

MVP Health Care

<http://www.mvphealthcare.com>



2007

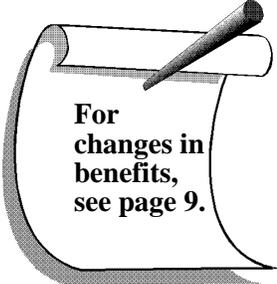
A Health Maintenance Organization

Serving: Upstate New York

Enrollment in this plan is limited. See page 7 for requirements.

Special Notice

We are offering Standard Option coverage under the Federal Employees Health Benefits Program for the first time during the 2006 Open Season.



For changes in benefits, see page 9.



This Plan has "Excellent" accreditation from the NCQA. See the 2007 Guide for more information on NCQA

Enrollment codes for this plan:

Eastern Region

High Option – GA1 Self Only
High Option – GA2 Self and Family
Standard Option – GA4 Self
Standard Option – GA5 Self and Family

Mid-Hudson Region

High Option – MX1 Self
High Option – MX2 Self and Family
Standard Option – MX4 Self Only
Standard Option – MX5 Self and Family

Central Region

High Option – M91 Self Only
High Option – M92 Self and Family
Standard Option – M94 Self Only
Standard Option – M95 Self and Family

Vermont Region

High Option – VW1 Self Only
High Option – VW2 Self and Family
Standard Option – VW4 Self Only
Standard Option – VW5 Self and Family

Authorized for distribution by the:



United States
Office of Personnel Management
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

Important Notice from MVP Health Care About

Our Prescription Drug Coverage and Medicare

OPM has determined that the MVP Health Care's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D..

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Table of Contents

Table of Contents	1
Introduction	3
Plain Language.....	3
Stop Health Care Fraud!	3
Preventing medical mistakes.....	4
Section 1 Facts about this HMO plan	7
General features of our High and Standard Options	7
How we pay providers.....	7
Your rights.....	7
Service Area	7
Section 2 How we change for 2007	9
Section 3. How you get care	10
Identification cards	10
Where you get covered care	10
• Plan providers	10
• Plan facilities.....	10
What you must do to get covered care	10
• Primary care	10
• Specialty care	10
• Hospital care	11
If you are hospitalized when your enrollment begins	11
Circumstances beyond our control.....	11
Services requiring our prior approval.....	11
Section 4 Your costs for covered services	13
Copayments.....	13
Deductible	13
Coinsurance.....	13
Your catastrophic protection out-of-pocket maximum	13
Section 5 High and Standard Option Benefits	14
Non-FEHB benefits available to Plan members	46
Section 6 General exclusions – things we don’t cover	47
Section 7 Filing a claim for covered services	48
Section 8 The disputed claims process	49
Section 9 Coordinating benefits with other coverage	51
When you have other health coverage	51
What is Medicare?.....	51
Should I enroll in Medicare?.....	51
The Original Medicare Plan (Part A or Part B).....	52
Medicare Advantage (Part C).....	52
Medicare prescription drug coverage (Part D).....	53
TRICARE and CHAMPVA	59
Workers’ Compensation.....	59
Medicaid.....	59
When other Government agencies are responsible for your care.....	59
When others are responsible for injuries.....	59
Section 10 Definitions of terms we use in this brochure	56

Section 11 FEHB Facts	57
Coverage information.....	57
No pre-existing condition limitation	57
Where you can get information about enrolling in the FEHB Program.....	57
Types of coverage available for you and your family.....	57
Children’s Equity Act.....	57
When benefits and premiums start	58
When you retire	58
When you lose benefits	59
When FEHB coverage ends	59
Upon divorce	59
Temporary Continuation of Coverage (TCC)	60
Converting to individual coverage	60
Getting a Certificate of Group Health Plan Coverage.....	60
Section 12 Three Federal Programs complement FEHB benefits	60
Index.....	64
Summary of Benefits for the High Option of MVP Health Care - 2007	65
2007 Rate Information for MVP Health Care.....	67

Introduction

This brochure describes the benefits of under our contract (CS 2362) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for MVP Health Care's administrative offices is:

MVP Health Care

625 State Street

Schenectady, NY 12305

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2007 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language 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 Care.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States 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 the structure of this brochure, let OPM know. Visit OPM's “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium. OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); o
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That’s about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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 pay only the copayments and coinsurance described in this brochure.

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.

General features of our High and Standard Options

We will offer both High Option coverage and Standard Option coverage for 2007. These two options of coverage provide you with a choice between lower premiums with higher out-of-pocket costs or higher premiums with lower out-of-pocket costs. The High Option coverage offers lower physician office visit and inpatient hospital copays. The Standard Option coverage provides lower premiums with higher office visit and inpatient hospital copays. Provider networks are identical for both options of coverage.

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.

Your rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (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 Care is licensed in the States of New York and Vermont to operate as an HMO.
- MVP Health Care has been in operation since 1983.
- MVP Health Care is a not-for-profit, federally qualified HMO, and has Excellent NCQA accreditation.

If you want more information about us, call 1-888-687-6277, or write to MVP Health Care, 625 State Street, Schenectady, NY 12305. You may also contact us by fax at 518-386-7700 or visit our Web site at www.mvphhealthcare.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: The New York counties of Albany, Fulton, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

Central Region: The New York counties of Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, and Tioga.

Mid-Hudson Region: The New York counties of Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan and Ulster.

Vermont: 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 out of our service area unless the services have prior plan approval.

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

Section 2 How we change for 2007

Do not rely on these change descriptions; this Section 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.

