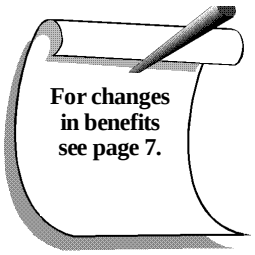
MVP Health Care

http://www.mvphealthcare.com

2002

A Health Maintenance Organization



Serving: Upstate New York and Vermont

Enrollment in this Plan is limited; see page 6 for requirements.

This Plan has Commendable accreditation from the NCQA. See the 2002 Guide for more information on NCQA.

Enrollment codes for this Plan:

Eastern Region

GA1 Self Only
GA2 Self and Family

Central Region

M91 Self Only
M92 Self and Family

Mid-Hudson Region

MX1 Self Only
MX2 Self and Family

Vermont Region

VW1 Self Only
VW2 Self and Family

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United States
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http://www.opm.gov/insure

Federal Employees Health Benefits Program

RI-73-465

Table of Contents

Introduction

MVP Health Care
111 Liberty Street
Schenectady, NY 12305

This brochure describes the benefits of MVP Health Plan, Inc. under our contract (CS 2362) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 55. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means MVP Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first
- Our brochure and other FEHB plans brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 888/687-6277 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE-- 202/418-3300
The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan s benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my health care

We are an Individual Practice Association (IPA) HMO. We have over 9,000 doctors who operate in private practices and are available to serve you as a Primary Care Physician (PCP) or Specialist. Our PCPs may refer you to any MVP Specialist, except in Vermont. Vermont PCPs who are part of the Vermont Managed Care (VMC) network may only refer you to VMC Specialists. Please refer to MVP s Provider Listing which clearly identifies all VMC physicians. If you have any questions regarding the referral process, please call our Member Services Department at 888/687-6277. You will be using the general acute hospital facilities located throughout our service area for hospital care, depending upon where your doctors have admitting privileges. If you need a service that is medically necessary, and is covered through MVP, and you cannot obtain that service at the community hospitals, it will be arranged for at other appropriate facilities.

Your Rights

OPM requires that all FEHB Plans to provide certain information to their FEHB members. You may get information about us, our networks, our providers and facilities. OPM s FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- MVP Health Plan is licensed in the States of New York and Vermont to operate as an HMO.
- MVP Health Plan has been in operation since 1983
- MVP Health Plan is a not-for-profit, federally qualified HMO

If you want more information about us, call 888/687-6277, or write to MVP Health Care, 111 Liberty Street, Schenectady, NY 12305. You may also contact us by fax at 518/356-7460 or visit our website at http://www.mvphealthcare.com

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is as follows:

Eastern Region (GA1 Self only, GA2 Self and family): The New York counties of Albany, Fulton, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

Central Region (M91 Self only, M92 Self and family): The New York counties of Broome, Chenango, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Otsego, and Tioga.

Mid-Hudson Region (MX1 Self only, MX2 Self and family): The New York counties of Columbia, Dutchess, Greene, Orange, Putnam, and Ulster.

Vermont (VW1 Self only, VW2 Self and family): The Vermont counties of Addison, Bennington, Caledonia, Chittenden, Essex, Franklin, Grand Isle, Lamoille, Orange, Orleans, Rutland, Washington, Windham, and Windsor.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services outside of our service area unless the services have prior plan approval.

If you or a covered family member moves outside of our service area, you can enroll in another plan. You do not have to wait until Open Season to change plans. If your dependents live out of the area you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Contact your employing or retirement office.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure, any language change not shown here is a clarification that does not change benefits.

