

MVP Health Plan

2009 Annual Notices



MVP Health Care 2009 Member Annual Required Notices

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The Rights and Responsibilities of MVP Members

Member Rights

The following are specific rights available to MVP members:

1. Members have a right to be treated with dignity. Members have a right to receive quality medical services, in a professional and courteous manner, regardless of their race, sex, religion, age or sexual orientation.
2. Members have a right to confidentiality. All information concerning members' medical histories and enrollment files is privileged and confidential. MVP will release no information regarding any member's care without a written statement or release signed by the member, except as otherwise required by law.
3. Members have a right to obtain information. Members have a right to obtain current information on their diagnoses and treatment programs from their doctors or other providers in terms they can understand. Members have a right to receive this information in order to give informed consent and to participate in making decisions regarding treatment or care proposed by their doctors. If a member is unable to make medical decisions, this information shall be made available to an authorized person appointed to make medical elections on his/her behalf.
4. Members have a right to know of treatment options. Members have a right to receive complete information regarding all appropriate or medically necessary courses of treatment for their conditions. Members also have a right to discuss all possible treatment plans with their doctors, regardless of cost or benefit coverage levels.
5. If a practitioner with an appropriate specialty is not available within the MVP network to treat a medical condition, members have a right to request out-of-plan services. All out-of-plan services must be requested by members' primary care physicians and prior-authorized by MVP.
6. Members have a right to refuse treatment recommended by their doctors or other providers, to the extent permitted by law, and with the understanding that they have been informed of the consequences of such refusal.
7. Members have a right to voice complaints or appeals. If a member is not fully satisfied with the medical or administrative services provided by MVP, he/she has a right to a thorough investigation of the complaint or appeal by qualified and impartial staff.
8. Members have a right to be provided with information regarding MVP's policies and procedures, covered services and the names and professional status of health plan providers. Members have a right to be provided with MVP's Rights and Responsibilities policy and to make recommendations regarding this policy.

Member Responsibilities

The following are responsibilities expected of members of MVP:

1. Members have a responsibility to select personal participating primary care physicians — for themselves and their dependents — who will coordinate their medical care.

2. Members have a responsibility to provide, to the extent possible, complete information needed by their physicians to properly care for them. This includes providing their physicians with accurate information regarding their medical histories; any prescription medications that they are taking; receipt of medical services (such as mammograms and immunizations) through programs at work, school or the Department of Health; and their general health and safety habits.
3. Members have a responsibility to participate in their health care: to develop good relationships with their physicians and medical providers, understand their health problems, develop mutually agreed-upon treatment goals to the degree possible and follow their practitioners' advice for agreed-upon treatments and care.
4. Members have a responsibility to keep all scheduled appointments with their physicians. If a member needs to cancel, he/she should do so at least 24 hours prior to the appointment.
5. Members have a responsibility to notify MVP of any changes in their status, such as adding or deleting dependents, change in marital status, etc.
6. Members have a responsibility to carry their membership cards at all times and never permit anyone else to use them.
7. Members have a responsibility to call MVP within 48 hours or as soon as reasonably possible, if either the member or a dependent is hospitalized in an out-of-area hospital for a medical emergency.
8. Members have a responsibility to obtain the necessary referrals, if any are required, before seeing specialists.
9. Members have a responsibility to pay all applicable copayments, coinsurance and deductibles to their health care providers, as specified in their Subscriber Contract or Certificate of Coverage.

How to Contact MVP

With extended hours and e-mail access, MVP makes it easy to contact our Member Services department when you have questions or need help. We're here to help seven days a week (excluding holidays) from 8 a.m. to 10 p.m. and 24-hours a day on our Web site www.mvphealthcare.com. Call toll-free 1-888-MVPMBRS (1-888-687-6277).

MVP After Hours

The MVP After Hours nurse advice line is staffed by registered nurses available to answer questions and offer guidance 24/7. Members should first try to consult with their primary care physician (PCP) on any medical issues, but if the PCP is unavailable, members have the option of calling the nurse advice line by calling MVP's Member Services number. Call toll-free 1-888-MVP MBRS (1-888-687-6277).