Changes to the High Option Coverage

- MVP Health Care will offer High option and Standard option coverage for 2007. If you are currently in the High Option coverage, you will remain in the High Option plan unless you make an Open Season enrollment change.
- If you are in enrollment code GA, your share of the non-Postal High Option premium will increase by 6% for Self Only and 13.5% for Self and Family.
- If you are in enrollment code M9, your share of the non-Postal High Option premium will increase by 3.8% for Self Only and 8.4% for Self and Family.
- If you are in enrollment code MX, your share of the non-Postal premium will increase by 18.6% for Self Only and 23% for Self and Family.
- If you are in enrollment code VW, your share of the non-Postal premium will decrease by 10.2% for Self Only and 8.8% for Self and Family.
- The copay for preventive dental care for children under the age of 19 will increase from \$10 to \$25 per office visit. See page 43 in Section 5(h) Dental Benefits.
- Your coinsurance for durable medical equipment will increase from 20% to 50%. See page 22.
- The number of days of skilled nursing facility care benefits will increase from 45 to 60 days per member per calendar year. See page 33.
- The facility copay for outpatient surgery at a hospital or ambulatory surgery center will be \$75. Previously, you paid the lesser of \$100 or 20%. See page 32.
- You pay \$20 for outpatient diagnostic radiology services at participating freestanding radiology centers. See page 16.
- The copay for diabetic insulin and supplies will be \$20 per item. Previously, you paid the lesser of \$20 or 20%. See page 22.
- You must use our MVP bariatric surgical network for bariatric surgery. See page 25.
- Under the organ/tissue transplant coverage, we no longer cover costs associated with donor search and screening, travel, food and lodging. See page 30.
- The copay for out-of-area emergency room services will increase from nothing to \$50. See page 35.

Standard Option Coverage

We will offer Standard Option coverage for the first time. If you would like to enroll in our Standard Option coverage, you must make an election to it during Open Season. The Standard Option enrollment codes are: GA4 and GA5 (Eastern Region); M94 and M95 (Central Region); MX4 and MX5 (Mid-Hudson Region); and VW4 and VW (Vermont Region).

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 fill 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 letter (for annuitants), or your electronic enrollment system (such as 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 1-888-687-6277 or write to us at MVP Health Care, 625 State Street, Schenectady, NY 12305. You may also request replacement cards through our web site www.mvphealthcare.com.

Where you get covered care You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.

- **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 Web site.

- **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 Web site.

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. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care** Your primary care physician can be a . 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 all 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 .

Here are some 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 (the physician may have to get an authorization or approval beforehand).
- 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 and 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 program 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 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 hospitalized when your enrollment begins**

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-888-687-6277. If you are new to the FEHB Program, we will arrange for you to receive care from the effective date of your coverage.

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 benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

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 pre-certification. Your physician must obtain pre-certification for services such as:

- Inpatient Hospital Admissions
- Organ/Tissue Transplants
- Bariatric surgery
- Cardiac rehabilitation programs
- Pulmonary rehabilitation programs
- Skilled nursing facility care

- Home health care
- Sexual dysfunction services and prescriptions
- Elective inpatient, and certain outpatient procedures
- Growth Hormone Therapy
- Mental health and substance abuse treatment

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 8 The Disputed Claims Process.

Section 4 Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: Under our High Option coverage you pay \$20 per office visit when you see your PCP or specialist. Under the Standard Option coverage, your office visit copay is \$25 for visits to your PCP or \$40 per visit to a specialist.

Deductible

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

Coinsurance

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

Example: In our Plan, you pay 50% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your copays are 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 prescription drugs do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for prescription drugs.

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

Section 5 High and Standard Option Benefits

See page 7 for how our benefits changed this year. Page 14 provides a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5 High and Standard Option Benefits Overview16

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....17

 Diagnostic and treatment services17

 Lab, X-ray and other diagnostic tests17

 Preventive care, adult18

 Preventive care, children19

 Maternity care.....19

 Family planning.....20

 Infertility services.....20

 Allergy care21

 Treatment therapies22

 Physical and occupational therapies.....22

 Speech therapy23

 Hearing services (testing, treatment, and supplies).....23

 Vision services (testing, treatment, and supplies).....23

 Foot care.....23

 Orthopedic and prosthetic devices24

 Durable medical equipment (DME).....24

 Home health services.....25

 Chiropractic25

 Alternative treatments25

 Educational classes and programs.....26

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals27

 Surgical procedures27

 Reconstructive surgery28

 Oral and maxillofacial surgery29

 Organ/tissue transplants29

 Anesthesia32

Section 5(c) Services provided by a hospital or other facility, and ambulance services33

 Inpatient hospital33

 Outpatient hospital or ambulatory surgical center34

 Extended care benefits/Skilled nursing care facility benefits34

 Hospice care35

 Ambulance35

Section 5(d) Emergency services/accidents36

 Emergency within our service area36

 Emergency outside our service area.....37

 Ambulance37

Section 5(e) Mental health and substance abuse benefits38

 Mental health and substance abuse benefits.....38

 Preauthorization40

 Limitation40

Section 5(f) Prescription drug benefits40

 Covered medications and supplies41

Section 5(g) Special features.....43
 After Hours MVP Unit.....43
 Services for deaf and hearing impaired.....43
 High risk pregnancies.....43
 Travel benefit/services overseas.....43
 Out-of-Area Student Benefits.....43
Section 5(h) Dental benefits.....44
 Accidental injury benefit.....44
 Dental benefits for children up to age 19.....44
Summary of Benefits for the High Option of MVP Health Care - 200765
Summary of benefits for the Standard Option of MVP Health Care - 2007.....66

Section 5 High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 1-888-687-6277 or at our Web site at www.mvphealthcare.com.

Each option offers unique features.

High Option

- We do not have calendar year deductible.
- The office visit copay is \$20 whether you see your PCP or specialist.
- You pay nothing for laboratory tests such as blood tests, urinalysis, and pap tests.
- You pay \$20 for radiology services such as X-ray, CT Scan/MRI, or Ultrasound.
- The copay for covered inpatient hospital care is \$240 per member per year.
- The outpatient facility copay is \$75 for surgery in the outpatient department of a hospital or ambulatory surgery center.
- You pay nothing for a physician's charge for surgery.
- The copay is \$50 per visit for accidental injury or medical emergency treatment at a hospital.
- Prescription drug copays are \$10 for generic formulary, \$30 name brand formulary, and \$50 non-formulary.