Program-wide change

- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover routine screening for chlamydial infection. (Section 5(a))
- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We clarified the brochure to show why we think you should use generic drugs whenever possible. We moved other language around within the Prescription drugs section but didn t change its meaning. (Section 5(f))
- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- If you are in Enrollment Code GA, your share of the non-Postal premium will increase by 12.6 % for Self Only and decrease by 10.8% for Self and Family
- If you are in Enrollment Code M9, your share of the non-Postal premium will increase by 16.8% for Self Only and decrease by 25.3% for Self and Family.
- If you are in Enrollment Code MX, your share of the non-Postal premium will decrease by 13.9 % for Self Only and increase by 14.1% for Self and Family.
- If you are in Enrollment Code VW, your share of the non-Postal premium will increase by 109.7% for Self Only and increase by 89.3% for Self and Family.
- We have removed the quantity (100 unit/300 unit) limit on prescription drugs.
- Members only pay one $10.00 copay per surgery. This copay is usually paid to the facility. (Section 5(b) and Section 5(c))
- Members pay the lesser of a $10.00 copay or 20 % of the cost of diabetes treatment services. (Section 5 (a))

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or obtain a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 888/687-6277.

Where you get covered care

You get care from Plan providers and Plan facilities. You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website (http://www.mvphealthcare.com).

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician (PCP). This decision is important since your PCP provides or arranges for most of your health care. Please use our provider directory or our website to choose your PCP.

- **Primary care**

Your PCP can be a doctor in Family or General Practice, Internal Medicine, OB/GYN, or Pediatrics. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize any follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see any Plan gynecologist for routine office visits, or care related to pregnancy without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan and must obtain authorization from a Plan Medical Director. Your PCP will submit his/her recommendation to our Medical Director and then the Medical Director will notify both you and your PCP in writing as to our decision. Please contact our Member Services Department at 1-888-687-6277 if you have any questions about this process.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the FEHB Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 1-888-687-6277. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefit of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process precertification. Your physician must obtain precertification for services such as:

- Inpatient Hospital Admissions
- Organ/Tissue Transplants
- Cardiac rehabilitation programs
- Pulmonary rehabilitation programs
- Skilled nursing facility care
- Home health care
- Health education and nutritional counseling
- Sexual dysfunction services and prescriptions
- Elective inpatient, and certain outpatient procedures

Your physician will contact our medical review staff in order to obtain our approval. We may contact you and ask you some questions about your condition and the treatment you have received in the past.

If our Medical Director does not approve this procedure, you may follow the disputed claims process detailed in Section 7.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

  A copayment is a fixed amount of money you pay when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing per admission.

- **Deductible**

  A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for those services. We do not have a deductible.

- **Coinsurance**

  Coinsurance is the percentage of our negotiated fee that you must pay for your care.

  Example: In our Plan, you pay 50% of our allowance for advanced infertility services and 20% for durable medical equipment.

Your out-of-pocket maximum

After you make copayments equal to or greater than two times the cost of the total, annual plan premium for two or more family members, you do not have to make any additional payments for certain services for the rest of the year. This amount is called your out-of-pocket maximum. However, copayments for your prescription drugs do NOT count toward this maximum and you must continue to make these copayments.

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 55 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; as they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 888/687-6277 or at our web site at http://www.mvphealthcare.com

Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician s office, including office medical consultations and second surgical opinions • Initial examination of a newborn child covered under a family enrollment	$10 per office visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing
At home	$10 per visit
Not covered: • *Dental treatment of temporomandibular joint(TMJ) syndrome* • *Costs for which a member fails to keep an appointment*	*All charges.*

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per visit
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol — once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test ••Sigmoidoscopy, screening —every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) —one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	$10 per office visit
Routine mammogram —covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 49, one every one or two calendar years • From age 50 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster — once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing if you receive these services during your office visit; otherwise, $10 per visit
Not covered: Immunizations or vaccinations for employment, educational, insurance, or travel purposes	*All Charges*

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Examinations, such as: - Well-child care charges for routine examinations, immunizations and care (through age 22) - Examinations done on the day of immunizations (through age 22)	Nothing
- Eye exams through age 17 to determine the need for vision correction. - Ear exams through age 17 to determine the need for hearing correction (exams for screening only)	$10 per office visit (for refraction only) $10 per office visit (for screening only)
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 copay for the initial office visit only and nothing thereafter
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
A broad rage of family planning services, such as: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphrams NOTE: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit

