MVP Health Care

Member Notices
For all Medicare Advantage Plan Members

2015

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About the MVP Medicare Customer Care Center
MVP Medicare Customer Care Center representatives are ready to answer your questions, explain your benefits and resolve any issues.

If you are most comfortable speaking a language other than English, we can arrange to have an interpreter available at no cost to you.

When to contact the MVP Medicare Customer Care Center

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

How to contact the MVP Medicare Customer Care Center

By phone:
1-800-665-7924 (toll free)
1-800-662-1220 (toll free TTY)

Representatives are available Monday—Friday from 8 am to 8 pm Eastern Time. From October 1 – February 14, call seven days a week from 8 am to 8 pm at the above numbers.

If you have an urgent concern after hours, please call the MVP Medicare Customer Care Center number listed above and follow the prompts. You also may find answers to many of your questions on the MVP website.
In writing:
MVP Health Care
Attention: Medicare Customer Care Center
220 Alexander Street
Rochester, NY 14607

By fax:
Send the MVP Medicare Customer Care Center a fax at 585-327-2298. Write on the fax “Attention: Medicare Customer Care Center”.

Visit the MVP Health Care website
Use MVP Health Care’s website to help manage your health plan and take charge of your health. Resources and information are available 24 hours a day at www.mvphealthcare.com. Select Medicare Members to find valuable information.

About our doctors and hospitals
MVP has more than 19,000 doctors, hospitals and other providers across New York State and Vermont. These health care professionals have contracted with MVP to provide your care and follow specific quality of care practices. You are free to choose doctors who may or may not be contracted with MVP. You may pay more for care received from non-contracted providers.

You can feel confident in MVP’s health care professionals. Each physician has been initially screened and is reviewed at least every three years for:

- State licensure
- Basic educational credentials, including Continuing Medical Education credits
- Malpractice insurance and malpractice claims (if any)
- Legal actions in any state
- Current drug enforcement agency license
- Sanctioning by the Centers for Medicare & Medicaid Services

No referral needed for specialists
You do not need to call your primary care doctor for a referral to a specialist, such as a podiatrist, rheumatologist, dermatologist, cardiologist, or specialists in behavioral health services. You will pay more for care received by a provider who is not contracted by MVP.

Medical services not available from MVP contracted providers
If you need or want a medical service not available from MVP contracted providers, you may refer yourself or be referred to a non-contracted doctor or service for your medically-necessary care. For example, a member needing a certain type of organ transplant is referred to a Medicare-approved transplant center. MVP covers this medically necessary care. Remember that it may cost you more to receive medical services from non-contracted providers.

Some services may have pre-authorization rules that apply to both contracted and non-contracted providers.
MVP will help you find a doctor!

If you can’t find the doctor you’re looking for, you may:

1. Visit our website, www.mvphealthcare.com, and select Find a Doctor on the homepage. The site is updated regularly. You can search for a doctor by name, location or specialty. You also can choose to search for doctors who:

   - Are currently accepting new patients
   - Admit to the hospital nearest you
   - Speak or understand other languages, such as Spanish or French

Or you can call the MVP Medicare Customer Care Center at 1-800-665-7924 Monday – Friday, 8 am to 8 pm Eastern Time. TTY: 1-800-662-1220. From Oct. 1 – Feb. 14, call us seven days a week from 8 am to 8 pm.

About your primary care physician (PCP)

MVP encourages all members to select a primary care physician (PCP). Your PCP is the internist, family practitioner, or general practitioner you choose to provide or arrange all of your care. Your PCP will work with you to manage your health. Women may choose an obstetrician/gynecologist in addition to their PCP.

If you choose a PCP who is not contracted with MVP to get covered services, it may cost more. Emergency room, urgently needed care, and renal dialysis copays are not affected.

Your PCP should be the first person you contact when you need medical care, except in an emergency or for urgently needed care. It is very important that you provide the name of your PCP when enrolling with MVP.

If you are an HMO-POS member and do not select a PCP, one will be assigned for you. You may later change your PCP if you wish.

The role of your PCP
You can expect your primary care physician to:

   - Provide treatment in a timely manner.
   - Inform you of your health condition and the full range of treatment options regardless of cost or benefit coverage.
   - Obtain your consent, or the consent of someone you authorize, for all treatment.
   - Maintain confidentiality about your care.
   - Be accessible 24 hours a day, 365 days a year and have a backup (or on-call) physician.
   - Know your medical history and what is normal for you.
   - Coordinate your medical care.
Choose a PCP who’s right for you
Choosing a primary care physician is one of the most important decisions you can make about your health care. Your doctor is your partner in health. He or she will work with you to manage all your health care needs. Think about the qualities you want in a health care professional and in the doctor-patient relationship. You need to feel comfortable with your doctor. You also need to feel secure with his or her expertise and level of experience.

You may want to consider the following when deciding on a PCP:

- The PCP’s location and office hours
- The age and/or gender of the PCP
- The PCP’s hospital affiliations
- Attitude of office staff

Here are some suggestions to help you choose the PCP who best meets your health care needs:

Do your research
The key to choosing a primary care physician is good research. Make sure you have as much information as possible before selecting your PCP. The more you know about a doctor, the better the chances are that you will choose one who meets your health care needs. Some things to consider:

Education and Training
- Where did the doctor train?
- When looking at educational background, you may want to consider the medical school attended and where the doctor completed his or her residency.
- How long has he or she been practicing?
- Does the doctor have an area of expertise?
- Does the doctor belong to any professional organizations?

Certification
- Make sure that the doctor is licensed.
- Is the doctor board-certified?
- You also may want to check to see if any complaints have been filed against the doctor and/or whether he or she has had any disciplinary actions.

Hospital Affiliations
Some doctors have privileges to admit to certain hospitals. You may want to ask the doctor where he or she may admit patients.

Office Policies
The policies for a doctor’s office may be important in making a decision about your PCP:
How long does it typically take to get an appointment?
How are payments handled?
Is the office staff friendly and well-trained?
Is there enough staff?
Is the office clean and easily accessible?

