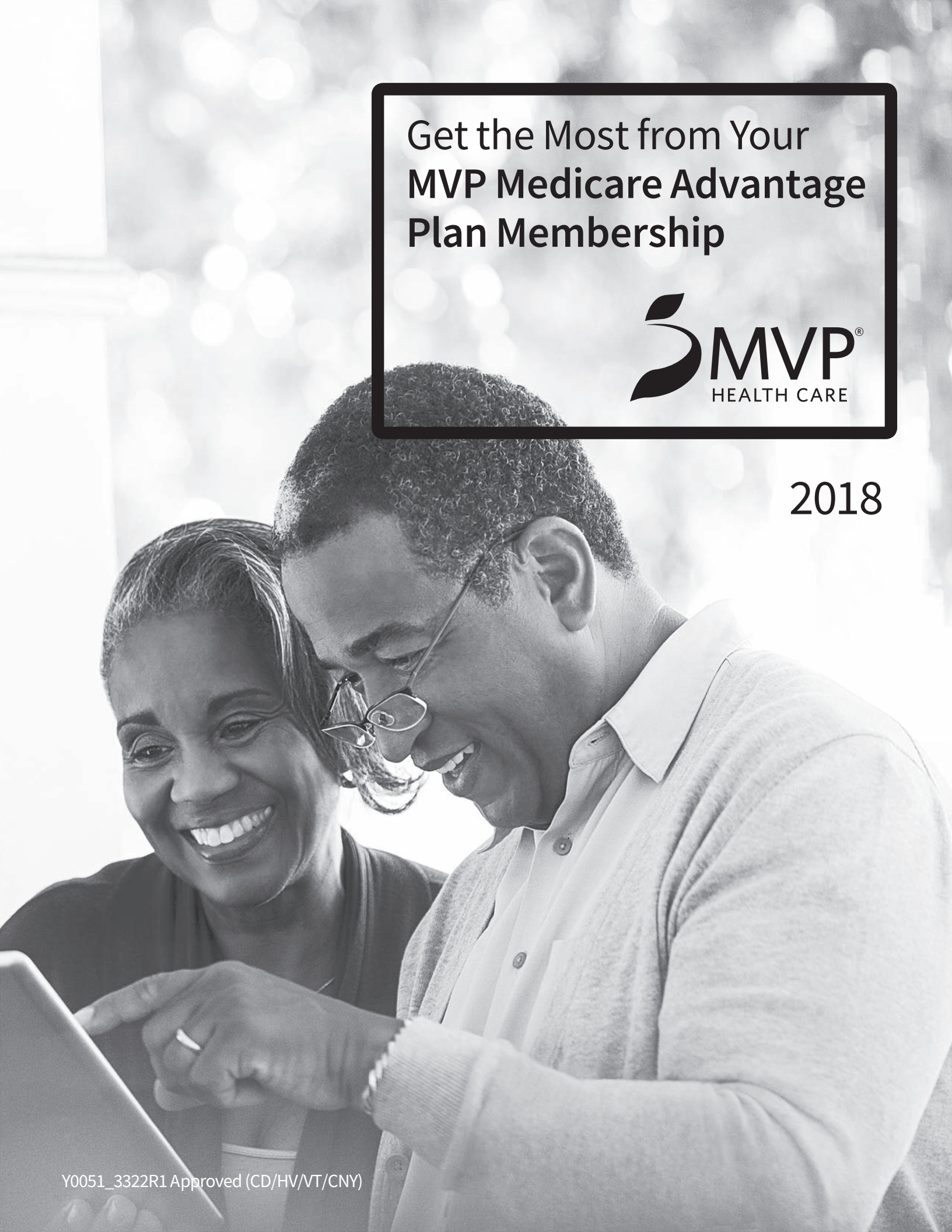


Get the Most from Your **MVP Medicare Advantage Plan Membership**

MVP® HEALTH CARE

2018

Y0051_3322R1 Approved (CD/HV/VT/CNY)

Welcome to MVP Health Care®!

MVP is committed to helping you understand, become involved in, and make the most of your health care coverage.

This handbook includes more information about:

- Your MVP health plan benefits
- The information you receive as a member
- Health and wellness programs

Get the most value from your plan by taking advantage of what MVP offers you.

If you have questions, please call the MVP Medicare Customer Care Center.

1-800-665-7924

Representatives are available Monday–Friday, 8 am–8 pm Eastern Time. From October 1–February 14, call us seven days a week, 8 am–8 pm.

TTY users may call **1-800-662-1220**.

These phone numbers are also listed on the back of your MVP Member ID card.

Each and every member of our plan is important to us. We look forward to helping you make your MVP Medicare Advantage plan work for you.

Thank you for choosing MVP Health Care!