Standard Option

- We do not have a calendar year deductible.
- The office visit copay is \$25 per visit to your PCP or \$40 per visit to a specialist.
- You pay nothing for laboratory tests such as blood tests, urinalysis, and pap tests.
- You pay \$40 for radiology services such as X-ray, CT Scan/MRI, or Ultrasound.
- The copay for covered inpatient hospital care is \$500 per admission.
- The outpatient facility copay is \$75 for surgery in the outpatient department of a hospital or ambulatory surgery center.
- Your copay for surgery is \$100 for the physician's charge for surgery.
- The copay is \$100 per visit for accidental injury or medical emergency treatment at a hospital.
- Prescription drug copays are \$10 for generic formulary, \$30 name brand formulary, and \$50 non-formulary.

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

Important things you should 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital. Please see Section 5(c) *Services provided by a hospital or other facility, and ambulance services* for information on the facility copay.
- 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.

Benefit Description	You pay	
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office, including office medical consultations and second surgical opinions • Initial examination of a newborn child under a family enrollment 	\$20 per office visit to your PCP or specialist	\$25 per office visit to your PCP or \$40 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing	Nothing
Professional services of physicians <ul style="list-style-type: none"> • At home • In an urgent care center 	\$20 per visit	\$25 per visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Dental treatment of temporomandibular joint (TMJ) syndrome</i> • <i>Costs for which a member fails to keep an appointment</i> 	<i>All charges.</i>	<i>All charges.</i>
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound 	\$20 per office visit to your PCP or specialist Nothing for lab tests at a participating freestanding laboratory \$20 per visit for radiology at a participating freestanding radiology center	\$25 per office visit to your PCP or \$40 per office visit to a specialist. Nothing for lab tests at a participating freestanding laboratory \$40 per visit for radiology at a participating freestanding radiology center

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Electrocardiogram and EEG 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for lab tests at a participating freestanding laboratory</p> <p>\$20 per visit for radiology at a participating freestanding radiology center</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist.</p> <p>Nothing for lab tests at a participating freestanding laboratory</p> <p>\$40 per visit for radiology at a participating freestanding radiology center</p>
Preventive care, adult	High Option	Standard Option
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol once every three years, ages 19 through 64 • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	<p>\$20 per office visit to your PCP or specialist</p> <p>Note: The \$75 facility copay will apply to surgery in the outpatient department of a hospital or in an ambulatory surgery center. See Section (c).</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for physician’s charge for surgery</p> <p>Nothing for lab tests at a participating freestanding laboratory</p> <p>\$40 per visit for radiology at a participating freestanding radiology center</p> <p>Note: The \$75 facility copay will apply to surgery in the outpatient department of a hospital or in an ambulatory surgery center. See Section (c).</p>
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	<p>\$20 per office visit to your PCP or specialist</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>Nothing for lab tests at a participating freestanding laboratory</p>
<p>Routine Pap test</p> <p>Note: You do not pay a separate copay for a Pap test performed during your routine annual exam.</p>	<p>\$20 per office visit to your PCP or specialist</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p>
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 49, one every calendar year • At age 50 and older, one every calendar year 	<p>\$20 per office visit to your PCP or specialist</p> <p>\$20 per visit for radiology at a participating freestanding radiology center</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$40 per visit for radiology at a participating freestanding radiology center</p>
<p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):</p>	<p>\$20 per office visit to your PCP or specialist</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p>

Preventive care, adult - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Preventive care, adult (cont.)		
<ul style="list-style-type: none"> Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) Influenza /Pneumococcal vaccine 	\$20 per office visit to your PCP or specialist	\$25 per office visit to your PCP or \$40 per office visit to a specialist
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges.</i>
Preventive care, children		
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing	Nothing
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) 	Nothing	Nothing
<ul style="list-style-type: none"> Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 19 to determine the need for vision correction Ear exams through age 19 to determine the need for hearing correction 	\$20 per office visit (for refraction only) \$20 per office visit (for screening only)	\$40 per office visit (for refraction only) \$40 per office visit (for screening only)
Maternity care		
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care Note: Here are some things to keep in mind: <ul style="list-style-type: none"> 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. Surgical benefits, not maternity benefits apply to circumcision. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$20 copay for the initial visit only to your PCP or specialist Note: The office visit copay applies to the initial visit to establish pregnancy. You pay nothing thereafter for routine maternity care. Note: The \$240 inpatient hospital copay applies to all inpatient admissions. Please see section 5 (c).	\$25 for the initial office visit to your PCP or \$40 for the initial office visit to a specialist \$200 for the physician’s charge for delivery Note: The office visit copay applies to the initial visit to establish pregnancy. You pay nothing thereafter for routine maternity care. Note: The inpatient hospital copay is \$500 per admission. Please see section 5 (c).
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, such as:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$20 per office visit to your PCP or specialist</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 per surgery</p>
<ul style="list-style-type: none"> • Voluntary sterilization (See surgical procedures Section 5(b)) 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for surgery</p> <p>Note: The \$75 facility copay will apply to surger in the outpatient department of a hospital or in an ambulatory surgery center. See Section 5 (c).</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 per surgery</p> <p>Note: The \$75 facility copay will apply to surger in the outpatient department of a hospital or in an ambulatory surgery center. See Section 5 (c).</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling, embryo transfer, GIFT,ZIFT, in-vitro fertilization</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Infertility services	High Option	Standard Option
<p>Basic infertility services include those services provided for the initial evaluation and testing for infertility.</p> <p>Advanced infertility services such as:</p> <ul style="list-style-type: none"> • Semen analysis • Post-coital examinations • Hysterosalpingograms • Varicocele surgery • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) <p>Note: We cover infertility services for members between twenty-one (21) and forty-four(44) years of age. You must obtain a referral from your PCP in order to see a Plan specialist for infertility services.</p>	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for lab tests at a participating freestanding laboratory</p> <p>Note: The \$75 facility copay will apply to surgery in the outpatient department of a hospital or in an ambulatory surgery center. See Section (c).</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 per surgery</p> <p>Nothing for lab tests at a participating freestanding laboratory</p> <p>Note: The \$75 facility copay will apply to surgery in the outpatient department of a hospital or in an ambulatory surgery center. See Section (c).</p>