Family planning *(Continued)*	**You pay**
Not covered: • *reversal of voluntary surgical sterilization,* • *genetic counseling, voluntary abortions, embryo transfer, GIFT, ZIFT, in-vitro fertilization*	*All charges.*
Infertility services	
Basic infertility services include those services provided for the initial evaluation and testing for infertility.	$10 per office visit for Basic services
Advanced infertility services such as: • Semen analysis • Post-coital examinations • Hysterosalpingograms • Varicocele surgery • Artificial insemination (up to six cycles): - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) Note: You and your spouse must have already received basic infertility services before you are eligible for advanced infertility services. You must obtain a referral from your PCP in order to see a Plan specialist for infertility services.	50% per visit for Advanced services
• Fertility drugs (including drugs taken orally) such as: HCG, Progesterone injections, Menotropins, Urofollitropins, Serophene (Clomid)	50% copay per cycle of fertility drugs
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in-vitro fertilization* - *embryo transfer, gamete GIFT and zygote ZIFT* - *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm or sperm banking* • *Cost of donor egg* • *Gender Selection* • *External pump for administration of infertility drugs* • *Reversal of vasectomy or tubal ligation*	*All charges.*

Allergy care	You pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page xx. • Respiratory and inhalation therapy • Dialysis — Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy — Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: — We will only cover GHT when we preauthorize the treatment. Call 1-888-687-6277 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask OR if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per office visit
Not covered: treatment that is not authorized or provided by a Plan doctor	*All charges.*
Physical and occupational therapies	
• Two consecutive months per acute condition for the services of each of the following: - qualified physical therapists and; - occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions	$10 per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*

Speech Therapy	You pay
• Two consecutive months per acute condition	$10 per office visit
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children through age 17 (see *Preventive care, children*). Exams for screening purposes only.	$10 per office visit
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• Routine eye refractions, covered once every 24 months Note: You do not need a referral for the refraction exam. You will need a referral from your Primary Care Physician for any eye exams involving a diagnosed or suspected illness.	$10 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Non-routine foot care such as care that you receive when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. You are limited to ten visits per year.	$10 per office visit
Not covered: • *Routine foot care such as cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotic devices such as arch supports and shoe inserts*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	20% of charges
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic repair or replacements unless authorized by MVP* • *Wigs and other hair prostheses*	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Wheelchairs; • Crutches; • Walkers; • Braces	20% of charges
• Blood glucose monitors; and • Insulin pumps.	20% of the cost or a $10 copay (whichever is less) for services and equipment necessary for the treatment of diabetes
Note: Call us at 888/687-6277 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call. Note: Services and equipment necessary for the treatment of diabetes is limited to a 31-day supply per each copay.	
Not covered: • *Motorized wheel chairs* • *Exercise Equipment* • *Car or Van Lifts* • *Hearing aids* • *Personal comfort items*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$10 per visit
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient s family;* • *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*

Chiropractic	You pay
For spinal manipulation only. Note: You must obtain a referral from your primary car physician	$10 per office visit
Alternative treatments	
Not covered: • *Acupuncture* • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management You may attend educational classes in most participating Plan hospitals — please contact the hospital directly for details. You need a referral from your PCP to attend a class.	$10 copay

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. Will only be covered with Plan preauthorization and when medically necessary. • Insertion of internal prostethic devices. See 5(a) — Orthopedic and prosthetic devices for device coverage information.	$10 per office visit

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member s appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Note: See Orthopedic and Prosthetic Devices for information on the actual breast prostheses. You pay 20% of charges for breast protheses.	$10 per office visit
Not covered: • *Cosmetic surgery — any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to the nondental: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges.*
Organ/tissue transplants	
Non-experimental transplants are limited to: • Cornea • Heart • Kidney • Liver • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas	Nothing

Organ/tissue transplants continued on next page

Organ/tissue transplants *(Continued)*	**You pay**
Note: You must receive prior approval from the MVP Medical Director. Note: National Transplant Program (NTP) — We contract with aCenters of Excellence network for all transplant services. The network we use is the United Resource Network (URN). URN selects facilities for participation in their network by using criteria such as: transplant experience, transplant volume, survival rates, geographic location, and medical education of the center and its staff. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in — • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center	Nothing
Professional services provided in — • Skilled nursing facility • Office	$10 per visit