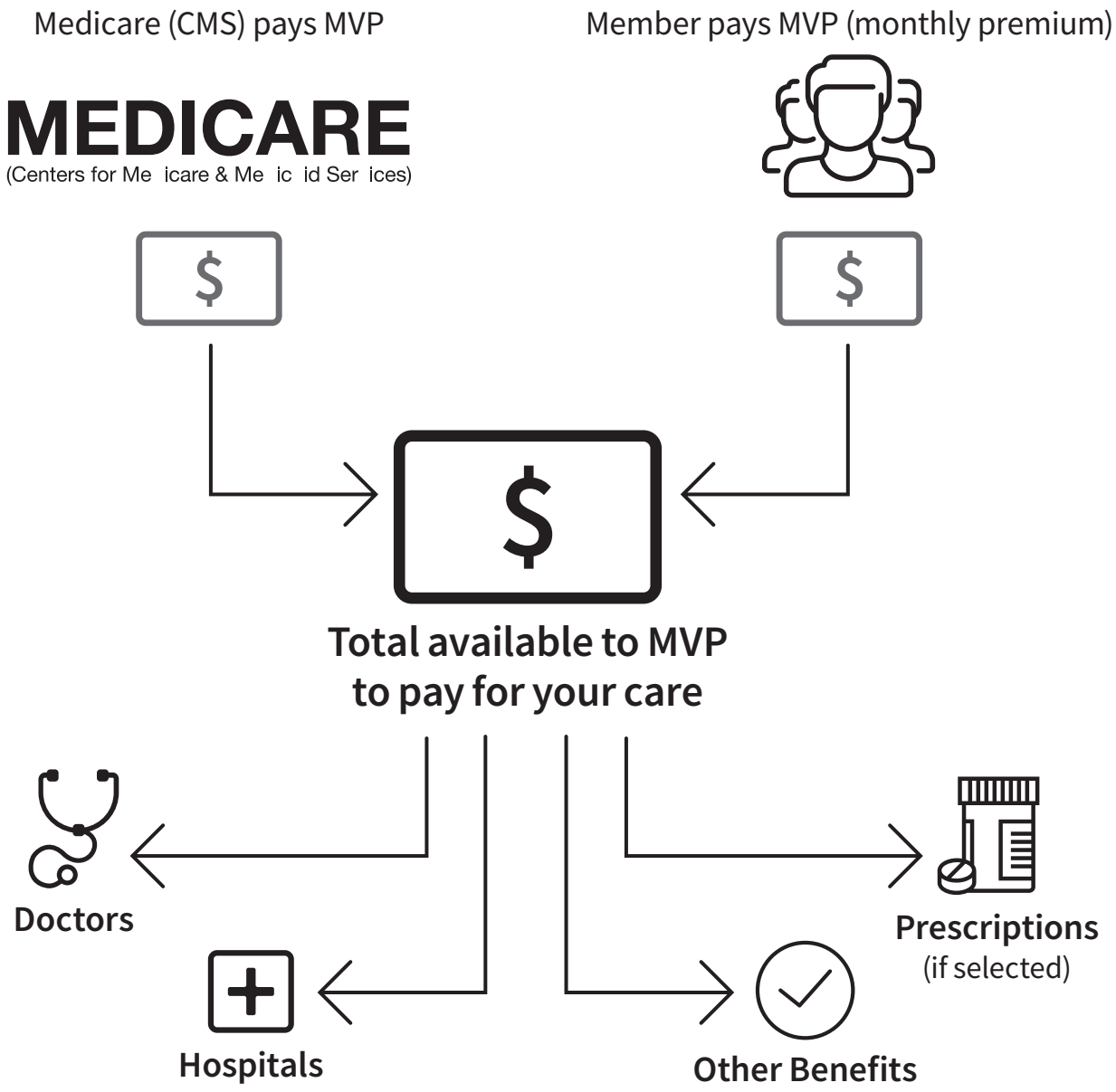
Please note, the information in this booklet may not apply to SmartFund (MSA) plan members.

Get the Most from Your MVP Medicare Advantage Plan Membership

Table of Contents

The Basics About Medicare Advantage Plans

You have joined a Medicare Advantage Plan with MVP. This is how your plan works.



The amount of the monthly plan premium paid by the member depends on which MVP Medicare Advantage plan you select at the time of enrollment and/or the contribution level of your former employer, if any.

You must be enrolled in Medicare Part A and continue to pay your monthly Medicare Part B premium (based on income).

MVP's Medicare Plan Quality Ratings

MVP works hard to give you the highest quality, service, and satisfaction in your health plan. Our dedication shows through our high quality ratings.

MVP's HMO-POS and PPO plans are rated 4.5 out of 5 Stars overall by Medicare

The Medicare star rating is a yearly comprehensive measure of health plans across the country. It is an impartial way to compare Medicare health plans on quality, service, and member satisfaction. Plans are rated on a scale of 1 to 5 stars, with 5 stars awarded for the highest rating.

