always have a way for you to reach them. If you get sick, call your PCP. Tell them you are a MVP Member. Do what the PCP says to do.

Emergency Services

In an Emergency, you should:

- (1) go to the nearest provider; or
- (2) call 911.

You do not need a referral from your PCP or prior approval from MVP.

MVP will not pay:

- (1) If it was not an Emergency; or
- (2) If you did not get Emergency Services.

Urgently-Needed Care

If you need Urgently-Needed Care, call your PCP. Do what the PCP says to do.

Gynecological and Obstetric Services for Women

You may see a Participating GYN without a referral. You may go there up to 2 times a year. You don't need a referral for related follow up care from that provider.

Pregnant Members don't need a referral to see their Participating OB.

Mental Health and Substance Abuse Services

You don't need a referral to get these services. You must get prior approval. Do what your Rider says. You must see a Participating Provider.

Transitional Services

You must get prior approval.

If you have certain serious conditions you may see your old provider for up to 60 days from the shorter of:

- (1) The date you became a Member; or
- (2) Until you get a Participating Provider.

If more than three months pregnant, you may see your old provider until the baby is born.

In both cases, your old provider must agree to MVP's rules.

If your Participating Provider leaves MVP, we will tell you. If you have certain serious conditions you may still see that provider. You may see that provider for up to 60 days from the shorter of:

- (1) When you get MVP's letter; or
- (2) You have a new Participating Provider.

If more than three months pregnant, you may see that provider until the baby is born.

In such cases, the provider must agree to MVP's rules. MVP will not pay if your provider leaves MVP for some serious reasons.

All others must pick a new Participating Provider.

Out-Of-Plan Services

Participating Provider Not Available

If a Participating Provider can't see you, MVP may pay for Covered Services from a Non-Participating Provider. MVP must prior approve it.

College Students

You may have a Rider that covers college students. The student should fill out a "student waiver" form if living away from home. Then the student's coverage will include sick care from Non-Participating Providers up to a certain dollar amount. Call Member Services to get the form.

Point of Service Riders

You may have a Rider that covers services by:

- (1) Participating Providers with no referral; and/or
- (2) Non Participating Providers.

You must pay a Deductible and Coinsurance. You may need to send a claim to MVP.

IV. UTILIZATION MANAGEMENT (UM)

UM decides if services are Medically Necessary. UM also looks at Out of Plan Services and Transitional Services. UM decides about preexisting conditions. Nurses and doctors make these decisions. Sometimes, other specialists help MVP decide. MVP does not give money or rewards for saying no.

Your coverage tells about the services that must be approved:

- (1) before you get the services; and/or
- (2) while you are getting the services.



Your provider must call UM to ask for approval.

MVP looks at all other services after you get them. MVP's approval does not mean that we will pay. MVP uses rules to decide if a service is Medically Necessary. If your condition and the service meet these rules, we approve it. If not, then a doctor looks at the case. The doctor may ask for more details. This request goes to you and your provider. You may see what your provider gave to MVP. If the doctor decides that your condition and the service meet these rules, we approve it. If not, we say no.

You may get a copy of the rules used in your case. Call Member Services toll-free at 1-800-318-8575.

We tell you no in writing. Each letter tells you 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 a grievance.

Time Frames for UM Decisions

Expedited Decisions

For Urgently Needed Care or when you are at risk for serious harm or pain, MVP will tell you what it decided within 24 hours from when you made the grievance. For other urgent cases, MVP will decide as follows. If MVP gets all needed information when you made the grievance, MVP will tell you what it decided within 48 hours. If not, MVP will tell you what is missing within 24 hours after we get your grievance. You will then have 48 hours to give us the missing information. We will then tell you what we decided within 48 hours after: (a) we get the missing information; or (b) the end of your time to give us the missing information, whichever is first.

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 you make the grievance, MVP will tell you what it decided within 2 working days. If not, MVP will tell you what is missing within 5 days after we get your grievance. You will then have 45 days to give us the missing information. We will then tell you what we decided within 2 working days after: (a) we get the missing information; or (b) the end of your time to give us the missing information, whichever is first.

Concurrent Decisions

When MVP must look at services while you are getting them, MVP will decide as follows. If MVP gets all needed information, we tell you what we decided within 24 hours. If not, we will tell your provider what is missing.

Post Service Decisions

When MVP looks at services after you get them, MVP will decide as follows. If MVP gets all needed information when you make your grievance, MVP will tell you what it decided within 30 days. If not, MVP will tell you what is missing within 5 days after we get your grievance. You will then have 45 days to give us the information. We will then tell you what we decided within 30 days after: (a) we get the missing information; or (b) the end of your time to give us the missing information, whichever is first. Unless information is missing, MVP will tell you our decision in not more than a total of 30 days.