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	High Option	Standard Option
<p>Note: We cover fertility drugs such as HCG, Progesterone injections, Menotropins, Urofollitropins, Serophene (Clomid) under the prescription drug benefits (Section 5(f)). You pay the applicable prescription drug copays</p>	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for lab tests at a participating freestanding laboratory</p> <p>Note: The \$75 facility copay will apply to surgery in the outpatient department of a hospital or in an ambulatory surgery center. See Section (c).</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 per surgery</p> <p>Nothing for lab tests at a participating freestanding laboratory</p> <p>Note: The \$75 facility copay will apply to surgery in the outpatient department of a hospital or in an ambulatory surgery center. See Section (c).</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm or sperm banking</i> • <i>Cost of donor egg</i> • <i>Gender selection</i> • <i>External pump for administration of infertility drugs</i> • <i>Reversal of vasectomy or tubal ligation</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$20 per office visit to your PCP or specialist</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p>
<ul style="list-style-type: none"> • Allergy serum 	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay	
	High Option	Standard Option
<p>Treatment therapies</p> <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 29-31.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. 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 <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$20 per office visit to your PCP or specialist</p>	<p>\$25 office visit to your PCP or \$40 per office visit to a specialist</p>
<p><i>Not covered: Treatment that is not authorized or provided by a plan doctor</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
<p>Physical and occupational therapies</p> <p>Two consecutive months per acute condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>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.</p>	<p>\$20 per office visit</p> <p>Nothing per visit during covered inpatient admission</p>	<p>\$40 per office visit</p> <p>Nothing per visit during covered inpatient admission</p>
<p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.</p>	<p>\$20 per office visit</p>	<p>\$40 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay	
Speech therapy	High Option	Standard Option
60 visits per calendar year for both habilitative and rehabilitative	\$20 per office visit Nothing per visit during covered inpatient admission	\$40 per office visit Nothing per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> Hearing testing for children up to age 19 (see <i>Preventive care, children</i>) Exams for screening purposes only. 	\$20 per office visit to your PCP or specialist	\$25 per office visit to your PCP or \$40 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing Hearing aids, testing and examinations for hearing aids 	<i>All charges.</i>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<p>Routine eye refractions, covered once every 24 months</p> <p>Note: You do not need a referral for the refraction exam. You will need a referral from your Primary Care Physician for any eye exam involving a diagnosed or suspected illness.</p>	\$20 per office visit	\$40 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses, except as shown above Eye exercises and orthoptics Radial keratotomy and other refractive surgery 	<i>All charges.</i>	<i>All charges.</i>
Foot care	High Option	Standard Option
<p>Non-routine foot care such as that type of medical care that you receive when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. You are limited to 10 visits per year.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts</p>	\$20 per office visit	\$25 per office visit to your PCP or \$40 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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) 	<i>All charges.</i>	<i>All charges.</i>

Foot care - continued on next page

Benefit Description	You pay	
Foot care (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Foot orthotic devices such as arch supports and shoe inserts</i> 	<i>All charges.</i>	<i>All charges.</i>
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • 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, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 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. 	50% of charges	50% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements unless authorized by MVP Health Care</i> • <i>Wigs and other hair prosthesis</i> 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)	High Option	Standard Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; 	50% of charges	50% of charges

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<p>Note: Call us at 1-888-687-6277 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.</p>	50% of charges	50% of charges
<ul style="list-style-type: none"> Blood glucose monitors; and Insulin pumps 	\$20 per item for services and equipment necessary for the treatment of diabetes	\$25 per item for services and equipment necessary for the treatment of diabetes
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Exercise equipment Car or Van Lifts Hearing aids Personal comfort items 	<i>All charges.</i>	<i>All charges.</i>
Home health services	High Option	Standard Option
<ul style="list-style-type: none"> 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. 	\$20 per office visit	\$25 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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.. 	<i>All charges.</i>	<i>All charges.</i>
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> Manipulation of the spine only <p>Note: You must obtain a prescription from your primary care physician.</p>	\$20 per office visit	\$40 per office visit
Alternative treatments	High Option	Standard Option
<p><i>We do not cover alternative treatments including but not limited to:</i></p> <ul style="list-style-type: none"> Naturopathic services Hypnotherapy Biofeedback Acupuncture 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Educational classes and programs	High Option	Standard Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self-management <p>Note: You may attend educational classes in most participating Plan hospitals. Please contact the hospital directly for details. You will need a prescription from your primary care physician to attend a class.</p>	\$20 per office visit	\$40 per office visit

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

Important things you should 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.
- 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 (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF 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

Benefit Description	You pay	
Surgical procedures	High Option	Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 <i>Reconstructive surgery</i>) • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>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.</p>	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> 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. <p>Note: Your physician must obtain our prior authorization. We will only cover medically necessary surgery that we have preauthorized. We cover two types of bariatric surgery (Gastroplasty - vertical banding and Gastric bypass). These surgical procedures reduce the size of the stomach and/or change the intestinal anatomy in order to treat morbid obesity.</p> <p>Note: The qualified candidate should: 1) be between the ages of 18 and 65; 2) have a body mass index (BMI) greater than 40 or or greater than 35 with at least one or more severe co-morbidities, e.g. diabetes, hypertension or cardiovascular disease; and 3) have documented history of repeated failure to maintain weight reduction through formal supervised weight loss programs.</p>	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician's charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician's charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay.</p>
Reconstructive surgery	High Option	Standard Option
<ul style="list-style-type: none"> Surgery to correct a functional defect. Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> 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; and webbed fingers and toes. All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> Surgery to produce a symmetrical appearance of breasts; Treatment of any physical complications, such as lymphedemas; Breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician's charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician's charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay.</p>
<i>Not covered:</i>	<i>All Charges.</i>	<i>All Charges.</i>