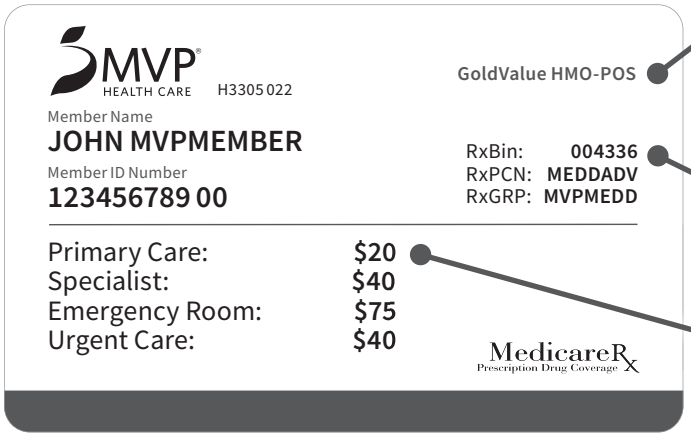
When rating plans, Medicare evaluates many things, such as:

- Member satisfaction with MVP and their doctors
- Customer service
- How we help members with screenings, tests, wellness programs, and more
- The care members receive for chronic (long-term) health conditions
- Patient safety such as helping members use recommended and safe prescription medications

MVP's Medicare Advantage plans are ranked 2018 "Best Medicare Plans" by U.S. News & World Report

Considered a global authority in health care rankings, U.S. News & World Report recognized our 2018 Medicare Advantage plans as "Best Medicare Plans", based on our consistently high ratings from the Centers for Medicare & Medicaid Services.

Get to Know Your MVP Member ID Card



Plan Type
You are a member of the plan named here. Use your plan type to search for providers using the *Find a Doctor* tool at **mvphealthcare.com**.

Pharmacy Info
This is information to be used by a pharmacist.

Costs
Your co-pays for services. If you have a PPO plan, there will be a second column labeled "**OUT-OF-NETWORK**" that lists what you pay to doctors or facilities that do not contract with MVP.

Important!
Here you'll find our web address and the MVP Medicare Customer Care Center phone number.

Member Info
Helpful contact information for members is included on the top half of the card.

Provider Info
Important contact information for providers.

- Check your Member ID card to make sure your information is correct.
- Carry your Member ID card with you and show it at the doctor or pharmacy. Make sure all of your doctors have your updated ID card on file.
- **Do not use your red, white, and blue Medicare card.** Keep it in a safe place.
- If you are getting diabetic supplies, show your Member ID card to the pharmacist or durable medical equipment supplier.
- If your Member ID card is lost, call the MVP Medicare Customer Care Center to request a new one.

Along with your Member ID card, you also received a quick reference of the benefits and services available as part of your MVP Medicare Advantage plan. Keep this handy for easy reference.

Note: If your plan includes additional dental coverage, you will also receive a separate DenteMax membership card with information about your dental benefit. Refer to your Evidence of Coverage (your contract) or plan Riders for more information.

Read Your Mail From MVP

MVP is required to send you certain documents explaining your benefits and coverage. Some of these documents are written in standard language that we are not allowed to change.

Be informed and knowledgeable about your health care by reading the MVP information you receive and keep important plan documents in a handy place for reference.

The Member Guide

This booklet includes:

- Your Evidence of Coverage (your contract)—detailed information about what your plan covers, what is not covered, and how to use your benefits.
- Benefit highlights information with more details about additional benefits offered as part of your health plan.
- Useful benefit forms.

We send you a Member Guide when you first join an MVP plan or if you choose a different MVP plan during the Annual Enrollment Period.

The Annual Notice of Change (ANOC)

This is a summary of plan changes for the upcoming year sent to all Medicare plan members. We send you the ANOC every September.

Monthly Medical and Hospital Claims and Prescription Drug* Summaries

These are summaries of the medical services or prescription drugs you have received. **These are not bills.** Please review your monthly summaries to be sure we are being billed only for the services you received. If you see any errors, call the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY: **1-800-662-1220**). You will receive a monthly summary when you fill a prescription or visit the doctor.

You will also receive:

Living Well Newsletter

The newsletter for MVP Medicare Advantage members contains useful membership, benefit, and wellness information to help you take on life and live well. We send you a newsletter four times a year.

MVP Member Surveys

MVP is committed to providing you with the best quality health care services possible. Your feedback and ideas help us to serve you better.

CVS ExtraCare® Card*

With the CVS ExtraCare Card, enjoy a 20% discount on thousands of over-the-counter, regularly priced CVS Pharmacy Brand® health-related items to help you manage your health.

Other Mailings

You may receive premium bills, decisions about coverage for medically-necessary services or prescriptions, or information from MVP or one of our trusted partners about additional programs and services available to you.

If you need help understanding any of the information we send to you, call the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY: **1-800-662-1220**).

*This item is sent to you if you have chosen an MVP Medicare Advantage plan with Part D prescription drug coverage.

Referrals and Prior Authorization

No Referrals! With all of MVP's Medicare Advantage plans, you do not need a referral to see a specialist. If you need to see a specialist, call the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY: **1-800-662-1220**) to find a provider who contracts with MVP. Or visit **mvphealthcare.com** and select *Find a Doctor* to search for providers in the MVP network.

What is Prior Authorization?

Prior authorization is a process in which MVP works with you and your doctors to make sure you receive medically-necessary, high-quality medical treatment at a reasonable cost.