How To Contact The Utilization Management Department

You may reach the Utilization Management department regarding authorizations for care during working hours and after working hours by calling MVP Member Services department toll-free at 1-888-MVP-MBRS (1-888-687-6277).

MVP Quality Improvement Program

MVP is dedicated to providing quality health care and services to our members. Our Quality Improvement (QI) program sets standards for the care and services that are provided to our members by MVP and by participating providers. MVP reports on its progress toward achieving the QI program goals in an annual Quality Improvement Evaluation report. You are welcome to participate in the development, implementation, or evaluation of the quality improvement system and/or, you may comment on MVP's Quality Improvement process. If you are interested in participating or commenting, please call our Quality Improvement department. To receive a summary of the program description document and the Executive Summary of the Annual Evaluation, please call our Quality Improvement department at 1-800-777-4793 ext. 2602.

How to Obtain Services

Coverage, Payment and General Information

Your Member Handbook and Certificate of Coverage provide detailed information about your MVP benefits, including covered services, access to care and any restrictions that may apply to your specific health plan. The MVP Health Plan, Inc. Member Handbook is available online at www.mvphealthcare.com/member (select "Member Handbooks" from the left menu) or in hardcopy, by request from MVP's Member Services Department.

Your MVP Member ID card is an easy reference tool for information about your copayments for doctor visits (PCP and specialist) and hospital care (inpatient and Emergency Room). On the back of your ID card you will find toll-free phone numbers to call if you have any questions about your health care benefits, including emergency care, hospital admissions, mental health/substance abuse services, receiving care from providers who are not part of MVP's network and locating participating pharmacies (if your MVP plan includes pharmacy benefits).

When you receive covered services from participating providers, you must pay the designated amounts for these services as listed in your Certificate of Coverage or any applicable riders. Other than the designated amounts, you should not have to pay for covered services that you receive from participating providers. In the rare instance that this may occur, please send the claim (itemized bill) to MVP. Include your name, address, MVP ID number, provider, date of service and diagnosis. Keep a copy of the claim for your records, and send the original to MVP Health Plan, Inc., Attention: Subscriber Claims, PO Box 2207, Schenectady NY 12301-2207.

Your Primary Care Physician

When you joined MVP, you and your covered dependents selected Primary Care Physicians (PCP) from those in the MVP provider network. Your PCP gives you care, such as routine well care,

preventive care, and basic health screening services, and coordinates any scheduled hospital care that you might require. In some cases your PCP must get prior approval from MVP before you can get some referrals and treatments.

Specialist as PCP

If you have a life-threatening, disabling or degenerative disease, you can have your specialist or specialty care center act as your Primary Care Physician. The specialist or specialty care center will take over coordination of all your primary care services. They will also okay visits for other specialty care, lab work, hospitalization and all other health services. Advanced cancer care, HIV disease and severe heart conditions are examples of cases where a specialist might act as your PCP. MVP must approve this arrangement. If you believe that your specialist should become your PCP, ask your current PCP to contact MVP. You and your PCP will be notified of MVP's decision in writing.

How to Obtain Behavioral Health Services

All it takes is a simple phone call to request to see a psychiatrist, psychologist, social worker or substance abuse counselor. That phone call can come from you, the behavioral health provider or your Primary Care Physician (PCP) prior to a behavioral health visit.

The Behavioral Health Access Center (for members in New York and New Hampshire) or PrimariLink (for members in Vermont) is your own customer service line for mental health and substance abuse care issues. If you don't know what provider to see, both the Behavioral Health Access Center and PrimariLink have specially trained clinical intake specialists to help you with your selection. They have profiled all of the behavioral health providers in MVP's network and can match your problem and location to a provider that will meet your needs. Give them a call when you need help. The telephone numbers are toll free: 1-800568-0458 to the Behavioral Health Access Center and 1-800-320-5895 to PrimariLink.

Emergency Care Policy

If you or a member of your family have an emergency that requires immediate medical care, you should go to the nearest hospital emergency room or medical facility, or call your local emergency number for medical assistance. MVP follows the prudent layperson standard when paying for emergency care. If MVP determines that the care you received did not meet the following standard, MVP will not pay for the care.