Access to Care
- What type of access to care does the doctor provide?
- Does he or she belong to a group practice where you may access other doctors in the group?
- Is he or she a sole practitioner?
- How does the office handle emergency care and weekend appointments?

Confidentiality
- How does the doctor handle confidentiality?
- Are your medical discussions done in private?
- Is the outer office sensitive to patients’ confidential concerns?

Recommendations and the web are good sources of information
Sometimes the best sources of information come from family, friends, and former or current coworkers. Another good source is the medical community in your area. If you know someone in the medical field, he or she might be able to recommend a doctor to you. Look online as well for national ratings and consumer reports that provide more information.

Call or visit the doctor’s office
Try calling the doctor’s office to set up a telephone interview or talk to the office staff. You also can try to meet with the doctor in person. Doctors are often willing to set up an initial visit with new or prospective patients. You’ll be able to use first-hand knowledge to decide if that PCP is right for you.

Make a personal connection
- Do you and your doctor “click”?
- Your PCP will manage all your health care needs. You will need to feel comfortable with him or her. How are you treated?
- Do you prefer a male or female doctor?
- Do you like the doctor’s “style?”
- Is the doctor “tough and straightforward” or more gentle and nurturing? Which do you prefer?
- Do you feel that you can speak openly and honestly about your health concerns?
- Does the doctor take time with you or do you feel hurried?

Other resources
Other resources available to help you choose your PCP include:

- American Medical Association (AMA) – Provides an online service that you can use to research doctors at www.ama-assn.org. You can write to them to get up to five physician
profiles. Profiles include information such as education, board certifications, and disciplinary actions. Call the AMA at 312-464-5199 for more information.

- New York State Department of Education Office of the Professions – Lets you search its website for physician licensing information. It also gives you general information on requirements for licenses. Visit www.op.nysed.gov/home.html or contact the office at 518-474-3817.

- New York State Department of Health – Lets you search its website for information on misconduct and physician discipline from 1992 to the present. Go to www.health.state.ny.us/nysdoh/opmc/main.htm or call the department at 1-800-663-6114.

- Visit www.mvphealthcare.com for a full listing of our directory of health care professionals.

You can change your PCP
You may change your PCP at any time. Simply confirm that your new PCP is accepting patients. Then call the MVP Medicare Customer Care Center at the phone numbers on the back of your Member ID card to give us the name of your new PCP. If possible, let us know of your new PCP at least 30 days before your first appointment. You also may change your PCP by going to www.mvphealthcare.com.

How to choose an OB/GYN
An OB/GYN doctor cannot be selected as a PCP. However, he or she is considered a “primary care professional” who can treat and refer non-OB/GYN conditions (for example, high blood pressure). The OB/GYN also will inform your PCP of any non-OB/GYN treatment you receive. Note: Even if your OB/GYN serves as your PCP, you will still need to select a PCP.

MVP recognizes the importance of the relationship between a woman and her OB/GYN. All female members may see their OB/GYN whenever they choose, without a referral from their PCP.

For behavioral health concerns
For any chemical dependency or mental health issue, call the MVP Medicare Customer Care Center number on the back of your Member ID card. A representative will assist you with getting services. You can also refer to your Evidence of Coverage for further information regarding chemical dependency and mental health benefits and services.

How to seek emergency or urgently needed care
To get the best care when you need immediate medical attention, ask yourself, “What is the danger to my health?”

- Choose urgently needed care if you need medical attention right away for an unplanned illness or injury, like a sprain, the flu, or a bad cut, but your health is not in serious danger.
You should get emergency care if you believe that your health is in serious danger and every second counts, with severe pain, a bad injury, a serious illness or medical condition that is quickly getting much worse.

Emergency and post-stabilization services and renal dialysis are covered worldwide. Urgently needed care is covered throughout the United States.

### About urgently needed care

Many health care professionals report that a significant number of people in emergency rooms could be better and more quickly cared for in a doctor’s office or an urgent care center. That is why an urgent care center may be a convenient, appropriate, and lower cost option to emergency room care when your doctor is unavailable.

- Urgent care is not designed to treat sudden, serious health problems. Rather, urgent care is for treating minor illnesses or injuries such as sprains, strains, minor cuts or burns, or the flu.
- Follow up with your doctor within 48 hours after receiving urgent care.

### Coverage for urgently needed care

If you need urgent care, whenever possible you should call your doctor first or go to an urgent care center. MVP covers urgent and follow-up care that you get from any provider as long as the care you are getting still meets the definition of “urgently needed care.” Some services may have prior authorization rules that apply to both contracted and non-contracted providers.

MVP Medicare Advantage plans do not cover urgently needed care outside of the United States.

### About medical emergencies

- You are covered for a medical emergency anywhere in the world.
- In an emergency, get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. You do not need to get permission first from your physician or other doctor.
- Make sure that your doctor knows about your emergency, because he or she will need to be involved in following up on your emergency care. Call your doctor about your emergency care as soon as possible, preferably within 48 hours.
- You receive post-stabilization care when the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over.

### Coverage for medical emergencies

You are covered for emergency medical care whenever you need it, anywhere in the world.

- Ambulance services are covered in situations where other means of transportation would endanger your health.
- Your post-stabilization care will be covered according to Medicare guidelines. In general, your doctor will try to arrange for MVP-contracted health care professionals to take over your care as soon as your medical condition and the circumstances allow.
What if it wasn’t really a medical emergency?
Sometimes it can be hard to know if you have a real medical emergency. For example, you might go for emergency care—thinking that your health is in serious danger—and the doctor may say that it was not a medical emergency after all. You are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger.

If you get any additional care after the doctor says it is not a medical emergency, you may pay more if the additional care is received from a non-contracted provider.

What if you need medical care when your doctor’s office is closed?
In an emergency, you should get care immediately. You do not have to contact your doctor or get permission in an emergency. You can dial 911 for immediate help by phone or go directly to the nearest hospital emergency room.