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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. 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Any dental care involved in the treatment of temporomandibular joint pain dysfunction syndrome)</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Organ/tissue transplants	High Option	Standard Option
<p>You must receive prior approval from the MVP Medical Director.</p> <p>National Transplant Program (NTP) – We contract with Centers 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.</p> <p>We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (the medical necessity is considered satisfied if the patient meets the staging description):</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myleogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myleogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (the medical necessity is considered satisfied if the patient meets the staging description):</p> <ul style="list-style-type: none"> • Autologous transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma - Breast cancer - Epithelial ovarian cancer - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolipidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Amyloidosis - Ependymoblastoma - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic lymphocytic leukemia - Chronic myelogenous leukemia 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician’s charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Sarcomas • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis 	<p>\$20 per office visit to your PCP or specialist</p> <p>Nothing for the physician's charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p> <p>\$100 for the physician's charge for surgery</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Travel, food, and lodging costs • Implants of artificial organs • Transplants not specifically listed as covered 	<p><i>All Charges</i></p>	<p><i>All Charges</i></p>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (Inpatient) • Hospital outpatient department • Ambulatory surgical center • Skilled nursing facility 	<p>Nothing</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>Nothing</p> <p>Note: The outpatient facility copay is \$75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>
<ul style="list-style-type: none"> • Office 	<p>\$20 per office visit to your PCP or Specialist.</p>	<p>\$25 per office visit to your PCP or \$40 per office visit to a specialist</p>

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

Important things you should 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 and you must be hospitalized in a Plan facility.
- 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital Room and board, such as <ul style="list-style-type: none"> • 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.	\$240 per admission (limited to one per person or three per family, per year)	\$500 per admission Note: The admission copay applies to all hospital confinements separated by 90 days. Note: There is a \$100 copay for the physician's charge for surgery. See Section 5(b) for information on copays that apply to the physician's charges
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • 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	Nothing
Not covered: <ul style="list-style-type: none"> • Custodial care 	All Charges	All Charges

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital (cont.)		
<ul style="list-style-type: none"> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care (unless medically necessary)</i> 	<i>All Charges</i>	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center		
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$75 copay per surgery	\$75 copay per surgery Note: There is a \$100 copay for the physician’s charge for surgery. See Section 5(b) for information on copays that apply to the physician’s charges
<ul style="list-style-type: none"> • Pre-surgical and diagnostic laboratory testing and pathology 	Nothing	Nothing
<ul style="list-style-type: none"> • X-rays and radiology services 	\$20 per visit	\$40 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Blood and blood derivatives not replaced by the member</i> • <i>Personal and comfort items such as telephone and television</i> 	<i>All charges.</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits		
<p>Extended care benefits/skilled nursing care facility benefits: We cover up to 60 days per calendar year when full-time skilled nursing care is necessary. All necessary services are covered including:</p> <ul style="list-style-type: none"> • 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. <p>Note: When there are no skilled nursing facilities near you, we may approve skilled nursing care in a hospital. When this happens, the inpatient hospital days count toward your 60-day skilled nursing facility annual maximum benefit.</p>	Nothing	Nothing

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Rest cures</i> • <i>Domiciliary or convalescent care</i> 	<i>All charges.</i>	<i>All charges.</i>
Hospice care	High Option	Standard Option
<p>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:</p> <ul style="list-style-type: none"> • Inpatient hospice care • Outpatient care, including drugs and medical supplies • Five visits for bereavement counseling of the immediate family 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing</i> • <i>homemaker services</i> 	<i>All Charges</i>	<i>All Charges</i>
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate	Nothing	\$100 per trip

Section 5(d) Emergency services/accidents

Important things you should 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.
- 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.

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 within or outside our service area:

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 an MVP Health Care 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 MVP Health Care 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, all follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office 	\$20 per office visit	\$25 per office visit to the PCP or \$40 per office visit to a specialist
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$20 per visit	\$25 per visit
<ul style="list-style-type: none"> • Emergency care in the outpatient at a hospital, including doctors’ services <p>Note: We waive the emergency room copay if you are admitted to the hospital.</p>	\$50 per hospital emergency room visit See Section 5(c) for information on the inpatient hospital copay.	\$100 per hospital emergency room visit See Section 5(c) for information on the inpatient hospital copay.
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>	<i>All Charges.</i>

Benefit Description	You pay After the calendar year deductible...	
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$20 per office visit	\$25 per office visit to the PCP or \$40 per office visit to a specialist
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$20 per visit	\$25 per visit
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors' services <p>Note: We waive the emergency room copay if you are admitted to the hospital.</p>	\$50 per hospital emergency room visit See Section 5(c) for information on the inpatient hospital copay.	\$100 per hospital emergency room visit See Section 5(c) for information on the inpatient hospital copay.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency</i> <i>Follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All Charges.</i>	<i>All Charges.</i>
Ambulance	High Option	Standard Option
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing	\$100 per trip
<i>Not covered: Air ambulance if not medically necessary</i>	<i>All Charges.</i>	<i>All Charges.</i>

Section 5(e) Mental health and substance abuse benefits

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.