You do not need a referral from your Primary Care Physician or prior approval from MVP to get emergency medical care if you believe that not getting immediate attention for your emergency condition would:

- place your physical or mental health in serious jeopardy;
- seriously impair your bodily functions;
- cause serious dysfunction of any organ or body part;
- and, in New York state, result in disfigurement.

If you are unsure if your condition is an emergency, call your PCP for guidance and to coordinate your medical care. Your PCP (or a covering physician) is on call twenty-four hours a day, including weekends and holidays.

In-Area Emergencies

The hospital emergency room or other medical facility will charge your normal emergency room copayment (this amount is printed on your MVP ID card). Please contact your Primary Care Physician as soon as possible following the emergency so that he or she can coordinate any follow-up care that you may need.

Out-of-Area Emergencies

Your MVP benefits provide coverage for non-emergency care that you receive from providers who practice within MVP's network. You are also covered when you need emergency care outside MVP's service area. If an emergency occurs while you are out of town, go to the nearest physician or hospital for treatment. Please notify MVP of the emergency within 48 hours or as soon as possible, so that we can arrange for any follow-up services outside the MVP service area.

MVP Referral Requirements

MVP Referral Requirements Eliminated for Most Plans

As of January 1, 2009, MVP eliminated the referral requirement for specialty care for all fully insured and self-funded MVP HMO and Point of Service (POS) plans for in-network benefits, Medicare HMO (MVP Gold) and Healthy New York. This change in MVP's referral policy does not affect services that require prior authorization. MVP network practitioners will continue to be responsible for obtaining prior authorization for inpatient admissions and select procedures and services.

Members who are enrolled in Medicaid (MVP Care), Family Health Plus/Child Health Plus and all CompCare products (individual HMO and POS plans) still need to have PCP referrals for some specialist care and services, and the following information pertains to these plans:

- MVP members do not need a referral for emergency care.
- MVP members do not need a referral for routine eye care, or for an annual dilated eye exam for members with diabetes.
- A woman does not need a referral from her PCP to receive care from a gynecologist or obstetrician (OB/GYN), except for infertility treatment. The OB/GYN must be in the MVP provider network. If your benefit plan covers infertility treatment, a referral is required.
- MVP does not require referrals for physical/occupational therapy; visits to an allergist; nutritional counseling; or oncology/hematology services (including chemotherapy and radiation therapy). Your physician's order/prescription is all that's required. All applicable benefit limitations remain in effect.

Except as noted in your subscriber contract or Certificate of Coverage, referrals are required for specialty care visits and are good for one year from the date written, unless specific visit limitations are prescribed by the referring practitioner. Members should continue to seek the specialty care services of a participating MVP practitioner to receive the maximum benefit level.

Please note: Your MVP subscriber contract or Certificate of Coverage and any pertinent rider(s) control your MVP benefits, coverage and any other terms of your coverage.

Standing Referrals

Members with conditions that require ongoing care can have standing referrals. This means that one referral is good for a year of visits to a specialist or specialty care center. Examples include cardiac conditions, cystic fibrosis, multiple sclerosis, and organ transplants.

Formulary and Exceptions Policy

If your MVP benefits include prescription drug coverage, that coverage is subject to the MVP Prescription Drug Formulary, our list of covered drugs. Depending on the benefit design non-formulary drugs might require pre-authorization or be available at a higher copayment.

Before MVP will cover a newly-introduced prescription drug, a committee of MVP physicians and pharmacists reviews the available data concerning the effectiveness and safety of the new drug to determine if the drug represents a significant improvement over existing covered medications. If a drug meets the committee's criteria, MVP approves that drug for coverage.

If a drug is not covered by your prescription drug benefit and your doctor believes that it is medically necessary for you, your doctor can request an exception from MVP. Members can also initiate an exception request using the Member Formulary Exception Form at www.mvphealthcare.com/member or by contacting MVP Member Services.

To find out if MVP covers a specific drug, or if MVP covers a drug with certain conditions such as pre-authorization or with quantity limits, log on to our Web site www.mvphealthcare.com or contact the MVP Member Services department.