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

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

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

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

Specialized medical care over a prolonged period of time
If you have a very serious degenerative or disabling condition or disease that requires specialized care over a prolonged period of time (for example, cancer) you may request that your specialist becomes your primary care physician. You also may request care at a specialty care center, if appropriate, for the same reason. All requests for this type of specialty care must be made through your primary care physician to MVP Health Care’s Utilization Management Department. We will inform you of the decision made on your request.
Transitional care for new members
If you are a new member and your doctor from your previous plan is not part of the MVP Health Care network, you may ask to continue seeing your former doctor for up to 60 days after you become a member if you are living with a life-threatening, deteriorating or disabling condition or disease. The doctor must:

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

To ask for this type of transitional care or help with choosing a new doctor, call the MVP Medicare Customer Care Center.

Medical bills
All MVP contracted health care professionals have agreed to provide care to our members at negotiated prices. Your doctor cannot bill you for unpaid balances or charge you any extra fees for covered services. You are only responsible for your copayments or coinsurance.

If you use non-contracted providers to get covered services, your out-of-pocket costs may be higher than if you use contracted providers (except for emergency and urgently needed care and renal dialysis).

If you receive any medical bill from a physician or other health care professional other than for your required coinsurance or copayment, do not pay it.

Contact the MVP Medicare Customer Care Center immediately so that it can be reviewed. Call us at the phone number on the back of your Member ID card.

Exclusions and services not covered by Medicare or MVP
Exclusions are services that are not covered by Medicare or by MVP’s HMO-POS and PPO health plans. They include:

- Custodial care
- Cosmetic surgery
- Private room in a hospital, unless medically necessary
- Routine foot care, unless associated with disease affecting the lower limbs, such as diabetes, that requires the care of a podiatrist or primary care physician
- Drugs not covered by Medicare – this includes drugs purchased outside of the U.S.

Only medically necessary services are covered, unless expressly indicated in your contract.

Prior authorization
Prior authorization is a process in which MVP responds verbally or in writing to a request for authorization before you receive specified non-emergency services. MVP works with you and your doctors to make sure you receive medically-necessary, high-quality medical treatment at a reasonable cost. Some services and procedures require prior authorization by MVP regardless of whether these services are received from contracted or non-contracted providers.

Services needing prior authorization are covered only if determined to be medically necessary. In most cases, your doctor will start the process and request an authorization whenever it is needed. Please note that you are ultimately responsible for ensuring the prior authorization is obtained from MVP for specified services. We encourage you to talk with your doctor about the process to ensure that prior authorization is obtained.

If you wish to receive services that need prior authorization, you should work with your doctor. Your doctor should contact MVP at least seven days in advance of the planned service or procedure.

Some examples of services needing prior authorization include:

- Diagnostic services, such as CT scans and MRIs
- Admissions to transitional care units, acute rehabilitation, skilled nursing facilities
- Durable medical equipment
- Implants and internal prosthetics
- Medically-necessary dental services
- Certain prescription drugs
- Home care services

If you need or want to get a medical service not available from MVP contracted providers, you may do so. Most often, your family doctor will begin the process and request authorization whenever it is needed. However, please remember that it may cost you more to receive medical services from non-contracted providers.

**Evaluating medical technology**

MVP draws upon the knowledge of its Medical Directors, participating physicians and allied health professionals to research new technologies, medical products, behavioral health treatments and pharmaceuticals for inclusion as benefits covered by the health plan.

MVP regularly assesses new technologies, and new applications of existing technologies, for inclusion as covered benefits. The research process includes a review of information from appropriate government regulatory bodies as well as published scientific evidence. Benefit policies are examined by physicians and other health care professionals across MVP’s service area, as well as by staff in several MVP departments, to decide whether the technologies will be included as covered benefits. MVP’s Quality Improvement Committee gives final approval. For more explanation of this process, call the MVP Medicare Customer Care Center.
MVP’s technology policies are reviewed at least annually with comprehensive updates triggered more often by changes in published medical evidence. Qualified specialists with expertise relevant to each topic are invited to participate in this process. By carefully considering new technologies before approving them for coverage, MVP assures our members that they are receiving safe, effective and high quality care.

**Physician incentive program regulation**
As a Medicare Health Plan, we must provide you with the following information if you request it:

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

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

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

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

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

If you suspect fraud in the health care system, please call our confidential Special Investigations Unit fraud hotline at **1-877-TELL-MVP (1-877-835-5687)**.

**How to submit a claim**
MVP Health Care is dedicated to prompt and accurate claim payments to our plan participants. If you have paid for services that are covered by your plan, fill out the Medical Claim Reimbursement Request Form completely and send it to:

Claims Submission
MVP Health Care
P.O. Box 2207
Schenectady, NY 12301
You can find and print additional claim forms at www.mvphealthcare.com by selecting Medicare Members, then Forms & Publications, or call the MVP Medicare Customer Care Center at the phone number on the back of your Member ID card.

To submit your claim electronically, Log In to your MVP online account at www.mvphealthcare.com and select Medical Claim Reimbursement.

So that we can process your claim promptly, please refer to the following guidelines:

- Use a separate claim form for different calendar years. A separate claim form must accompany each bill. Original bills must be submitted with your claim form. Keep copies for your own records.
- Make sure your bills include:
  - Name and address (on letterhead) of the provider of service or supply (hospital, doctor, etc.) including tax ID and NPI Number.
  - Patient’s full name and health plan identification number.
  - Type of service or supply (office visits, chest x-ray, etc.), including CPT or HCPCs code.
  - Place of service (inpatient or outpatient hospital, office etc.).
  - Date and charge, for each service or supply provided.
  - Patient’s diagnosis codes (the medical condition for which the patient was treated), or ICD-CM diagnosis code.
- Cash register receipts, cancelled checks, money orders, credit card vouchers and personal lists of services or bills stating only ‘balance forward’ are not acceptable as substitutes for bills.
- If another insurance carrier has made payment on this service, an explanation of benefits from the other insurance carrier must be attached.
- Payment will be made directly to provider, unless proof of payment is attached, in which case reimbursement will be sent directly to the subscriber.