Some services require prior authorization by MVP regardless of whether these services are given by MVP contracted or non-contracted providers.

Some examples of services needing prior authorization include:

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

Most often, your doctor will begin the process and request prior authorization whenever it is needed.

Part D Prescription Drug Coverage

For Members Who Chose an MVP Medicare Advantage Plan With Part D

Use the Formulary to find out if a prescription drug is covered, how much you will pay, how to order refills, and more.

MVP covers many commonly used generic drugs for low or no cost. Tier 1 of the Formulary, Preferred Generic Drugs, includes select drugs to treat diabetes, blood pressure, bone health, and high cholesterol. Talk to your doctor if these drugs may be right for you.

For safety reasons and/or cost savings, some drugs may have additional requirements or limits on coverage, including prior authorization, quantity limits, or step therapy requirements. Refer to the "Abbreviations and Definitions of Formulary Terms" section of the Formulary and talk to you doctor if a drug you take has any of these restrictions.

Some drugs and medical supplies are covered under the Part B, or medical, portion of your health plan coverage. Examples of Part B drugs and supplies include the flu shot, pneumonia vaccine, diabetic testing supplies, and oral chemotherapy drugs. What you pay for Part B drugs and supplies counts toward your plan's maximum out-of-pocket protection, which is the most you will pay during the calendar year for covered medical services. Other drugs may be covered under either the Part B or Part D benefit, depending on certain criteria. Refer to your Evidence of Coverage (contract) or Formulary for more information.

Medicare does not allow MVP to pay for certain prescription drugs, including drugs used for weight loss, cough and colds, erectile dysfunction, most vitamins, and drugs purchased outside of the U.S.

How MVP's Part D Benefit Works

The Part D prescription drug benefit has different payment stages. What you pay for your prescriptions depends on the payment stage you are in when a prescription is filled, as described on page 7. You will move through these stages as you fill prescriptions during the year.

Note: What you pay during these payment stages will vary based on the plan you choose and if you qualify for Low Income Subsidy or Extra Help, have EPIC or VPharm, or if your coverage is through a former employer or union group.

Prescription Drug Benefit Payment Stages and What You Pay

Stage 1: Yearly Deductible

This payment stage applies to BasiCare with Part D (PPO) plan members only.

You will pay a $2 co-pay for drugs on Tier 1, $11 for drugs on Tier 2, and the full cost of drugs on Tiers 3–5 until you reach the deductible amount.

Stage 2: Initial Coverage

Most MVP Medicare plan members start the year in this payment stage.

You pay your tier co-pay or co-insurance for covered prescription drugs. MVP also pays a portion of your drug costs in this stage. When the total of what you and MVP both pay reaches $3,750 in 2018, you move to the next payment stage.

Stage 3: Coverage Gap

You pay 44% of the cost of generic drugs and 35% of the cost of brand name drugs. For plans without a deductible, Tier 1 drugs will continue to be the same cost in the Coverage Gap Stage. When your total out-of-pocket costs reach $5,000 in 2018, you move to the next payment stage.

Stage 4: Catastrophic Coverage

During this payment stage, MVP pays most of the cost for your covered drugs. You pay the greater of $3.35 for generic drugs, $8.35 for brand-name drugs, or 5% co-insurance. You will remain in this payment stage for the rest of the calendar year.

A Warning About Medicare Rules

MVP offers the convenience of both medical coverage and Part D coverage together in one Medicare Advantage plan! **Do not enroll in a Part D drug plan from another insurance company or pharmacy company.** Medicare allows you to be a member of only one Medicare Advantage plan at a time. If you try to join a separate Part D plan, Medicare will:

1) Automatically disenroll you out of your MVP plan, *and*
2) Enroll you in that drug plan for your Part D drug coverage.
3) Enroll you into Original Medicare (Parts A and B only) for your medical coverage for the remainder of the year, along with the other drug plan you chose.

Filling Your Prescriptions

CVS Caremark is MVP's pharmacy benefits manager and mail order pharmacy vendor. If you have questions about your prescription drug coverage, call CVS Caremark Customer Care at **1-866-494-8829** (TTY: **711**) 24 hours a day, seven days a week.

You must fill your prescriptions at a pharmacy that is contracted with MVP. You do **not** have to go to a CVS Pharmacy. Show your Member ID card every time you go to the pharmacy. Prescriptions filled at a pharmacy that is not contracted with MVP are covered only in certain situations.

Your Medicare Part D coverage with MVP offers a **mail order program through CVS Caremark Mail Service Pharmacy.** Using this mail order service, you can save money on drugs in Tiers 1–3 of the Formulary that you take regularly—you receive a three-month supply of your prescriptions for two monthly co-pays (for example, if your co-pay for a 30-day supply is $10, you will receive a 90-day supply by mail for $20). Shipping is free!

Not all drugs are available by mail order. Check the Formulary to see how your drug is covered.

Note: BasiCare with Part D (PPO) members will continue to pay 100% of the cost for drugs on Tier 3 ordered through mail order until the deductible is reached.