MVP Case Management Program

The MVP Case Management Program is designed to meet the needs of members who experience a high-risk medical condition or complicated life threatening illness. Under this program members with these kinds of medical problems are assigned to a Case Manager. Case Managers are registered nurses with special training and certification.

MVP hopes you don't experience a serious complicated condition, but if you do, our case managers are here to help you. Case managers work closely with you, your family, your physicians and other members of your health care team. Many times the health care system seems complex and sometimes overwhelming. Your health care team may consist of many providers: multiple doctors, home health care nurses, durable medical equipment suppliers, pharmacists, and physical

and occupational therapists. Case managers are there to help you and your family navigate through the health care system. They can answer many questions about your medical condition and the care you need and will help you and your family understand and maximize your health care benefits. They help coordinate your care by communicating your medical needs with all the various health care professionals of your health care team. And most importantly, case managers are there to lend an ear and give support when you and your family need it most.

If you think you need a case manager to assist you or your family member Case Managers are Registered Nurses with specialty certifications in their area of expertise. To contact them simply call 1-800-777-4793 Ext. 2587, or 1-888-MVP-MBRS if after Hours or a weekend.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, MVP provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment of complications resulting from a mastectomy, including lymphadema. To obtain a detailed description of the mastectomy-related benefits available through MVP, please contact the Member Services department.

Obtaining Information Online About Practitioners Who Participate with MVP

Both New York state and Vermont make information available to consumers who would like to know more about their physicians, with easy online searches.

The New York State Physician Profile Web site (www.nydoctorprofile.com) was created with the passage of the New York Patient Health Information and Quality Improvement Act of 2000. Using this New York Web site, MVP members may find information about the doctor's medical education, translation services at the doctor's office and information about legal actions taken against the doctor. To see all the information that is available for each doctor, search on any doctor's name.

For information about practitioners in Vermont, members may check the Vermont Department of Health Physician Profiles at http://www.healthvermont.gov/hc/med_board/profiles.aspx.

Members can find information about physicians practicing in New Hampshire and Massachusetts at <http://www.docboard.org>. Launched in 1996, the AIM DocFinder is recognized for its easy-to-use search engine. DocFinder contains licensing, background, and disciplinary information of physicians and other health care practitioners in more than thirty states. DocFinder provides a link to the New Hampshire State Board of Medicine (www.state.nh.us/medicine) for information regarding the education, medical license, board certification and specialty of physicians in New Hampshire.

These Web sites offer information free to the public and can be accessed via the Members' Home page of MVP's Web site, www.mvphealthcare.com. If you do not have Internet access and would like to receive a printed report from either of these sites about a specific practitioner, contact the MVP Member Services department toll-free at 1-888-MVP-MBRS (1-888-687-6277).

How MVP Assesses New Technology

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

MVP regularly assesses new technologies, and new applications of existing technologies, for inclusion as covered benefits. The research process includes a review of information from appropriate government regulatory bodies as well as published scientific evidence. Benefit policies are examined by physicians and other health care professionals across MVP's service area, as well as by staff in several MVP departments, to decide whether the technologies will be included as covered benefits. MVP's Quality Improvement Committee gives final approval.

MVP's technology policies are reviewed at least annually, with comprehensive updates triggered more often by changes in published medical evidence. Qualified specialists with expertise relevant to each topic are invited to participate in this process. By carefully considering new technologies before approving them for coverage, MVP assures our members that they are receiving safe, effective and high quality care.

Transition Care

If your practitioner leaves the MVP network, MVP will send you a letter to notify you. If you are undergoing treatment for a life-threatening, disabling, or degenerative condition, you may be able to continue to see that practitioner for covered services for up to 90 days (60 days in New Hampshire) from the effective date of the provider's termination. This also applies if you are in your second or third trimester of pregnancy. You may continue to receive care from your practitioner throughout your pregnancy, delivery and through the completion of your post-partum care.

You cannot do this if the provider was dropped from the MVP network for the following reasons:

- Concern of imminent harm to patients;
- A determination of fraud;
- A final disciplinary action by a state licensing board that impairs the provider's ability to practice.