V. COVERED SERVICES

If you get non-Covered Services, MVP will not pay. You will have to pay. Covered Services are listed in your coverage document. MVP uses rules to decide if a service is a Covered Service.

You may get copies of the rules used in your case. Call Member Services.

Experimental and Investigational Services

MVP will provide benefits for these services only if we decide:

- (1) that the service seems promising for you; and
- (2) that experts looked at the service and said it was proper for you.

Prescription Drugs

You may be covered for prescription drugs. You must get drugs from Participating drug stores. MVP does not use a list of approved drugs. Some drugs need prior approval. To ask for it, call Member Services toll-free at 1-800-318-8575.

Your coverage may limit the amount MVP will pay yearly for drugs. If there is a limit, you should track your expenses. Call Member Services if the expenses are close to the limit. MVP can help look at other ways to get the drugs if you reach the limit.



Mail Order Service

Call Member Services. Visit MVP's Web site. You can find out if you can get drugs by mail order. You can also find out your Copayment or Coinsurance.

VI. PREEXISTING CONDITIONS

Your coverage may exclude certain conditions you had before you became a Member. If so, the exclusion time may be reduced. We may subtract the time you had other coverage before MVP. When your old coverage ends, that plan must give you a Certificate of Creditable Coverage. If you did not get one, you should call that plan.

MVP will decide if your old coverage is Creditable Coverage. If so, we will credit you for certain benefits.

When your MVP coverage ends, we will give you a Certificate of Coverage. You may also ask MVP for a certificate at any time. Call Member Services.

VII. RESOLVING PROBLEMS WITH MVP

MVP has a grievance process if you have a problem with MVP.

Grievances

A grievance is a complaint about:

- (1) how quickly, where, or how services were given to you;
- (2) MVP services; or
- (3) your coverage.

Making an Oral Grievance

Call Member Services at 1-800-318-8575. Member Services is open every day from 8:00 a.m. to 12:00 midnight.

Filing a Written Grievance

Write to: MVP Health Plan, Inc., Member Appeals Unit, PO Box 2207, Schenectady, New York 12301.

Level One Grievance

You must make a first level grievance within the time listed in your coverage.

You must tell us:

- (1) what your grievance is;
- (2) why you disagree with MVP; and
- (3) give us any other information you think is important.

MVP will get back to you as follows.

1. For grievances about Emergency Services or Urgently-Needed Care, and in other urgent matters, MVP will decide within 24 hours after we get the grievance.

For urgent matters about mental health and substance abuse services, we will decide within 24 hours after we get the grievance.

2. For all others, MVP will decide within 15 days after we get the grievance. For mental health and substance abuse services, we will decide within 10 days after we get the grievance.

Level Two Grievance

You must make a second level grievance within the time listed in your coverage.

You must tell us:

- (1) what your grievance is;
- (2) why you disagree with MVP's decisions; and
- (3) give us any other information you think we need.

MVP will get back to you as follows:

- 1. For Emergency Services or Urgently-Needed Care, and in other urgent matters, MVP will decide within 48 hours after we get the grievance.
- 2. For all others, MVP will decide within 15 days after we get the grievance.
- 3. For mental health and substance abuse services, you must make a second level grievance to the Independent Panel of Mental Health Care Providers. This Panel is set by the Vermont Department of Banking, Insurance, Securities and Health Care Administration. You may call the Department's Consumer Assistance Hotline at 1-800-631-7788/802-828-2900.

Who looks at my grievances?

A doctor who did not make the first decision looks at level one medical grievances. A member of MVP's senior staff may look at level one non-medical grievances.

A group of doctors and senior MVP staff look at second level grievances. These people did not make the first decision. These people also did not decide the first level grievance.

MVP will tell you about the grievance reviewers when it gets back to you about your grievance.



Independent External Review

You may ask that a state-approved external review agent look at your grievance.

You may request this only if MVP denies coverage, except for mental health or substance abuse services, because:

- (1) it is not Medically Necessary; or
- (2) it is experimental, investigational or the off-label use of a drug;

You may also request this if you think that:

- (1) MVP wrongly limited your choice of a provider; or
- (2) MVP wrongly decided you have a pre-existing condition.

MVP must have said no to your first and second level grievances. You must ask within 90 days of when you got MVP's answer to your second level grievance.