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST RECEIVE OUR APPROVAL FOR ALL HOSPITAL STAYS**. Please refer to Section 3 for a list of services that require preauthorization.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: — We cover hospital services and supplies related to certain dental procedures when a Plan doctor believes that there is a need for hospitalization for reasons totally unrelated to the dental procedure. This would include conditions such as hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition. We do not cover the dental procedures.	$10 per outpatient surgery or procedure
Not covered: • *Blood and blood derivatives not replaced by the member* • *Personal comfort items such as telephone and television*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Extended care benefits/skilled nursing care facility benefits: We cover up to 45 days per calendar year when full-time skilled nursing care is necessary. All necessary services are covered including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. Note: In certain situations, we may approve skilled nursing care in a hospital. This happens when there are no skilled nursing facilities that are near you. y (for example, when there is no skilled nursing facility near you). In these instances, the Please remember that the inpatient hospital days will count toward your 45-day skilled nursing facility annual maximum benefit.	Nothing
Not covered: custodial care, rest cures, domiciliary or convalescent care	*All charges*

Hospice care	You pay
We cover up to 210 days of hospice care for a terminally ill member in the home or a hospice facility. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. Covered services must be billed by the hospice and include: • Inpatient hospice care • Outpatient care, including drugs and medical supplies • Five visits for bereavement counseling of the immediate family	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance services when appropriate, medically necessary, and ordered or authorized by a Plan doctor	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies — what they all have in common is the need for quick action.

What to do in case of emergency:

Please call your primary care doctor when you are in an emergency situation. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us. You or a family member should notify us within 48 hours by calling 1-888-687-6277. It is your responsibility to ensure that the Plan has been timely notified. If you need to be hospitalized, we **must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time.

If you need to be hospitalized in a non-Plan facility, we must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in non-Plan facilities and we believe that care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. However, follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$35 per urgent care center visit or hospital emergency room visit Note: We waive this copay if you are admitted to the hospital
Not covered: • *Elective care or non-emergency care* • *Prescriptions written by non-Plan doctors*	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	Nothing
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *Prescriptions written by non-Plan doctors*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate and ordered or authorized by a Plan doctor See 5(c) for non-emergency service.	Nothing
Not covered: air ambulance if not medically necessary	*All charges.*

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Call us at 1-888-687-6277 before seeking mental health and substance abuse care. See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	Nothing if you receive these services during your office visit; otherwise, $10 per visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

- Call our Member Services Department at 1-888-687-6277 before seeking treatment.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We administer an open prescription drug formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a copy of our prescription drug formulary please call us at 1-888-687-6277.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed Plan physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail for a covered maintenance medication. Please call our Member Services Department at 1-888-687-6277 or visit our website at http://www.mvphealthcare.com to determine whether or not a maintenance medication is available through our mail order program.
- **We use a formulary.** Our formulary is a list of medications that we approved for your use. Our Plan doctors prescribe drugs and Plan pharmacies dispense them in accordance with our formulary. A committee of primary care and specialty physicians, pharmacists and other healthcare professionals used clinical data to develop our formulary. They periodically review it and choose the most effective drugs for treating illness and disease. We will cover non-formulary drugs when prescribed by a Plan doctor. If you have questions about our formulary, please visit our website at http://www.mvphealthcare.com or call our Member Services Department at 1-888-687-6277
- **These are the dispensing limitations.**
  - You may obtain up to a 30-day supply per copay from a participating Retail pharmacy.
  - Under our mail-order program, we limit prescription drug amounts to a 90-day supply per copay. **You may contact our Member Services Department at 1-888-687-6277 or visit our website at** http://www.mvphealthcare.com **to find out if a certain drug is covered through our mail order program. You will also need an order form which you can download from our website to use this benefit. Unfortunately, all drugs are not available through the mail-order program.**
  - Ask your doctor to write two prescriptions when your doctor prescribes a drug eligible for the mail order program — one for up to 30-days to be filled at your local pharmacy, and one to last up to 90-days which should be filled through familymeds.com. Complete and sign an order form and attach the 90-day prescription. Then, mail everything to Familymeds.com, PO Box 150404, Hartford, CT 06115-0404.
- **Why use generic drugs?**