Your Monthly Medical and Hospital Claims and Prescription Drug Summaries
Each month you receive medical care or prescription drugs, MVP will send you summaries of the services we received claims for on your behalf. These are not bills. Please review your monthly summaries to be sure we are being billed only for the services you received. If you see any errors, call the MVP Medicare Customer Care Center at the number on the back of your Member ID card.

Quality Improvement Program
MVP is dedicated to providing quality health care and services to our members. Our Quality Improvement (QI) program sets standards for the care and services that are provided to our members by MVP and by participating providers. MVP reports on its progress toward achieving the QI program goals in an annual Quality Improvement Evaluation report. You are welcome to participate in the development, implementation, or evaluation of the quality improvement system, and/or you may comment on MVP’s Quality Improvement process. If you
are interested in participating or commenting, please call our Quality Improvement Department.

To receive a summary of the program description document and the Executive Summary of the Annual Evaluation, please call our Quality Improvement Department at 1-800-777-4793, ext. 12247.

Member Rights and Responsibilities
MVP Health Care encourages members to learn and exercise their rights and responsibilities. This policy briefly outlines what Medicare Advantage Plan members can expect from MVP Health Care and what MVP Health Care expects from members. Listed below are the member rights and responsibilities that all MVP Health Care members receive.

Medicare Member Rights

1. You have a right to make recommendations regarding MVP’s member rights and responsibilities policy. You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

   Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan’s benefits that is accessible and appropriate for you.

   If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

2. MVP members have the right to be treated with dignity, fairness and respect at all times. Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person’s race, religion, sex, health, ethnicity, creed (beliefs), age or national origin.

   If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights 1-800-368-1019 (TTY: 1-800-537-7697) or your local Office for Civil Rights.

   If you have a disability and need help with access to care, please call us at MVP. If you have a complaint, such as a problem with wheelchair access, the MVP Medicare Customer Care Center can help.

3. As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services. Call the MVP
Medicare Customer Care Center to learn which doctors are accepting new patients. You also have the right to go to a women’s health specialist (such as a gynecologist) without a referral. With MVP Medicare Advantage plans, you have the right to go to any specialist without a referral.

As a plan member, you have the right to get appointments and covered services from the plan’s network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

4. Federal and State laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal Statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.
You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call the MVP Medicare Customer Care Center or visit our website www.mvphealthcare.com.

5. **As a member of our plan, you have the right to get several kinds of information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.**

If you want any of the following kinds of information, please call the MVP Medicare Customer Care Center or visit our website www.mvphealthcare.com:

- **Information about our plan.** This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance rating, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.

- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan’s network, see the MVP Health Care Professionals Directory (Medicare Advantage Plans).
  - For a list of the pharmacies in the plan’s network, see the Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call MVP’s Medicare Customer Care Center or visit our website www.mvphealthcare.com.

- **Information about your coverage and rules you must follow in using your coverage.**
  - To get the details on your Part D prescription drug coverage, see the List of Covered Drugs. The List of Covered Drugs tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call the MVP Medicare Customer Care Center or visit www.mvphealthcare.com.

- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision.
6. **You have the right to know your treatment options and participate in decisions about your health care**

You have the right to get information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you; your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision.

**You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself**

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.
The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “Living Will” and “Power of Attorney for Health Care” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact the MVP Medicare Customer Care Center to ask for the forms.

- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

- If you have not signed an advanced directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?
If you have signed an advance directive, and you believe that a doctor or hospital hasn’t followed the instructions in it, you may file a complaint with the New York State Department of Health at 1-800-206-8125.

7. You have the right to voice complaints or appeals about MVP or the care MVP provides.

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to
change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal or make a complaint – we are required to treat you fairly.

- You have the right to get a summary of information about the appeals and complaints that others have filed against our plan in the past. To get this information, please call the MVP Medicare Customer Care Center or visit www.mvphealthcare.com.

8. What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.
If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697), or call your local Office for Civil Rights.

Is it about something else?
If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call the MVP Medicare Customer Care Center
- You can call the State Health Insurance Assistance Program at 1-800-701-0501 or 585-244-8400.

9. There are several places where you can get more information about your rights:

- You can call the MVP Medicare Customer Care Center or visit www.mvphealthcare.com.
- You can call the State Health Insurance Assistance Program at 1-800-701-0501 or 585-244-8400.
- You can contact Medicare.
  - Visit www.medicare.gov to read or download the publication Your Medicare Rights & Protections.
  - Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Medicare Member Responsibilities
The things you need to do as a member of the plan are listed below. If you have any questions, please call the MVP Medicare Customer Care Center.

1. Get familiar with your covered services and the rules you must follow to get these covered services. Use the Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
2. **If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us.** Please call the MVP Medicare Customer Care Center to let us know.

We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it.

3. **Tell your doctor and other health care providers that you are enrolled in our plan.**

   Show your plan membership card whenever you get your medical care or Part D prescription drugs.

4. **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**

   - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

   - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

   - Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

5. **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other facilities.

6. **Pay what you owe.** As a plan member, you are responsible for these payments:

   - You must pay your plan premiums to continue being a member of our plan.

   - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost).

   - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

7. **Tell us if you move.** If you are going to move, it's important to tell us right away. Call the MVP Medicare Customer Care Center.
If you move outside of our plan service area, you cannot remain a member of our plan. We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.

If you move within our service area, we still need to know so we can keep your membership record up to date and know how to contact you.

8. **Call the MVP Medicare Customer Care Center for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.

**Population Health Management**

*We’re there when you need us!*  
Living well sometimes takes an extra helping hand. That’s why MVP has a team of nurses, respiratory therapists, health coaches, social workers and other health care professionals to help you.