To ask for the review, you must call the Vermont Department of Banking, Insurance, Securities and Health Care Administration Consumer Assistance Hotline number at 1-800-631-7788/802-828-2900. You must pay a \$25 filing fee unless it is waived.

State Assistance

You may always ask for help from the Vermont Department of Banking, Insurance, Securities and Health Care Administration's Consumer Assistance Hotline. You may call the Hotline at 1-800-631-7788 or 802-828-2900. You may write to them at:

Vermont Department of Banking, Insurance,
Securities and Health Care Administration,
Consumer Insurance Division,
89 Main Street, Drawer 20,
Montpelier, Vermont 05620-3101.

The State of Vermont also has a Health Care Ombudsman's office. If you have a problem with MVP, this office may be able to help.

The address is:

The Office of Health Care Ombudsman
P.O. Box 1367
264 North Winooski Avenue
Burlington, Vermont 05402
The telephone number is 1-800-917-7787.
Hearing impaired members can call TTY: 888-884-1955 or 802/863-2473.

VIII. MEMBER FINANCIAL RESPONSIBILITIES

In-Plan

When you go to Participating Providers for Covered Services, you must pay the Copayments, Coinsurance and/or Deductible listed in your Copayment Schedule. You must pay these amounts when you get services. If you pay a provider for Covered Services, other than the Copayment, Coinsurance and/or Deductible, you must send a claim 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

Keep a copy for your records.

Self-Referral

MVP will not pay and you must pay all charges if:

- (1) you do not get services from your PCP; or
 - (2) you do not get a PCP referral and the service needs a PCP referral.
- Your coverage document tells you what services do not need a referral.

Not Medically Necessary

MVP will not pay, and you must pay all charges if:

- (1) you do not get MVP's prior approval where it is needed; or
- (2) MVP decides, after you got services, that services were not Medically Necessary.

Services Not Covered

MVP will not pay, and you must pay all charges if:

- (1) you get services that are not Covered Services; or
- (2) you get services that are excluded under your coverage.

Emergency Care

MVP will not pay, and you must pay all charges if:

- (1) you get services that are not Emergency Services; or
- (2) you get services for a condition that is not an Emergency.

Out-of-Plan Services

You must pay the Copayments, Coinsurance and/or Deductible listed in your Copayment Schedule for in-plan services if:

- (1) you get prior approval for Out-of-Plan Services or
- (2) you get Transitional Services.

You must pay when you get the services.

If you have a Point of Service Rider, you must:

- (1) Pay your Non-Participating Provider. Submit a claim to MVP; or
- (2) If the Non-Participating Provider agrees, pay the Coinsurance and Deductible. The provider will bill MVP.

IX. PROVIDER PAYMENTS

In-Plan Care

Participating Providers will bill MVP. Members pay only the Copayment, Coinsurance or Deductible. Usually, you will not need to file claims.

Hospital and Facility Care

Participating Providers bill MVP. MVP pays set rates based on the services you get. You may get a bill from a Non-Participating Provider.



Physician and Practitioner Care

Fee For Service

MVP pays most providers based on a fee schedule. Part of the fees may be held back from each provider's payments. This is called a withhold. At year's end, provider bills are looked at. If they are less than the budgeted amount, the provider may get back all or part of the payments.

Capitation

MVP pays some providers a monthly set amount. This amount is based on the number of Members that the provider serves. It is paid no matter how many services are provided to Members during the month.

Out-of-Plan Care

Many Non-Participating Providers will also bill MVP. If you properly got Out-of-Plan Services, MVP will work out a rate with the provider and pay them directly. You may get a bill from a Non-Participating Provider. You will then need to make a claim for payment.

X. MVP'S RELATIONSHIP WITH PROVIDERS

How MVP selects Participating Providers

MVP picks Participating Providers based on the numbers and health needs of Members in an area. Participating Providers may take part in other health plans. They are free to see non-MVP patients. MVP looks into Participating Providers' professional backgrounds. We look at their licenses, education and experience. We check for a history of malpractice and fraud. We visit offices to see if they meet standards for care, access, follow-up, safety and confidentiality. We review Participating Providers every two years.

For questions, please call MVP's Credentialing Department at 1-800-777-4793.

All providers are responsible for the services they gave to Members. MVP does not tell providers how to provide services. MVP does not tell providers whether to provide services. Providers are not punished for:

- (1) discussing with you your condition or possible tests and treatments, regardless of whether MVP provides coverage;
- (2) discussing with you your coverage;
- (3) filing a complaint about any MVP policies or practices; or
- (4) advocating to MVP for coverage of a certain service for a Member.