Your medication will usually arrive within 7–14 days after CVS Caremark receives your prescription. Per Medicare rules, you will need to give CVS Caremark authorization before they will mail your medication if you have not used mail order in the past.

For your convenience, many retail pharmacies in MVP's network will fill a 90-day supply of medications, including major chains. You will still pay three full co-pays for prescriptions filled at a retail pharmacy.

Each month that you fill a prescription, you will receive a Prescription Drug Summary statement. We are required to send you this statement to show how much you have spent on your drugs and what payment stage you are in.

Programs That May Help Save You Money on Part D

Low Income Subsidy (LIS) (or "Extra Help")

This subsidy may help reduce your monthly prescription drug premium and drug co-pays. To see if you qualify for Extra Help, call:

- **1-800-MEDICARE** (**1-800-633-4227** or TTY: **1-877-486-2048**), 24 hours a day, seven days a week
- the Social Security Office at **1-800-772-1213**, 7 am–7 pm, Monday–Friday (TTY: **1-800-325-0778**).

You can also call your state Medicaid office.

State Pharmaceutical Assistance Programs

These programs may help pay for prescription drug coverage. To see if you are eligible:

- In New York State call the EPIC (Elderly Pharmaceutical Insurance Coverage) program at **1-800-332-3742**.
- In Vermont, call VPharm at **1-800-250-8427**.

We've Got You Covered!

Emergency Room and Urgently Needed Care Anywhere In the World

MVP covers you anywhere in the world for emergency room and urgently needed care. When seen in an emergency room or urgent care facility in the U.S., you simply pay your co-pay. When traveling outside of the U.S., you may need to pay upfront for the services and submit your bills to MVP when you return home. In the end, you are still only responsible for your emergency room or urgently needed care co-pay.

Follow up with your doctor at home as soon as possible after an emergency or urgent care situation to coordinate any further care you may need.

Other Out-of-Network Coverage (Non-Emergency Care From a Provider Who Does Not Contract With MVP)

With all of MVP's Medicare Advantage plans, you are able to choose doctors anywhere in the U.S. who may or may not have a contract with MVP for services such as allergy shots, physical therapy, or maintenance lab work. You may pay more for care received from providers who do not have a contract with MVP.

HMO-POS Plans

Your out-of-network coverage is capped. You pay 30% and MVP pays 70% up to a $2,500 maximum if you receive care from a provider who does not contract with MVP. Once what MVP pays reaches $2,500, you are responsible for all out-of-network service costs. There are some restrictions—all services are not covered from non-contracted providers.

PPO Plans

Your out-of-network coverage is not capped. You pay your out-of-network co-pay or co-insurance if you receive care from a provider who does not contract with MVP.

Prior authorization rules are the same for HMO-POS and PPO plans.

Show your MVP Member ID card whenever and wherever you receive medical services!

Maximum Out-of-Pocket Protection

MVP Medicare Advantage plans include a limit on how much you will pay out-of-pocket during the calendar year for covered medical services. **This is for your protection**—if you meet the maximum amount, MVP pays in full for covered medical services for the rest of the year.

What you spend on Part D prescription drugs, eyewear, dental, and acupuncture does not count toward your out-of-pocket maximum.

In-Patient Hospital Coverage

If you are admitted to the hospital, your in-patient hospital co-pay covers all the services you receive during your stay, including lab work and diagnostic services such as CT or MRI scans. Also, if you move through different levels of care while at the hospital, you will pay only one co-pay based on the last place of service. For example, if you visit the emergency room, stay for a day in observation, and then are admitted as an in-patient to the hospital, you are only responsible for your in-patient co-pay.

Hearing Aid, Eyewear, and Dental Coverage

Some MVP Medicare Advantage plans offer coverage for hearing aids, eyewear, and dental services. Refer to your Evidence of Coverage (your contract) and plan Riders for information about your plan's benefits.

TruHearing® Hearing Aid Benefit

MVP Medicare Advantage plans provide coverage for high-quality, high-tech hearing aids at an affordable cost, with savings up to 60% off the average retail price. Coverage also includes follow-up visits for programming, fitting, and adjustments.

Your hearing aid benefit is offered through TruHearing. To use your benefit, call TruHearing at **1-855-542-1710** (TTY: **1-800-975-2674**), Monday–Friday, 8 am–8 pm. A TruHearing representative will verify your coverage and help you set up an appointment with a provider in your area.

If your coverage is offered through a former employer, and includes a hearing aid allowance, you can use your allowance toward the already discounted TruHearing price or any other hearing aid. Refer to your plan Rider for more information.

Plans that Include Eyewear Coverage

You can go to any eyewear provider with a prescription from your doctor for new glasses or contacts.

You may have to pay the full cost of your glasses or contacts upfront. Download the *Routine Eye Glasses/Contact Lens Reimbursement Form,* available by visiting **mvphealthcare.com** and selecting *Members*, then *Medicare member*, and then *Forms/Resources,* or calling the MVP Medicare Customer Care Center. Send us the completed form and your receipts for reimbursement up to the amount covered by your benefit.