Important things you should 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.
- We do not have a 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 OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
	High Option	Standard Option
Mental health and substance abuse benefits		
All 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 illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$20 per office visit to your PCP or specialist	\$25 per office visit to your PCP or \$40 per office visit to a specialist
Diagnostic tests	\$20 per office visit to your PCP or specialist Nothing for lab tests at a participating freestanding laboratory \$20 per visit for radiology at a participating freestanding radiology center	\$25 per office visit to your PCP or \$40 per office visit to a specialist Nothing for lab tests at a participating freestanding laboratory \$40 per visit for radiology at a participating freestanding radiology center
<ul style="list-style-type: none"> • 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 	\$240 per inpatient hospital admission or \$75 copay per hospital or ambulatory surgery center visit Nothing for surgery	\$500 per inpatient hospital admission \$75 copay per hospital or ambulatory surgery center visit \$100 for the physician’s charge for surgery

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
	<p>Note: The \$75 outpatient facility copay applies to surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$240 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>	<p>Note: The \$75 outpatient facility copay applies to surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is \$500 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network 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 things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- We do not have a 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

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 may 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 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 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. If you are in the military and are called to active duty, please contact us if you need to fill a prescription before you depart.
- Under our mail-order program, we limit maintenance 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 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 Medco Health Solutions, Inc. Complete and sign an order form and attach the 90-day prescription. Then, mail everything to MEDCO P.O. Box 30493, Tampa, FL 33660-3493
- **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.

Benefit Description	You pay	
	High Option	Standard Option
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Enteral Formulas when medically necessary (contact MVP Health Care for details) • Drugs for sexual dysfunction (see note below concerning prior authorization and dose limits) • Contraceptive drugs <p>Note: We reserve the right to limit or restrict coverage of certain prescription drugs (i.e. drugs to treat sexual dysfunction) in accordance with policies governing medical necessity and quality of treatment. Please contact Plan for dose limits and prior authorization.</p> <p>Note: You may obtain up to a 90-day supply of maintenance medication by mail-order. All prescription drugs are not available through mail-order.</p> <p>Note: Infertility prescriptions will only be dispensed for members between twenty-one (21) and forty-four (44) years of age</p>	<p>Retail Pharmacy</p> <p>\$ 10 per Generic prescription unit or refill from a participating Retail pharmacy</p> <p>\$ 30 per Brand Name prescription unit or refill from a participating Retail pharmacy</p> <p>\$ 50 per Non-Formulary prescription unit or refill from a participating Retail pharmacy</p> <p>Note: We do not waive the name brand copay when a generic drug is not available.</p> <p>Mail-order Pharmacy (approved maintenance medication only)</p> <p>\$20 per Generic prescription for up to a 90-day supply by Mail Order</p> <p>\$60 per Brand Name prescription for up to a 90-day supply by Mail Order</p> <p>\$100 per Non-Formulary prescription for up to a 90-day supply by Mail Order</p>	<p>Retail Pharmacy</p> <p>\$ 10 per Generic prescription unit or refill from a participating Retail pharmacy</p> <p>\$ 30 per Brand Name prescription unit or refill from a participating Retail pharmacy</p> <p>\$ 50 per Non-Formulary prescription unit or refill from a participating Retail pharmacy</p> <p>Note: We do not waive the name brand copay when a generic drug is not available.</p> <p>Mail-order Pharmacy (approved maintenance medication only)</p> <p>\$20 per Generic prescription for up to a 90-day supply by Mail Order</p> <p>\$60 per Brand Name prescription for up to a 90-day supply by Mail Order</p> <p>\$100 per Non-Formulary prescription for up to a 90-day supply by Mail Order</p>
<p>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</p>	<p>\$20 copay per boxed item</p>	<p>\$25 copay per boxed item</p>
<p>Disposable needles and syringes for the administration of covered medications, as well as dressings and antiseptics</p>	<p>20% copay for disposable needles and syringes needed to inject covered prescription medications</p>	<p>20% copay for disposable needles and syringes needed to inject covered prescription medications</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Prescriptions written by non-Plan physicians</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicine</i> • <i>Refills due to a lost or misused prescription drug supply</i> 	<p><i>All Charges.</i></p>	<p><i>All Charges.</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Drugs used in connection with the provision of a non-covered service or benefit</i> 	<i>All Charges.</i>	<i>All Charges.</i>

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 – 10:00pm, 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	<p>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.</p> <p>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.</p>
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 Benefits	<p>We offer extended out-of-area coverage for your dependent children up to age 22 as long as 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.</p> <p>This benefit is limited to \$2,500 maximum per year. We will reimburse you for the cost of covered services minus your applicable copay. You must submit claims to us within one year of the date of service for us to consider them. Submit claims to: 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.</p>

Section 5(h) Dental benefits

Important things you should 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 care 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. See Section 5(c) for inpatient hospital benefits. 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.

Benefit Description	You Pay	
	High Option	Standard Option
Accidental injury benefit		
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. Covered treatment must be performed within 12 month of the accident	\$20 per office visit to your PCP or specialist Note: Hospital services are subject to the \$240 inpatient hospital copay or the \$75 copay for outpatient services.	\$25 per office visit to your PCP or \$40 per office visit to a specialist Note: Hospital services are subject to the \$500 inpatient hospital copay or the \$75 copay for outpatient services and \$100 physician surgical copay
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>
<ul style="list-style-type: none"> • <i>Dental services not shown as covered</i> • <i>Dental services that result from injury to teeth while eating</i> 		

Benefit description	You Pay	
	High Option	Standard Option
Dental benefits for children up to age 19		
The following preventive and diagnostic services are covered for Plan members under age 19:	\$25 per office visit	\$25 per office visit
<ul style="list-style-type: none"> • 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 periapical x-rays, as needed 		

Dental benefits for children up to age 19 - continued on next page

Benefit description	You Pay	
Dental benefits for children up to age 19 (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Sealants once per tooth per child (only covered to age 16) <p>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 \$25 copay. You may obtain a claim form by calling us at 1-888-687-6277. Claim forms should be mailed to: Upstate Administrative Services (UAS), P O Box 6589, Syracuse, NY 13217</p> <p>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</p>	\$25 per office visit	\$25 per office visit
<p><i>Not Covered</i></p> <ul style="list-style-type: none"> • <i>Other dental services not shown as covered</i> • <i>Services which are not approved by the Council of Dental Therapeutics of the America Dental Association (ADA)</i> • <i>Services rendered by a medical department, clinic, or similar facility of the child's employer, labor union, mutual benefits association, or other similar group</i> • <i>Charges for dental appointments that are not kept</i> • <i>Dental implants</i> 	<i>All charges.</i>	<i>All charges.</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 catastrophic protection out-of-pocket maximums.