If you are living with a serious physical or mental health concern, you may call MVP for help and support (**1-866-942-7966**). In some situations, MVP may reach out to you to offer assistance. MVP will match you with one of our free programs or connect you with other wellness resources that can help.

**How MVP can help**  
When you are faced with a health issue, MVP can point you to programs and resources that can help you manage or improve a medical condition, guide you through a medical event, and learn how to take the best care of yourself.

We offer health care management programs for members living with:

- Asthma  
- Cancer (Oncology)  
- Heart Conditions (heart attack or blockages)  
- Chronic Obstructive Pulmonary Disorder (COPD)  
- Depression (provided by our Behavioral Health partner, ValueOptions®)  
- Diabetes  
- Dialysis  
- Heart Failure  
- Low Back Pain

We also offer special programs to help members whose health concerns are complicated, and can lead to hospital or emergency room visits. If you think that you might benefit from one of these programs, call MVP for further assistance at **1-866-942-7966**.

- Acute Case Management for members who have been in the hospital or emergency room within the last year with heart problems, stroke or another chronic illness
- Social work services that help connect members to community resources and services.
- Transplant Case Management for members who are being evaluated for a bone marrow or organ transplant
What our programs include:

**Education and Support**
Program participants can talk with an MVP health care professional who can answer your questions and help you find community-based resources and health care solutions. Our nurses, respiratory therapists, health coaches, social workers and other health care professionals are available to offer information about healthy eating habits, medication management, symptom monitoring and management, weight monitoring and fitness activities. You will also receive personalized mailings and newsletters with the latest health information!

**Self-Care Resources**
Whether you are researching a health condition or treatment, looking for simple answers to your health questions, or reaching your health improvement goals, taking care of yourself is easier when you use MVP’s online wellness tools at [www.mvphealthcare.com](http://www.mvphealthcare.com). MVP’s health care professionals can direct you to helpful online resources.

**How to find out more**
Not all resources are available to all MVP members. Call 1-866-942-7966 for more information or to see if you qualify. You may also visit [www.mvphealthcare.com](http://www.mvphealthcare.com). Select Members, then Live Healthy and then Population Health Management Programs to find detailed information on program offerings and current program newsletters. We are committed to connecting you with the help you need to live well!

**Utilization Management – Reviewing the care you receive**

Utilization management is a process that MVP uses to review the health care services our members receive. The process makes sure you get the right care for your health needs—effective care that you are able to get in a timely manner and at a place that best meets your specific health care needs. MVP asks questions when reviewing a service or making coverage decisions, such as:

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

Not all the care you get will be reviewed by MVP. Visits to a specialist’s office do not require approval by MVP. It is still important for you to work with your PCP to coordinate care. Types of care that may be reviewed include services that are high cost (such as gastric bypass surgery) or services often not considered by Medicare to be medically necessary (such as cosmetic surgery).

It’s important for you to know that MVP wants to make sure you receive the best care and coverage available to you. MVP has a medical team — nurses, medical directors, pharmacists, social workers, and other health care professionals — on staff. This medical
team will help answer questions you may have about your care. Doctors, specialists, and other health care professionals are not encouraged to deny care or coverage for care to our members. MVP does not reward or offer incentives to employees or health care professionals to deny health care services to you. Our Utilization Management program follows these principles:

- Utilization Management decisions are based only on appropriateness of care and the benefit provisions of the subscriber’s coverage.
- MVP does not reward practitioners, providers or staff, including Medical Directors and Utilization Management staff, for issuing denials of requested care.
- Financial incentives, such as annual salary reviews and/or incentive payments do not encourage decisions that result in under-use of health care and services by members.

Call the MVP Medicare Customer Care Center at the phone numbers on the back of your Member ID card if you have questions about a review of your medical care. You have a right to request to be put in contact with someone on our medical team who can answer your questions.

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

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

There are three basic types of review:

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

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

MVP will make a decision all pre-service requests within either standard or expedited timeframes.
A **standard** decision means we will give you an answer no later than 14 calendar days after we get your request.

If your health requires a quick response because it is urgent, an **expedited** decision means we will give you an answer no later than 72 hours after we get your request.

However, we can take up to 14 more calendar days to make a decision if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. You have the right to file a complaint if you believe we should not take extra days. You can find information on how to file a complaint in the Grievance and Appeal Procedures section.

You and your doctor will be informed of the MVP decision about whether this care will be covered under your health plan in writing. If you have chosen a person to represent you, that person will also be notified.

**Concurrent review (during treatment)**

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

MVP will make a decision on all concurrent requests within either **standard** or **expedited** timeframes.

A **standard** decision means we will give you an answer no later than 14 calendar days after we get your request.

If your health requires a quick response because it is urgent, an **expedited** decision means we will give you an answer no later than 72 hours after we get your request.

However, we can take up to 14 more calendar days to make a decision if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. You have the right to file a complaint if you believe we should not take extra days. You can find information on how to file a complaint in the Grievance and Appeal Procedures section. You and your doctor will be informed of the MVP decision about whether this care will be covered under your health plan in writing. If you have chosen a person to represent you, that person will also be notified.

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

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

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

MVP will make a decision on every request. If a decision is not made within the stated timeframe, you may consider this a denial and appeal the MVP decision.

**Utilization management for prescription drugs**

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

If you have Medicare Part D prescription drug coverage through MVP, please check your Evidence of Coverage (your contract) for more information. You also may visit [www.mvphealthcare.com](http://www.mvphealthcare.com) and review the current Formulary (list of covered drugs) to see if your medications require prior authorizations (notated with a ‘PA’ in the Requirements/Limits column). There is also a list of medications that may require prior authorization under your Part D coverage. Or, call the MVP Medicare Customer Care Center at the phone number on the back of your Member ID card for answers to your questions.