If the cost of your glasses or contacts is more than the amount covered by your benefit, you are responsible for the additional cost.

Plans that Include Dental Coverage

Some MVP Medicare Advantage plans offer dental coverage, including preventive services like exams, cleanings, periodontal maintenance, and x-rays. If your plan offers dental coverage, you will receive a separate dental ID card. Show this card when you receive dental services.

Under your MVP dental benefit, you have access to the DenteMax network of dentists or you can choose to go to any dentist.

Generally, your costs will be lower if you go to a DenteMax dentist. DenteMax dentists have agreed to accept a fixed amount for all of the services they provide as payment in full.

If you choose to go to a dentist who is not a DenteMax dentist, you may pay more. The dentist can bill you for additional costs if what they charge is more than the fixed amount covered by the plan. You may also have to pay the full cost of your dental services upfront. Download the *Dental Claim Form* by visiting **mvphealthcare.com** and selecting *Members*, then *Medicare member*, and then *Forms/Resources,* or calling the MVP Medicare Customer Care Center. Send us the completed form and your receipts for reimbursement up to the amount covered by your benefit.

You can also see a DenteMax dentist for additional services that are not covered by your MVP benefit, for a lower cost than other dentists may charge.

Get the Most from Your MVP Membership

MVP considers ourselves your partner in health. Our Medicare Advantage plans offer many ways to help you maintain and improve your health:

- Start by scheduling a **Welcome to Medicare** or **Annual Wellness Visit** with your Primary Care Physician (PCP). This is your time to talk with your doctor about your overall health, the medications you take, and important topics like physical activity and fall risk.
- Be sure to talk to your doctor about preventive screenings that are covered in full, like mammograms, prostate exams, immunizations, and bone density measurement.

Take advantage of MVP wellness resources to be fit, well, and independent.

SilverSneakers® Fitness Program

SilverSneakers features a gym membership, basic fitness center amenities, and fitness classes available at thousands of locations across the country.

Wellness Rewards

An incentive program where you can earn a $75 gift card by working with your doctor to receive important screenings and preventive services.

myVisitNow℠*

Connect with a doctor 24/7 by video using a computer, tablet, or smartphone. Get help with an urgent, non-emergency health issue at **myvisitnow.com** or via the **myVisitNow** mobile app. Download the free **myVisitNow** mobile app on the App Store® or Google Play™ (MSG&DATA rates may apply).

Medication Therapy Management Program

Speak with an MVP pharmacist over the phone about the medications and any supplements you take, drug safety, and possible lower-cost alternatives.

Living Well Health Education Classes and Physical Activity Programs

Classes and programs designed to empower and motivate the individuals we serve to live healthy and vibrant lives. Classes are free or discounted for MVP members.

MVP/Matrix Medical Network In-Home Health Visit

Meet with a nurse practitioner for a comprehensive, convenient health evaluation. This visit is not meant to replace your regular doctor visits. Your home visit enhances your overall health care to help you feel more informed and in charge of your health.

Health/Care Management Programs

These programs include education and training, personalized mailings, and health coaching to support members living with a serious condition make healthy lifestyle changes and better manage their condition.

24/7 Nurse Advice Line

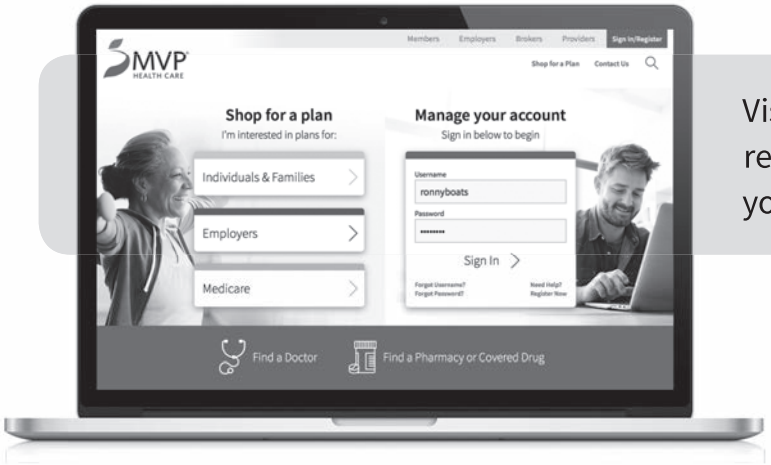
Speak to a nurse who can help you (especially when your doctor's office is closed) with issues such as a "what do I do if" health questions, information about prevention and wellness, treatments, chronic conditions, and other health topics or concerns. You can also listen to selections from an audio library of more than 400 prerecorded messages on general health topics.

Phone Call Reminders

Reminders for important tests to help you manage an ongoing condition, like diabetes or osteoporosis, or to visit your doctor for a preventive screening.

*__myVisitNow__ from MVP Health Care is powered by American Well. Regulatory restrictions may apply.

Online Member Resources



Visit **mvphealthcare.com** for additional resources and benefit information to help you manage your health plan at any time!