  You can save money by using generic drugs. However, you and your physician have the option to request a name-brand if a generic option is available. Using the most cost-effective medication saves money.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician s prescription for their purchase, except as excluded below. • Enteral formulas when medically necessary (contact Plan for details) • Drugs for sexual dysfunction (see note below) • Contraceptive drugs Note: Drugs to treat sexual dysfunction are limited. Please contact Plan for dose limits and prior authorization.	$ 5 per Generic prescription unit or refill from a participating Retail pharmacy $ 20 per Brand Name prescription unit or refill from a participating Retail pharmacy Note: We do not waive the name brand copay when a generic drug is not available.
• Diabetic supplies such as insulin, needles and syringes, glucose test tablets and test tape, Benedict s solution or equivalent, glucose monitors and acetone test tablets (31-day supply per dispensing)	Lesser of $10 or 20% for the cost of insulin and other diabetic supplies
• Disposable needles and syringes for the administration of covered medications, as well as dressings and antiseptics	20% copay for disposable needles and syringes needed to inject covered prescription medications
Up to a 90-day supply of maintenance medication by Mail-order Note: All prescription drugs are not available through mail.	$10 per Generic prescription for up to a 90-day supply by Mail Order $40 per Brand Name prescription for up to a 90-day supply by Mail Order
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs obtained at a non-Plan pharmacy (except for out-of-area emergencies)* • *Drugs to enhance athletic performance* • *Refills due to a lost or misused prescription drug supply* • *Drugs used in connection with the provision of a non-covered service or benefit*	*All Charges*

Section 5 (g). Special Features

Feature	Description
After Hours MVP Unit	For any of your health concerns, or if you have a question concerning your benefits, from 8:00 am — Midnight, 7 days a week, you may call 1-888-687-6277 and talk with a registered nurse or Member Services Representative who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	If you are hearing impaired and wish to speak with a Member Services Representative please first contact a relay operator at 1-800-662-1220 and then they will call our Member Services Unit (at 1-888-687-6277) and help you during your conversation with our representative.
High risk pregnancies	MVP's Little Footprints is a special program for women who have had a problem with a past pregnancy or who are at risk for having problems during their current pregnancy. You must have at least three months left in the pregnancy to be eligible to participate. As part of this program one of our prenatal nurses will call you every month to discuss the progress of your pregnancy and what can be done to help ensure a healthy pregnancy and to answer any questions she may have. You or your physician may contact us concerning this program. If you feel you might benefit from this program please contact our Member Services Department at 1-888-687-6277.
Travel benefit/ services overseas	As an MVP member you are covered for emergency care anywhere in the world. If you or your family member ever have a medical emergency, either outside of our service area or outside of the United States, please go to the nearest hospital or medical facility. Please contact our Member Services Department as soon as possible at 1-888-687-6277 so that we may arrange for any necessary follow-up care that you may need.
Out-of-area student benefit	We offer extended coverage for any of your dependent children up to age 22 provided that your child is a full-time student at an accredited college (full-time means 12 or more credit hours per semester). This benefit covers your child for care and services outside of our service area that he or she would normally obtain within our service area such as sick visits, outpatient surgery, and physical therapy. This benefit does not include coverage for routine preventive care such as physical exams, immunizations, and elective inpatient hospital services. This benefit is limited to $2,500 maximum per year. You will be reimbursed the cost of covered services minus your applicable copay. You will not be reimbursed if you submit claims to us one year after the date of service. You must submit claims to us at: MVP Health Plan, PO Box 2207, Schenectady, NY 12301. If you have any questions about claims submission or this out-of-area benefit please contact our Member Services Department at 1-888-687-6277.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Our preventive dental benefits are only for children under age 19**.**
- You may bring your child to any dentist that you wish to receive these covered services
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. You pay nothing. Treatment must be performed within 12 months of the accident.	Nothing
Not Covered: • *Dental services not shown as covered* • *Dental services that result from injury while eating*	*All Charges*