MVP's decisions relate only to whether we will pay. MVP does not pay money or give rewards to persons making decisions to limit Members' use of health care services.

XI. MEMBER SERVICES

Call Member Services at 1-800-318-8575 if you have questions or concerns. Member Services is open every day from 8:00 a.m. to midnight.

MVP After Hours

You can talk to a nurse from 5:00 p.m. to midnight and on weekends from 8:00 a.m. to midnight through MVP After Hours. You can call After Hours with routine questions. The nurse will tell your provider about your call so that follow up can be planned. You do not have to call MVP After Hours.

Services for Hearing-Impaired Members

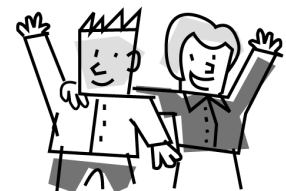
You should call a Verizon relay operator. The operator will call MVP. The number is 1-800-662-1220.

XII. QUALITY IMPROVEMENT (QI)

MVP wants you to get good health care. We also want you to be happy with MVP's services and Participating Providers. Different kinds of Members and Participating Providers are on our QI Committee. It helps make decisions about our QI Program.

The main goals of the Program are:

- To measure and improve Member satisfaction.
- To make sure Participating Providers meet our standards.
- To offer Member health programs, like MVP's Asthma and Diabetes Management Programs. To learn more, please call the numbers at the end of this book.
- To set and monitor goals for access, availability and outcomes of care.



MVP involves Members in policy development and development of QI activities.

At least a third of the seats on MVP's Board of Directors are for Members. The Board sets the policies for the plan. The Board approves new QI activities.

MVP also welcomes your ideas about policies and QI activities.
Call 1-800-318-8575 or write to this address.

Vermont Vice President
MVP Health Care
66 Knight Lane, Suite 10
Williston, VT 05495

MVP reviews all ideas.

XIII. ACCESS TO MEMBER MEDICAL RECORDS

When you sign your enrollment form, you are also authorizing MVP to get your health information from your providers. MVP needs this information to decide benefits, pay claims and for other activities, such as quality improvement. MVP keeps your records private. MVP only discloses them for these reasons and as allowed by law. MVP employees sign confidentiality agreements. MVP contracts require that your records be kept private.

Employer Access to Member Information

MVP does not disclose specific medical information to your employer or group without your specific written consent unless allowed by law without your consent.

Member Access to Medical Records

MVP does not have a central file of Member medical records. Each provider keeps these records. Members must get information from the provider. Call Member Services to ask for the information that MVP does have. MVP will let you see or make copies of the information. Nothing can be deleted from MVP's records, but you may ask to correct or add to the information.

XIV. ACCESS TO CARE

Travel Time

Members should not usually have to travel more than 30 minutes from home or work for:

- PCP services
- Outpatient mental health and substance abuse treatment

Members should not usually have to travel more than 60 minutes for:

- Prescription drugs
- Labs
- X-rays
- MRIs
- Eye Exams
- Inpatient mental health treatment
- Inpatient medical rehab.



Members should not usually have to travel more than 90 minutes for:

- Kidney transplants
- Major trauma treatment
- Open-heart surgery

Members will have reasonable access to specialty care such as:

- Major burn care
- Organ transplants (other than kidney)
- Special kids care

Some members may get services at “centers of excellence” outside Vermont.

Waiting Times for Appointments

Members have instant access to Emergency care.

Appointment: Members should not usually have to wait longer than:

- 24 hours for Urgently Needed Care.
- Two weeks for routine initial treatment. Prompt follow-up visits and referrals to specialists, if needed.
- Thirty days for routine lab, x-ray and other routine services.
- Ninety days for preventive care. This includes routine physical exams.

XV. HEALTH CARE LAWS IN VERMONT

Rule 10 sets standards for health plans. It sets protections for Members. Rule 10 helps make sure that plans give quality services to Members.

The **Mental Health Parity Law** stops plans from placing more financial burden on Members for access to covered mental health services than for any other service. Plans may limit services to Participating Providers.

Questions? Call the Vermont Department of Banking, Insurance, Securities and Health Care Administration’s Consumer Assistance Hotline at 1-800-631-7788/802-828-2900.

XVI. STATEMENT OF MEMBER RIGHTS AND RESPONSIBILITIES

Members must be treated with respect and dignity. Members have a right to privacy. You should get services from providers and MVP in a professional and polite way. Your race, color, creed, national origin, ancestry, religion, sex, marital status, sexual orientation, disability, veteran status, age, type of illness or condition, or source of payment do not matter. Also, MVP keeps your health records private. These records are not disclosed without your consent unless allowed by law.