Manage Your Account

Sign In/Register for an online account to access information specific to your health plan—check your claims status and history, view your benefit details, access personalized pharmacy information, or order a replacement Member ID card. All you need to get started is your MVP Member ID number and a valid email address.

Make an Online Payment

If you pay MVP directly for your health plan, pay your bill online each month or set up automatic recurring payments. Choose to go paperless and receive an email notification when your monthly invoice is ready to view instead of getting a paper invoice in the mail. *Sign In* to your online account and select *Payment Center* to get started.

Find a Doctor

Use the search tool to find the most current listing of doctors and facilities that contract with MVP. Select *Find a Doctor*.

Medicare Plan Information

Find details about the benefits and services available to you as an MVP Medicare member, including Part D prescription drug coverage, health and wellness program, and useful forms and publications. Select *Members*, then *Medicare member* to get started.

myMVP Mobile App

Access your health plan information anywhere with **myMVP** mobile app. Using **myMVP**, you'll always have fast and free access to your health plan information whenever you need it.

- Find a Doctor or Facility
- View ID Cards
- Search Claims
- Review Deductibles & Limits
- View Member Details
- Contact MVP

Visit the App Store® or Google Play™ to download myMVP for free onto your iPhone® or Android™ mobile device. MSG and data rates may apply.

The Medicare Annual Enrollment Period

Medicare allows you to change plans only at certain times of the year or under certain circumstances.

Every fall you have the opportunity to review your Medicare health plan coverage. You can either keep the same plan or change to a different plan that better meets your needs.

The Annual Enrollment Period runs **October 15–December 7** each year to begin your coverage on January 1 for the upcoming calendar year.

You should review the Annual Notice of Change (ANOC) document we send to you that explains the changes to your plan for the next year. Please note that this document is written in standard language that we are not allowed to change. Call the MVP Medicare Customer Care Center at the number on the back of your Member ID card if you need help understanding this information.

- If you decide to keep you current plan, you don't need to do anything. If you don't make a change by December 7, you will automatically stay enrolled in your current plan for the next year.
- If you're thinking about changing plans, you always have choices with MVP. Call the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY: **1-800-662-1220**) to help you understand your choices and answer your questions.

The MVP Medicare Customer Care Center is Here to Help!

Call the MVP Medicare Customer Care Center team and speak to a real person dedicated to MVP Medicare members:

1-800-665-7924

Representatives are available to assist you Monday–Friday, 8 am–8 pm Eastern Time. October 1–February 14, call us seven days a week, 8 am–8 pm.

TTY users should call **1-800-662-1220**.

These numbers are also listed on the back of your Member ID card.

If you would like to allow someone else to speak with or receive information from MVP about your health plan:

- Complete an *Authorization to Disclose Information (ADI)* form. You can name a representative, what health information you would like us to share, and how long you want us to be able to share your information with that person. You can request a copy of an ADI form by calling the MVP Medicare Customer Care Center or download the form by visiting **mvphealthcare.com** and selecting *Members*, then *Medicare member,* and then *Forms/ Resources*.
- Let us know if you have named a Power of Attorney (POA), giving someone else the legal right to act on your behalf. Unlike the ADI, your POA can make changes for you, such as updating your mailing address, enrolling you in a different MVP plan during the Annual Enrollment Period, or filing an appeal on your behalf. Send a copy of the legal Power of Attorney document to: Attn: Customer Care Center, MVP Health Care, 220 Alexander Street, Rochester, NY 14607.

Medicare Advantage Glossary of Terms

These commonly used terms are important to know as a member of a Medicare Advantage plan. Additional terms and definitions can be found in your Evidence of Coverage (your contract).

Allowed Amount

The maximum billed amount that is payable by MVP for covered services.

Annual Enrollment Period

A set period of time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal

A process if you disagree with our decision to deny a request for coverage of health care services or prescription drugs, or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item or service you think you should be able to receive.

Balance Billing

A situation in which a provider (such as a doctor or hospital) bills a member more than the member's co-payment or co-insurance amount for services.

Benefit Period

The way that MVP and Original Medicare measure your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS)

The Federal agency that runs the Medicare program.

Co-insurance

An amount you may be required to pay as your share of the cost for services, after you pay any deductibles. Co-insurance is usually a percentage (for example, 30% for out of area services such as allergy shots).

Co-payment

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit or prescription. A co-payment is a set amount, rather than a percentage. For example, you might pay $20 for a doctor's visit.

Cost-Sharing Tier

Every drug on the Formulary (list of covered drugs) is in one of five cost-sharing Tiers, which tells what the drug costs you.

Coverage Determination

A decision the health plan makes about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage.

Covered Drugs

The prescription drugs covered by the plan you are in.

Creditable Prescription Drug Coverage

Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible

An amount you may pay for health care or prescriptions before a plan begins to pay.

Durable Medical Equipment

Certain medical equipment that is ordered by your doctor. Examples are walkers, wheelchairs, or hospital beds.

Emergency

A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that your health is in serious danger and every second counts, with severe pain, a bad injury, a serious illness, or medical condition that is quickly getting much worse. Emergency care is covered worldwide.