Except in New Hampshire, transition care also applies when you are a new member. If you are seeing a non-participating provider when you join MVP, you must switch to a participating provider. However, if you have a life-threatening, disabling, or degenerative condition, you may be able to continue to see that practitioner for covered services for 60 days from your date of enrollment. If you are in your second or third trimester of pregnancy, you may stay with your practitioner throughout your pregnancy, delivery and through the completion of your post-partum care. In either situation, the provider must agree to:

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

If the provider will not agree to the above, MVP cannot offer you Transition Care.

Member Complaints, Appeals and Grievances

MVP wants to solve any problems you may have with us fairly and in a friendly manner. Call the Member Services department toll-free at 1-888-MVP-MBRS (1-888-687-6277) if you have a problem with MVP. A Member Services representative can often resolve your problem on the spot. The Member Services department is open seven days a week from 8:00 a.m. to 10:00 p.m. except for holidays. MVP has interpreters if you do not speak English. If you are hearing impaired, TTY users may call a Verizon relay operator at 1-800-662-1220. The relay operator will contact MVP and assist in the call.

If the Member Services representative cannot resolve your problem, you or your representative may file a complaint, appeal or grievance by contacting the Member Appeals department:

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

A complaint is a written or verbal expression of dissatisfaction. Examples of complaints are problems scheduling appointments with providers or timeliness of claim payment issues. An appeal (or grievance) is a request from a member for MVP to change a decision it has made. It may concern whether or not a requested service is a benefit covered by MVP or the way a complaint has been resolved.

First level medical complaints and appeals are handled by a licensed health care professional who is qualified to review the issue at hand. In an appeal (or grievance), the reviewer must not have been involved in making MVP's original decision. If your complaint, appeal or grievance concerns an administrative matter, it will be handled by a member of the senior administrative staff with the necessary education and background to resolve the matter. Second level appeals and grievances are reviewed by the MVP Appeals Committee. MVP will never retaliate or take any discriminatory action against a member should he or she file a complaint or appeal.

If you are covered under a New York or Vermont subscriber contract or Certificate of Coverage and have been denied coverage on the basis of medical necessity or because the service is deemed experimental or investigational, you have the right to request a review by a state-approved external appeal agent. You may obtain an external appeal application by contacting:

- The New York State Department of Insurance at 1-800-400-8882 or its Web site at (www.ins.state.ny.us)
- The New York State Department of Health at 1-518-486-6074 or its Web site at (www.health.state.ny.us)
- MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

If you are covered under a Vermont subscriber contract or Certificate of Coverage you may also contact the Health Care Ombudsman Program. The Office of Health Care Ombudsman is a statewide program operated by Vermont Legal Aid, Inc. Full-time health care counselors staff the program to help Vermont residents resolve problems and complaints with their health insurance. The office is in the Burlington office of Vermont Legal Aid and can be reached by calling toll-free 1-800-917-7787. You may also contact the State of Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) for assistance. You can reach BISHCA's Division of Health Care Administration Consumer Assistance by calling (802) 828-2900 or toll free at 1-800-631-7788.

MVP Policy for Approving Medically Necessary Health Care

MVP supports and encourages the delivery of appropriate health care to our members and through our Utilization Management program, monitors our members' use of health care services to detect and correct potential under- and over-use of health care services.

The MVP Utilization Management program does not provide financial incentives to employees, providers or practitioners who make utilization management decisions that would encourage or create barriers to members getting appropriate health care and services.

Our Utilization Management program follows these principles:

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

Criteria we use to make decisions are available on request.

MVP medical staff comprised of physicians, registered nurses and other health care providers review requests for health care services to determine if the requested service is medically necessary. They use specific clinical review criteria including clinical protocols, practice guidelines and written policies to make these decisions. You and your doctor can get copies of these review criteria by contacting a member services representative toll-free at 1-888-MVP-MBRS (1-888-687-6277) anytime from 8:00 a.m. until 10:00 p.m., seven days a week, excluding holidays. You can also reach a member services representative via our web site, www.mvphealthcare.com at any time.