Expanded vision care

You are entitled to various discounts on designated eyewear purchases just by being an MVP Health Care Member. Please visit the MVP Health Care website (www.mvphealthcare.com) for information on our member discounts for expanded vision care services.

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 visit our website 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 at 1-888-MVP-XTRA (1-888-687-9872) or by visiting our website at www.mvphealthcare.com.

Lasik Eye Surgery

You are entitled to discounts on lasik eye surgery just by being an MVP Member. Please visit our website for listings of participating lasik eye surgeons, and the type of discounts that they offer.

Acupuncture

You are entitled to various discounts on acupuncture services just by being an MVP Member. Please visit our website for listings of participating acupuncturists, and the type of discounts that they offer.

If you have any questions about any of these benefits, please contact the MVP Member Services Department at 1-888-687-6277.

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 services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies 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 (see specifics regarding transplants);
- 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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

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. Your facility 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 services you received outside the Plan’s service area – 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
625 State 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 1-800-480-5640 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 \$25 copay.

Submit your claims to:

MVP Health Care
P.O. Box 763
Schenectady, NY 12301

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 benefits for 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/prior approval required by Section 3.

1 Ask us in writing to reconsider our initial claims decision. We have a two-step internal review process for appeals. The process consists of a first level appeal and a second level appeal. To request a first level appeal you must:

- a) Write to us within 6 months from the date of our initial decision on your claim; and
- b) Send your request to us at: MVP Health Care 625 State Street , Schenectady, NY 12305; and
- c) Include a statement about why you believe our initial claim decision was wrong, based on specific benefit provisions in this brochure; and
- d) Include copies of documents that support your appeal, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2 We will usually provide you with our decision when you file a standard first level appeal within 15 days of the date that we receive it but under our contract with OPM, we have 30 days from the date we receive your of 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

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 If you do not agree with our first level appeal decision, you may request that we perform a second level appeal. We will provide instructions for the second level appeal in the decision letter that we send to you after the first level appeal. A panel of senior MVP medical and administrative staff and MVP board members will review the second level appeal. This second level appeal is not mandatory and you may proceed with OPM review of the first level appeal decision. If you would like to request a second level appeal, you must do so within 180 days of the date of first level appeal decision. We will provide you with our decision on the second level appeal within 15 days of the date we receive it.

If you do not agree with our first or second level appeal decision, you may request that OPM to review it.

You must write to OPM within:

- 90 days after the date of our first level or second level appeal letter; 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

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 more than one claim, 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.

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 may call OPM's Health Insurance Group 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 or a covered family member have coverage under any other 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 or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **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.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need 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 claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-888-687-6277 or visit our Web site at www.mvphealthcare.com.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage 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 Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare 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 you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) 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) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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	✓ *	
B. When you or a covered family member?		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you?		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

**TRICARE and
CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under TRICARE or CHAMPVA.

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.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

**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 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	We do not cover custodial care. This 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. Custodial care that lasts beyond 90 days could be considered Long Term Care. Please refer to the Long Term Care section in the back of this brochure.
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 13.
Experimental or investigational service	<p>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.</p> <p>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.</p> <p>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.</p>
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 Care
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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 your FEHB coverage. These materials tell you:

- 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 benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

• **When benefits and premiums start**

The benefits in this brochure are effective 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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. 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.

• **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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **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 Federal 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 (HIPAA) 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 at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. 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 information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program(FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents, which are not covered or reimbursed by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

- For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).
- For the LEX HCFSA – Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).
- For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves
- AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental plans will provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period.
- Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

You can find a comparison of the plans available and their premiums on the OPM Web site at www.opm.gov/insure/dentalvision. This site also provides links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season – November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment Web site sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental/or vision plan you select. For those without access to a computer, call 1-877-888-FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Accidental injury.....	16, 29, 42	Educational classes and programs	26	Organ/tissue transplants.....	11, 29-32
Allergy care.....	21	Effective date of enrollment.....	10, 11, 56	Orthopedic and Prosthetic devices...23, 24,	27
Allogeneic (donor) bone marrow transplant	11, 29-32	Emergency.....	36, 37, 43, 47	Out-of-pocket expenses.....	13
.....	11, 29-32	Experimental or investigational.....	45, 54	Oxygen.....	24, 32, 33
Alternative treatments.....	25	Eyeglasses.....	23	Pap test	18
Ambulance.....	34, 36	Family planning	20	Physical therapy.....	22
Anesthesia.....	31, 35	Fecal occult blood test.....	18	Prescription drugs.....	13, 39-40,
Autologous bone marrow transplant...11, 21,	29-32	Foot care.....	23, 24	Preventive care, adult.....	18-19
Biopsy	27	Fraud.....	3, 4	Preventive care, children.....	19
Blood and blood plasma.....	34	General exclusions	47	Prior approval.....	11, 21, 29-32
Casts	33, 34	Hearing services	23, 25, 43	Radiation therapy	22
Catastrophic protection (out-of-pocket	13	Home health services.....	12, 25	Reconstructive surgery.....	27, 28, 29
maximum).....	13	Hospital...4, 5, 6, 7, 9, 11, 19, 26, 32-33,	35-38, 41	Room and board.....	33
Changes for 2007.....	9	Immunizations	18, 19	Skilled nursing facility care ...9, 11, 17, 31,	33-34
Chemotherapy.....	22	Infertility.....	20, 21, 41	Speech therapy.....	23
Chiropractic.....	25	Inpatient hospital benefits.....	33-34	Splints.....	32
Cholesterol tests.....	18	Insulin.....	9, 25, 41	Subrogation.....	53
Claims.....	12, 46, 47-50	Magnetic Resonance Imagings (MRIs)	16, 17	Substance abuse.....	38-39
Coinsurance.....	13, 54	16, 17	Surgery.....	20, 26-33
Colorectal cancer screening.....	18	Mammogram.....	18	Syringes.....	41
Congenital anomalies.....	26, 27	Maternity benefits.....	19, 32	Temporary Continuation of Coverage	(TCC).....58, 59
Contraceptive drugs and devices.....	20, 41	Medicaid.....	53	Transplants.....	29-32
Crutches.....	24	Medically necessary.....	47, 56	Treatment therapies.....	22
Deductible	13, 56	Medicare.....	51-54	Vision services	23
Definitions.....	56	Mental Health/Substance Abuse Benefits	38-39	Wheelchairs	24
Dental care.....	17, 24, 29, 44-45	Newborn care	17, 19	Workers Compensation.....	54, 55
Diagnostic services.....	17, 18, 25, 33, 34, 38	Non-FEHB benefits.....	44	X-rays	17, 33, 34, 42, 43
Donor expenses.....	21, 28, 31	Occupational therapy	22		
Dressings.....	32, 33, 40	Oral and maxillofacial surgical.....	28		
Durable medical equipment.....	24				