**About the Formulary and your pharmacy benefit**

The [MVP Health Care Medicare Part D Formulary](http://www.mvphealthcare.com) is a list of drugs that MVP covers for members enrolled in our Medicare Part D benefit. The list has been reviewed by a team of doctors and pharmacists, and has been approved by Medicare. In general, MVP will cover these drugs as long as:

- The drugs are medically necessary (meaning reasonable and necessary to treat your illness or injury and is an accepted treatment for your condition),
- The prescriptions are filled at an MVP Health Care network pharmacy, and
- All other plan rules are followed. Check your Evidence of Coverage (your contract) to read these rules.

As you look through the formulary, you will see that MVP has additional requirements for certain drugs. These restrictions ensure that our members use these drugs in the safest and most effective way, which keeps your drug coverage more affordable. If you notice that a drug that you are taking has a restriction or limit, you should talk with your doctor to determine if an alternative drug might work just as well for you. If your doctor says you have a medical reason to remain on your current therapy, you or your doctor may request an exception for coverage.
# Types of Restrictions

<table>
<thead>
<tr>
<th>Request</th>
<th>Why you would request it</th>
<th>How we determine our response</th>
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<tbody>
<tr>
<td><strong>PA:</strong> Prior authorization</td>
<td>MVP requires a review of certain drugs. The review helps to ensure that the most appropriate medication was selected. Reviews also are done to determine if a drug is covered by Medicare rules, or to determine which benefit a drug falls under. For example, some drugs such as albuterol nebulizer solution, could be covered under Part B (medical services) or Part D (pharmacy benefit) depending on your medical condition. MVP must review your specific request to determine which benefit (Part B or Part D) your drug would be covered under. Your cost sharing will be based on this determination. If you fill your prescription before you get approval -- the drug may not be covered.</td>
<td>Approval will be granted if your request meets certain criteria which can be found in our Medicare Part D policies (posted on the Website or available by calling the MVP Medicare Customer Care Center). Our Medicare Part D policies are reviewed by a team of doctors and pharmacists, and approved by Medicare.</td>
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<td><strong>B/D:</strong> B vs. D review</td>
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<td><strong>QL:</strong> Quantity Limit</td>
<td>In some cases, MVP limits the amount of the drug that you can get per prescription or for a defined period of time. For example, MVP will provide up to 30 capsules per month for Nexium®. If you and your doctor believe you need more of a drug than what’s typically covered, you can ask for an exception.</td>
<td>Approval will be granted for a quantity limit exception request if the allowed quantity has not been effective in treating your condition and other formulary drugs are not appropriate.</td>
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<td><strong>ST:</strong> Step Therapy</td>
<td>MVP requires you to first try one drug to treat your medical condition before we will cover another drug. For example, MVP may require the use of a generic</td>
<td>Approval will be granted if you had previously tried the first drug and it was not effective or caused a side effect, or if your doctor does not believe the first</td>
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<tr>
<td>Request</td>
<td>Why you would request it</td>
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<td>medication before using a brand name medication in the same medication class. If you and your doctor believe that taking the first drug will not help your medical condition, you can ask for an exception.</td>
<td>drug would be effective in treating your medical condition.</td>
</tr>
<tr>
<td>What if my drug is not listed on the MVP Formulary?</td>
<td>If your medication is not on the MVP Formulary, you should talk with your doctor to see if you should switch to a medication on the MVP Formulary. If your doctor does not feel that another medication on the formulary is right for you, you or your doctor may submit a request for MVP to cover a non-formulary drug. Please note that some medications are not on our formulary because Medicare has determined that they are not Medicare Part D benefits. MVP cannot approve a formulary exception request to cover a drug that the federal Medicare program does not allow us to cover.</td>
<td>Approval will be granted if you tried drugs on the MVP Formulary and they were not effective or caused side effects, or if your doctor does not believe that the drugs on the formulary would treat your medical condition as well as the non-formulary drug. If we grant your request, the drug will be covered in Tier 3 (or Tier 4 if it meets certain cost requirements). You can not ask us to cover the drug in a lower tier.</td>
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**Submitting a request for an exception**

- You or your doctor must complete the *Request for Medicare Prescription Drug Coverage Determination* form.

  The form is available at [www.mvphealthcare.com](http://www.mvphealthcare.com). Select *Medicare Members*, then your county if prompted, and select *Forms and Publications*. Choose *Coverage Determination Form* under *Pharmacy*.

  You can also call the MVP Medicare Customer Care Center at the phone number on the back of your Member ID card to obtain a form.

- Make sure the form includes:
  - Physician’s or prescriber’s signature
- Supporting information (medical documentation (chart notes) and/or supporting statement) from your doctor

**Timeframe for a decision**

- Generally, we must make our decision within **72 hours** of getting your physician’s or prescriber’s supporting information.
- You can request an **expedited** (fast) exception if you or your physician or prescriber believe that your health could be seriously harmed by waiting up to 72 hours for a decision.

  If your request to expedite is granted, we must give you a decision no later than **24 hours** after we get your prescribing physician’s or prescriber’s supporting information.

If your physician or prescriber does not provide us with the supporting information, we will wait up to 28 days to make our decision. **If we don’t receive the supporting information within 28 days, we will make the decision with the information that we have.**

**Obtaining Formulary information**

The Formulary and other information about your pharmacy benefit are on our website. Go to [www.mvphealthcare.com](http://www.mvphealthcare.com) and select *Medicare Members*, choose your county if prompted to do so, and then select *Drug Coverage (Part D)*. You can also call the MVP Medicare Customer Care Center at the phone number on the back of your Member ID card with questions or for information.

**How to Voice Your Concerns to MVP**

**Call Us First – We’re Here to Listen**

**Grievance and Appeal procedures**

You have rights as an MVP Health Care member and as someone who is getting Medicare. MVP is committed to honor your rights, to take your problems and concerns seriously, and to treat you with respect. You have the right to voice concerns, to make complaints, or to ask MVP Health Care to reconsider decisions we have made about your coverage.