Members must provide information needed by providers or MVP to provide services. You must give your providers complete information, including medical history, drugs used, and your general health habits, as well as other medical services you get. You must also tell MVP right away of name and address changes.

You must also tell us right away about the following changes:

- (1) Marriage or civil union.
- (2) Birth or adoption of a child.
- (3) Divorce.
- (4) If your job ends.
- (5) If you are Medicare eligible.
- (6) If you have or get other health insurance coverage.
- (7) If you are getting services because of a car accident, work injury, or an injury caused by someone else.

You must also give MVP information we need to decide your coverage. You must do this as quickly as possible.

Members have the right to discuss treatment options with their providers, regardless of cost or coverage. Members have the right to participate with providers in making decisions about their health care. You have the right to receive information about your condition and treatment options, regardless of the cost or whether MVP provides coverage. Your provider must explain this to you so you can understand.

Members must follow plans and instructions for care. Once you and your provider have agreed upon a course of treatment, you should follow your provider’s advice and instructions. Keep all appointments.

Members have the right to receive information about MVP. You have the right to receive the information in this package. You will also receive MVP’s *Healthy News*, which gives updates about health news and changes to your coverage. You also have the right to certain additional information:

You have a right to this information. You can find this information here.

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| <ol style="list-style-type: none"> 1. A list of providers, updated every 6 months. 2. Information about your coverage. | <ol style="list-style-type: none"> 1. This is in your Provider Directory, which is updated twice a year. The Provider Directory is also posted on MVP’s Web site and is updated more frequently. 2. This is in your Subscriber Contract or Certificate of Coverage and Riders. |
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| 3. Information on prior approval and UM. | 3. This is in your Subscriber Contract or Certificate of Coverage and Member Handbook. |
| 4. A description of the financial arrangements between MVP and Participating Providers. | 4. This is in your Member Handbook and Subscriber Contract or Certificate of Coverage. |
| 5. Member responsibility to pay premiums, Coinsurance, Copayments, and Deductibles. | 5. This is in your Subscriber Contract or Certificate of Coverage and Riders , your Copayment Schedule , and your Member Handbook. |
| 6. Member payment for non-Covered Services or for services without a PCP referral. | 6. This is in your Member Handbook, Subscriber Contract or Certificate of Coverage. |
| 7. MVP's process for picking Participating Providers | 7. This is in your Member Handbook. Call the Credentialing Department for more information. |
| 8. What to do when you have a grievance. | 8. This is in your Subscriber Contract or Certificate of Coverage and Member Handbook. |
| 9. Members as part of MVP's quality improvement program. | 9. This is in your Member Handbook. Call Member Services for more information. |
| 10. How MVP decides whether services are Medically Necessary. UM staff and procedures. | 10. This is in your Member Handbook. |
| 11. Getting Emergency care and Urgently Needed Care. | 11. This is in your Subscriber Contract or Certificate of Coverage and the Member Handbook. |

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| 12. MVP addresses and telephone numbers. | 12. These are in your Member Handbook, Subscriber Contract or Certificate of Coverage and Riders. |
| 13. The rules for picking and changing PCPs, and getting referrals, including standing referrals. | 13. This is in your Member Handbook. |
| 14. Waiting and travel time standards. | 14. This is in your Member Handbook. |
| 15. How providers are paid and that they can see non-MVP patients. | 15. This is in your Subscriber Contract or Certificate of Coverage and Member Handbook. |
| 16. The services offered by the Vermont Division of Health Care Administration. | 16. This is in your Member Handbook. |
| 17. Access to Member medical records and procedures to keep medical records private. | 17. Call Member Services for more information. |

IMPORTANT TELEPHONE NUMBERS

Member Services Department	1-800-318-8575
Relay Services	1-800-662-1220
MVP After Hours	1-800-318-8575
Healthy Starts Program (8:30 a.m. to 5:00 p.m. Mon.-Fri.) (for pregnant Members)	1-888-357-4687
Little Footprints (8:30 a.m. to 5:00 p.m. Mon.-Fri.) (for Members with pregnancy problems)	1-800-777-4793 ext. 2398
Asthma Care Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.)	1-888-357-4687
Diabetes Care Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.)	1-888-357-4687
Cardiac Care Program	1-888-357-4687
Personal Health Improvement Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.) (for Members with stress-induced symptoms and chronic pain)	1-888-357-4687
Mail Order Pharmacy	Call toll-free 1-866-635-5305