Dental Benefits

Service	You pay
The following preventive and diagnostic services are covered for Plan members under age 19: • One initial oral exam followed by periodic exams, once every six months • Bite wing x-rays, once every six months • Full mouth x-rays and panoramic x-rays, once every 36 months • Routine cleaning, scaling, and polishing of teeth, once every six months • Fluoride treatments, once every six months, to age 16 • Pulp vitality testing and diagnostic casts, as needed • Space maintainers and recementation thereof, as needed • Intra-oral and periepical x-rays, as needed • Sealants once per tooth per child (only covered to age 16)	$10 per office visit

Dental benefits - Continued on next page

Dental Benefits *(Continued)*	**You pay**
Note: You may see the dental provider of your choice to receive benefits. Your dentist may require you to pay for the services at the time they are rendered, in which case you should submit a claim to us for full reimbursement, less your $10 copay. You may obtain a claim form by calling us at 888/687-6277. Claim forms should be mailed to: Dental Benefit Providers, 7200 Wisconsin Ave, Suite 800, Bethesda, Maryland, 20814. If you do not file your claims promptly, we will still accept them if they are filed as soon as reasonably possible. We will neither accept nor provide coverage for claims that are submitted later than one (1) year after a service is performed.	
Not covered: • *Other dental services not shown as covered* • *Services which are not approved by the Council of Dental Therapeutics of the America Dental Association (ADA)* • *Services rendered by a medical department, clinic, or similar facility of the child s employer, labor union, mutual benefits association, or other similar group* • *Charges for dental appointments that are not kept* • *Dental implants*	*All charges*

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Expanded vision care

You are entitled to various discounts on designated eyewear purchases just by being an MVP Member. Please see the MVP Health Plan Something Extra brochure for listings of participating optical shops, and the type of discounts that they offer.

Fitness programs

Also by being an MVP member you may receive discounts from local Health and Fitness Clubs and Weight Control Centers on designated enrollment, membership or registration fees. Please see the MVP Health Plan Something Extra brochure for a listing of participating Health and Fitness Clubs and Weight Control Centers.

Safety equipment

MVP Health Plan offers you discounts on safety equipment for the home and car, and for personal use when purchased through our Something Extra program. Items such as bicycle helmets, child car seats and smoke detectors are available by calling our Member Services Department at 888/687-6277 or by visiting our website at http://www.mvphealthcare.com .

If you have any questions about any of these benefits, please contact the MVP Member Services Department at 888/687-6277.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital and prescription drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-888-687-6277.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: MVP Health Care,
111 Liberty Street
Schenectady, NY 12305.

Dental services

For children s preventive dental benefit, the dentist may have you pay the cost of the entire visit. If so, please call Member Services at 1-888-687-6277 to obtain a claim form. As long as the visit was for covered care, you will be reimbursed the cost of the visit less your $10 copay.

Submit your claims to: Dental Benefit Providers
7200 Wisconsin Avenue, Suite 800
Bethesda, MD 20814.

We will not accept, or provide coverage for claims that are submitted more than one year after the date of service.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies — including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: MVP Health Care, 111 Liberty Street, Schenectady, NY 12305; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, D.C. 20415-3630.

The Disputed Claims Process *(continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM s decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-888-687-6277 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called double coverage.

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

•What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies). Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

• The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure and use our providers in order for us to cover your care. We will not waive any of our copayments or coinsurance.

(Primary payer chart begins on next page.)

The following chart illustrates whether the Original Medicare Plan or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and	**Then the primary payer is**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		**X**
2) Are an annuitant,	**X**	
3) Are a reemployed annuitant with the Federal government when a) The position is excluded from FEHB	**X**	
b) Or, the position is not excluded from FEHB (Ask your employing office which of these applies to you.)		**X**
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	**X**	
5) Are enrolled in Part B only, regardless of your employment status,	**X** (for Part B services)	**X** (for other services)
6) Are a former Federal employee receiving Workers Compensation and the Office of Workers Compensation Programs has determined that you are unable to return to duty,	**X** (except for claims related to Workers Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		**X**
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	**X**	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	**X**	
C. When you or a covered family member have FEHB and		
1) Are eligible for Medicare based on disability, and a) Are an annuitant	**X**	
b) Are an active employee, or		. **X**
c) Are a former spouse of an annuitant, or	. **X**	
d) Are a former spouse of an active employee		. **X**

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan — You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-888-687-6277.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan — a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another plan s Medicare managed care plan: You may enroll in another plan s Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out or the managed care plan s network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan s service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can t get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Includes any service which can be learned and provided by an average individual who does not have medical training. Examples of custodial care include: help with walking or getting out of bed, or assistance in daily living activities such as feeding, dressing, and personal hygiene.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.