If you have a problem or concern, please call us first. Your health and satisfaction are important to us. We will work with you to try to find a satisfactory solution to your problem. You may call the MVP Medicare Customer Care Center at the phone number on the back of your MVP Member ID card, or listed below.

We’re available to help:
Monday – Friday, 8 am – 8 pm Eastern Time
From Oct. 1 – Feb. 14, call seven days a week, 8 am – 8 pm

**1-800-665-7924**
TTY: **1-800-662-1220**
If you do not wish to call, or you called and were not satisfied, you can put your complaint in writing and send it to us at:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207
625 State Street
Schenectady, NY 12301

Two ways to deal with concerns
Sometimes you might need to use a more formal process to address a concern or problem you are having as a member of our plan. There are two ways to formally handle these issues:

- For some issues you need to use the process for making a complaint, also called a grievance.
- For other issues, you need to use the process to question or challenge a coverage decision, also called an appeal.

Which process should you use? That will depend on the type of problem you are having. Please call MVP first for help, or refer to the chapter of your Evidence of Coverage (your contract) entitled, “What to do if you have a problem or complaint (coverage decisions, appeals, complaints)” to help you decide which process to use and to find more details about grievances and appeals.

Filing a grievance
A grievance is a complaint about the way your Medicare health plan is giving care or service. Issues that might lead you to file a grievance include concerns with:

- The service you receive from the MVP Medicare Customer Care Center.
- The quality of care you receive from a doctor, hospital or other health care provider in MVP’s network.
- Getting appointments when you need them, or waiting too long on the phone or to be seen.
- Cleanliness or conditions of doctors’ offices, clinics, or hospitals.

To file a grievance, you must contact MVP within 60 days after the incident occurred.

Filing an appeal
An appeal is the process you use if you disagree with certain kinds of decisions made by MVP. Issues that might lead you to file an appeal include:

- A claim being denied for a service you already received and which you believe is covered by your MVP contract.
- MVP not approving medical care that you believe is covered by your contract.
- You are asking MVP to cover a Part D drug that is not on our list of Medicare-approved covered drugs.

To file an appeal, you must contact MVP within 60 days from the date on the denial letter that we send you.

Both the grievance and the appeal processes have been approved by the Medicare program. To ensure fairness and prompt handling of your concerns, each process has a set of rules, procedures, and deadlines that must be followed by us and by you. Refer to your Evidence of Coverage (your contract) for further details on appeals and grievances.

**Exclusions and non-covered services**

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

**Preventive care guidelines**

These guidelines are recommendations for healthy adults over age 65. Call the MVP Medicare Customer Care Center for information on health care guidelines for people under age 65. It is important to work with your physician to develop a schedule that is appropriate for your health care situation.

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<td>Complete or update a health assessment with your doctor, including family history, activity, tobacco, alcohol, drug use and sexual practices</td>
</tr>
<tr>
<td><strong>Tests</strong></td>
<td>Complete or update a health assessment with your doctor, including family history, activity, tobacco, alcohol, drug use and sexual practices</td>
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<td><strong>Height and weight (Body Mass Index)</strong></td>
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<td><strong>Blood pressure</strong></td>
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<tr>
<td><em><em>Hearing and vision</em> screening</em>*</td>
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<tr>
<td><strong>Screen for lipid disorders (for example, cholesterol)</strong></td>
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<tr>
<td><strong>Screen for colorectal cancer using fecal occult blood testing, sigmoidoscopy or colonoscopy until age 75. Multi-target stool DNA test (like Cologuard™) beginning at age 50 and continuing until age 85. Talk with your doctor about the frequency of screening needed.</strong></td>
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<tr>
<td><strong>Tuberculosis screen by PPD test as indicated</strong></td>
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<tr>
<td><strong>Screen for Type 2 diabetes if blood pressure is higher than 135/80, you are obese, or you have a history of high blood sugar.</strong></td>
<td></td>
</tr>
<tr>
<td>Also for women:</td>
<td></td>
</tr>
</tbody>
</table>

32
<table>
<thead>
<tr>
<th><strong>Women and men ages 65 and older</strong></th>
<th></th>
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</thead>
</table>
| • Pap test is optional after age 65; discuss with your doctor whether you should have this test  
• Mammogram every 1-2 years until age 74; then as indicated after age 74  
• Osteoporosis screening for women ages 65 and up |  |
| **Immunizations** |  |
| • One-time dose Tetanus/Diptheria/Pertussis; Tetanus/Diptheria booster every 10 years  
• Flu vaccine annually  
• Pneumococcal vaccine once in a lifetime from age 65; booster as recommended  
• Zoster vaccine unless contraindicated  
• Hepatitis B vaccine if you are at high risk for hepatitis B. Talk with your doctor. |  |
| **Counseling / Screening** |  |
| • Diet (for women, discuss calcium and vitamin D)  
• Exercise  
• Smoking cessation  
• Alcohol/substance abuse prevention  
• Sexually transmitted diseases/HIV/sexual behavior  
• Dental health  
• Sun exposure  
• Bladder control problems  
• Injury prevention (including seat belt, helmet use and ways to prevent falls)  
• Life stage issues (bereavement)  
• Depression  
• Health Care Proxy/Advance Directives  
Also for women:  
• Menopause management |  |
| **High Risk Individuals** |  |
| • Aspirin therapy should be considered for adults ages 45-79 when benefits outweigh risks  
• Menigococcal, Varicella, Hep B, Measles/Mumps/Rubella and Hep A immunizations for |  |
### Women and men ages 65 and older

<table>
<thead>
<tr>
<th>Those at risk</th>
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<tbody>
<tr>
<td>• Screen for Abdominal Aortic Aneurysm (AAA) x 1 in men ages 65 to 75 who are smokers or who smoked at any time</td>
</tr>
<tr>
<td>• Lung cancer screening every year for ages 55 – 77 who are current or former smokers. Talk with your doctor.</td>
</tr>
</tbody>
</table>

*If you have a family history of glaucoma talk to your doctor about whether screening may be right for you

**Prostate Cancer Screening: The United States Preventive Services Task Force (USPSTF) has determined that for men younger than age 75 years, evidence is inadequate to determine whether prostate cancer screening improves health outcomes. The balance of harms and benefits cannot be determined. If you are a man younger than 75 years, talk with your doctor to determine if you are at risk for prostate cancer and if prostate cancer screening is right for you.