Evidence of Coverage (EOC)–Your Contract

This document, along with your enrollment form and any other attachments or riders, explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help
(also called "Low Income Subsidy (LIS)")

A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and co-pays.

Formulary

A list of Medicare-approved prescription drugs covered by the plan. This is where you find what cost-sharing Tier your drugs are in and how much you will pay. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Grievance

A type of complaint you are able to make about MVP or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not apply to coverage or payment disputes.

Hospital Inpatient Stay

A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Late Enrollment Penalty

An amount added by Medicare to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

Maximum Out-of-Pocket (MOOP)
Amount for Medical Services

The most that you pay during the calendar year for covered Medicare Part A and Part B services. Once you reach the maximum amount, MVP pays in full for covered services for the rest of the calendar year.

Medically Necessary

Services or supplies that are needed for the diagnosis or treatment of your medical condition and that meet accepted standards of medical practice.

Medicare (also "Original Medicare" or "Traditional Medicare" or "Fee-for-Service Medicare" or "Basic Medicare")

The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities and people with End-Stage Renal Disease. Original Medicare has two parts: Part A (Hospital insurance) and Part B (Medical Insurance).

Medicare-Covered Services

Services covered by Medicare Part A and Part B. All Medicare health plans, including MVP Medicare Advantage plans, must cover all of the services that are covered by Medicare Part A and B.

Medicare Part A

If you are entitled to Part A, Part A helps cover basic hospitalization for no monthly premium but you may still have to pay out-of-pocket costs for some services, including a deductible.

Medicare Part B

Part B helps cover medical services such as visits to a doctor's office and outpatient care. Some services will require that you pay a percentage of the cost in addition to a yearly deductible. You pay a monthly premium, based on income, for Part B, which is usually deducted directly from your Social Security check.

Medicare Part C

Part C is a special kind of Medicare choice called a Medicare Advantage plan (GoldValue with Part D HMO-POS from MVP is one example). It is administered by private health insurance companies and may include all the benefits of Parts A and B, plus more. You usually pay a monthly premium to the health insurance company for a Part C plan, and continue to pay your Part B premium that is usually deducted from your Social Security check each month.

Medicare Part D-Medicare Prescription Drug Coverage

There is generally a monthly premium for Part D coverage. There are different drug plan options—including adding it to your Medicare Part C plan for one monthly premium. Based on income, you may pay a Part D surcharge to Medicare, which is usually deducted from your Social Security check. If you are low income or on both Medicare and Medicaid, you may be eligible for extra help with Part D drug coverage. If you don't join Part D when you first become eligible, or do not have prescription drug coverage as good as Medicare's, you may have to pay a penalty if you join at a later date.

Network

A group of medical professionals, hospitals, and other facilities who contract with a health plan to provide your care.

Network Pharmacy

A pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Observation Stay

A hospital stay in which an individual receives care to help determine whether he or she should be formally admitted to the hospital for skilled medical services as an inpatient or should be discharged. Observation stays may occur when patients go to the emergency room and have symptoms that need to be monitored.

Organization Determination

A decision the health plan makes about whether items or services are covered or how much you have to pay for covered items or services. MVP's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service.

Premium

What you pay, usually monthly, for health and/or prescription drug coverage.

Point of Service (POS) Benefit

The Point of Service (POS) (out-of-network) limited benefit that comes with MVP's HMO plans covers some medically necessary services you get from providers who are not contracted with MVP.

Preferred Provider Organization (PPO) Plan

A Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from in-network (contracted) or out-of-network (non-contracted) providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on member out-of-pocket costs for services

received from in-network providers and a higher limit on member total combined out-of-pocket costs for services from both in-network and out-of-network providers.

Prior Authorization

Approval in advance to get some medical services or certain drugs that may or may not be on MVP's Formulary. These services or drugs are covered only if your doctor or other contracted provider gets "prior authorization" from the plan. Covered drugs that need prior authorization are indicated in the Formulary.

Service Area

A geographic area where a health plan accepts members based on where people live. You may be disenrolled you if you move out of the plan's service area.

Special Enrollment Period

A time period when members can change health or drug plans or return to Original Medicare based on situations in which you may be eligible. Special Enrollment Periods include: moving outside the service area, getting "Extra Help" with your prescription drug costs, moving into a nursing home, or if the plan violates the contract with you.

Urgently Needed Care

Care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care, such as sprains, strains, minor cuts or burns ,or the flu. Urgently needed care is covered worldwide.

MVP's Medicare Customer Care Center

1-800-665-7924

Monday–Friday, 8 am–8 pm Eastern Time
From October 1–February 14, call us seven days a week, 8 am–8 pm
TTY **1-800-662-1220**

mvphealthcare.com

MVP® HEALTH CARE

MVP Health Plan, Inc. is an HMO-POS/PPO/MSA organization with a Medicare contract. Enrollment in MVP Health Plan depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. Benefits, premiums, and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Medicare evaluates plans based on a 5-star rating system. Star Ratings are calculated each year and may change from one year to the next.

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