Experimental or investigational services

Services that are generally not accepted by informed health care providers in the United States as effective in treating the condition for which their use is being recommended.

We will only provide coverage for these type of services if the proposed treatment has: shown promising results in treating the underlying condition through a nationally recognized program, and a group of experts has reviewed the proposed treatment and thinks that it is appropriate.

If an appeal agent, outside of our Plan approves coverage for experimental or investigational services for you, and you would be part of a scientific trial or test, than our Plan would only provide limited benefits for these services, and you would be responsible for the rest.

Group health coverage

Coverage you are eligible to receive through your employer. This Plan is offered as group health coverage to you, and all other eligible employees of the Federal Government.

Medical necessity

Covered services that we determine are necessary to prevent, detect, correct, or cure conditions that cause you or a family member acute suffering, endanger your life, result in illness, interfere with your capacity for normal activity or threaten you with a significant medical handicap

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. We determine and base our allowance on the reasonable and customary charge that most providers would bill you for the service, procedure or office visit in question. Our participating providers have agreed to accept payment from us in full — you and your family members are only responsible for your copay.

Us/We

Us and we refer to MVP Health Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don t determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse s enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse s employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **Temporary continuation of coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert):
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27. Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site **(www.opm.gov/insure/health); ** refer to the TCC and HIPAA frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are WRONG!
- How are YOU planning to pay for the future custodial care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It s insurance to help pay for long term care services you may need if you can t take of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer s.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. It can supplement care provided by family members, reducing the burden you place on them.

I m healthy. I won t need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it s not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that s before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won t my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the *Not Covered* blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don t cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state s poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

NOTES:

NOTES:

Summary of benefits for the MVP Health Plan - 2002

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office.....	$10 per office visit	13
Services provided by a hospital:		
• Inpatient.....	Nothing	26
• Outpatient.....	$10 per surgery	27
Emergency benefits:		
• In-area.....	$10 per office visit or $35 per Urgent Care Center or Hospital Emergency Room	30
• Out-of-area	Nothing	30
Mental health and substance abuse treatment.....	Regular cost sharing.	31
Prescription drugs:		33
Retail Pharmacy (up to a 30 day supply).....	$5 Generic/$20 Name Brand per prescription unit or refill	
Mail Order (up to a 90 day supply).....	$10 Generic/$40 Name Brand	
Dental Care		36
Preventive Care for children up to age 19	$10 per office visit	
Accidental Injury	Nothing	
Vision Care (one covered eye exam every 24 months).....	$10 per office visit	18
Special features: MVP After Hours Unit; Little Footprints; Out-area-student benefit; Travel benefit/services overseas		35
Protection against catastrophic costs (your out-of-pocket maximum).....	Stated copays for covered benefits	11

2002 Rate Information for MVP Health Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, RI 70-2B; and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov t Share	Your Share	Gov t Share	Your Share	USPS Share	Your Share
Eastern New York							
Self Only	GA1	$ 86.03	$28.68	$186.41	$ 62.13	$101.81	$ 12.90
Self and Family	GA2	$222.21	$74.07	$481.46	$160.48	$262.95	$ 33.33
Central New York							
Self Only	M91	$ 88.79	$ 29.60	$192.38	$ 64.13	$105.07	$ 13.32
Self and Family	M92	$223.41	$ 82.32	$484.06	$178.36	$263.75	$ 41.98
Mid-Hudson							
Self Only	MX1	$ 97.25	$ 32.41	$210.70	$ 70.23	$115.07	$ 14.59
Self and Family	MX2	$223.41	$111.47	$484.06	$241.51	$263.75	$ 71.13
Vermont							
Self Only	VW1	$ 97.86	$ 89.24	$212.03	$193.35	$115.52	$ 71.58
Self and Family	VW2	$223.41	$259.85	$484.06	$563.00	$263.75	$219.51