Guidelines adapted from the U.S. Preventive Services Task Force. Talk with your doctor about what preventive services are right for you. Your benefits may allow for services more frequently than what is listed here.

### Advance care planning

Advance Care Planning is a process of planning for future medical care in case you are unable to make your own decisions. It is a continual process and not merely a document or isolated event. Advance Care Planning assists you in preparing for a sudden unexpected illness from which you expect to recover, as well as the dying process and ultimately death.

Our website, [www.mvphealthcare.com](http://www.mvphealthcare.com), provides links to brochures explaining advance care planning guidelines and forms. Select Medicare Members, choose your county if prompted and then select Forms/Publications to find Advance Directives/Advance Care Planning.
Member Protections – How we protect and keep your personal health information confidential

MVP’s Privacy Notice (October 19, 2015)

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

MVP Health Plan, Inc., MVP Health Services Corp., MVP Health Insurance Company, MVP Health Insurance Company of New Hampshire, Inc., and Hudson Health Plan, Inc. (collectively “MVP”) 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.

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

The terms and conditions of this privacy notice supplement any other communications, policies, or notices that MVP may have provided regarding your health information. In the event of conflict between this notice and any other MVP communications, policies, or notices, the terms and conditions of this notice shall prevail.

MVP’s Duties Regarding Your Health Information

MVP is required by law to:

• Maintain the privacy of information about your health in all forms including oral, written, and electronic.
• Train all MVP employees in the protection of oral, written, and electronic protected health information (PHI).
• Limit access to MVP’s physical facility and information systems to the required minimum necessary to provide services.
• Maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard PHI.
• Notify you following a breach of unsecured health information.
• Provide you with this notice of our legal duties and health information privacy rules.
• Abide by the terms of this notice.

We reserve the right to change the terms of this notice at any time, consistent with applicable law, and to make those changes effective for health information we already have about you. Once revised, we will advise you that the notice has been updated, provide you with information on how to obtain the updated notice, and will post it on www.mvphealthcare.com.
How We Use or Disclose Your Health Information

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

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

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

**For health care operations.** We may use or disclose your health information for health care operations that are necessary to enable us to arrange for the provision of health benefits, the payment of health claims, and to ensure that our members receive quality service. For example, we may use and disclose your health information to conduct quality assessment and improvement activities (including, e.g., surveys), case management and care coordination, licensing, credentialing, underwriting, premium rating, fraud and abuse detection, medical review, and legal services. We will not use or disclose your health information that is genetic information for underwriting purposes. We also use and disclose your health information to assist other health care providers in performing certain health care operations for those health care providers, such as quality assessment and improvement, reviewing the competence and qualifications of health care providers, and conducting fraud detection or investigation, provided that the information used or disclosed pertains to the relationship you had or have with the health care provider.

**Health-related benefits and services.** We may use or disclose your health information to tell you about alternative medical treatments and programs, or about health-related products and services that may be of interest to you.

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

**Disclosures to a plan sponsor.** We may disclose limited 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.

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

**Email communications to you.** You agree that we may communicate via email with you regarding insurance premiums or for other purposes relating to your benefits, claims, or our products/services and that such communications (utilizing encryption software for our email transmissions) may contain confidential information, protected health information, or personally identifiable information.
Disclosures authorized by you. Except for the scenarios described in this notice, HIPAA prohibits the disclosure of your health information without first obtaining your authorization. MVP will not use or disclose your health information to engage in marketing, other than face to face communications, the offering of a promotional gift, or as set forth in this notice, unless you have authorized such use or disclosure. MVP will not use or disclose your health information for any reason other than those described above, unless you have provided authorization. We can accept an Authorization to Disclose Information form if you would like us to share your health information with someone for a reason we have not stated above. Using this form, you can designate whom you would like us to share information with, what information you would like us to share, and how long you want us to be able to share your information with that individual. A copy of this form is available by calling the MVP Customer Care Center or at www.mvphealthcare.com. You must complete this form and send it to the address or fax it to the fax number on the form. You can cancel this Authorization at any time in writing and per the requirements on the form.

Special Use and Disclosure Situations

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

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, to inspect or copy your health information, or questions about this notice can be made by using the Contact Information below.

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

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

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

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

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

Right to a copy of the notice of privacy practices. You have the right to obtain a copy of this notice at any time.
Exercising Your Rights
Unless you provide us with a written authorization, we will not use or disclosure your health information in any manner not covered by this notice. If you authorize us in writing to use or disclose your health information in a manner other than described in this notice, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your authorization; however, we will not reverse any uses or disclosures already made in reliance on your authorization before it was revoked.

You have a right to receive a paper copy of this notice at any time. You can also view this notice at www.mvphealthcare.com.

If you believe that your privacy rights have been violated, you may file a complaint by contacting a Customer Care Representative at the address or phone number indicated in the Contact Information below.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request.

We Will Not Take Any Action Against You for Filing a Complaint
We will not retaliate in any way if you choose to file a complaint in good faith with us or with the U.S. Department of Health and Human Services. We support your rights to the privacy of your medical information.

Contact Information
You can reach the MVP Medicare Customer Care Center at:

MVP Health Care
220 Alexander St.
Rochester, NY 14607
1-800-665-7924
TTY: 1-800-662-1220
Monday – Friday, 8 am – 8 pm Eastern Time
Oct. 1 – Feb. 14, call seven days a week, 8 am – 8 pm

MVP Health Plan, Inc. is an HMO-POS/PPO/MSA organization with a Medicare contract. Enrollment in MVP Health Plan depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.