Summary of Benefits for the High Option of MVP Health Care - 2007

- **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	\$20 per office visit	17
Services provided by a hospital		
• Inpatient	\$240 per admission copay (limited to one per person or three per family per year)	33-34
• Outpatient	\$75 copay at outpatient facility	34
Emergency benefits:		
• In-area	\$20 per office visit or urgent care center visit; \$50 per visit to hospital emergency room	36
• Out-of-area	\$20 per office visit or urgent care center visit; \$50 per visit to hospital emergency room	36-37
Mental health and substance abuse treatment	Regular cost sharing	38-39
Prescription drugs:		
• Retail pharmacy	\$10 Generic/\$30 Name brand/\$50 Non-formulary per prescription unit or refill	40-42
• Mail-order	\$20 Generic/\$60 Name brand/\$100 Non-formulary per prescription unit or refill	40-42
Dental care: Preventive care for children up to age 19 only	\$25 per office visit	44-45
Vision care:	\$20 per office visit (one covered eye exam every 24 months)	23
Special features: MVP After Hours Unit; Little Footprints; Out-of-Area student benefit; travel benefit/overseas benefit		43
Protection against catastrophic costs (out-of-pocket maximum):	Stated copays for covered benefits	13

Summary of benefits for the Standard Option of MVP Health Care - 2007

- **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 enroll or change 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.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$25 per primary care office visit; \$40 per office visit to a specialist	17
Services provided by a hospital:		
• Inpatient	\$500 per inpatient admission; \$100 for the physician's charge for surgery	33-34
• Outpatient	\$75 copay at outpatient facility; \$100 for the physician's charge for surgery	34
Emergency benefits:		
• In-area	\$25 per visit to urgent care center; \$100 per hospital emergency room visit	36
• Out-of-area	\$100 per hospital emergency room visit	36-37
Mental health and substance abuse	Regular cost sharing	38-39
Prescription drugs:		
• Retail pharmacy	\$10 Generic/\$30 Name Brand/\$50 Non-Formulary per prescription unit or refill	40-42
• Mail-order	\$20 Generic/\$60 Name Brand/\$100 Non-Formulary per prescription unit or refill	40-42
Dental care: Preventive care for children up to age 19 only	\$25 per office visit	44-45
Vision care: One covered eye exam every 24 months	\$40 per office visit	23
Special features: MVP After Hours Unit; Little Footprints; Out-of-area-student benefit; Travel benefit/ services overseas		43
Protection against catastrophic costs (out-of-pocket maximum):	Stated copays for covered benefits	13

2007 Rate Information for MVP Health Care

Non-Postal rates apply to most non-Postal employees. 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 a special FEHB guide is published 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.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Eastern New York

High Option Self Only	GA1	\$127.68	\$42.56	\$276.64	\$92.21	\$151.09	\$19.15
High Option Self and Family	GA2	\$321.89	\$117.78	\$697.43	\$255.19	\$380.01	\$59.66
Standard Option Self Only	GA4	\$112.28	\$37.43	\$243.28	\$81.09	\$132.87	\$16.84
Standard Option Self and Family	GA5	\$289.97	\$96.66	\$628.28	\$209.42	\$343.13	\$43.50

Central New York

High Option Self Only	M91	\$137.33	\$45.77	\$297.54	\$99.18	\$162.50	\$20.60
High Option Self and Family	M92	\$321.89	\$151.00	\$697.43	\$327.17	\$380.01	\$92.88
Standard Option Self Only	M94	\$120.77	\$40.26	\$261.88	\$87.22	\$142.91	\$18.12
Standard Option Self and Family	M95	\$311.92	\$103.97	\$675.83	\$225.27	\$369.10	\$46.79

Mid-Hudson

High Option Self Only	MX1	\$141.92	\$53.22	\$307.49	\$115.31	\$167.54	\$27.60
High Option Self and Family	MX2	\$321.89	\$119.32	\$697.43	\$258.53	\$380.01	\$61.20
Standard Option Self Only	MX4	\$128.30	\$42.77	\$277.99	\$92.66	\$151.82	\$19.25
Standard Option Self and Family	MX5	\$321.89	\$119.32	\$697.43	\$258.53	\$380.01	\$61.20

Vermont

High Option Self Only	VW1	\$141.92	\$119.22	\$307.49	\$258.31	\$167.54	\$93.60
High Option Self and Family	VW2	\$321.89	\$352.73	\$697.43	\$764.25	\$380.01	\$294.61

Standard Option Self Only	VW4	\$141.92	\$111.61	\$307.49	\$241.83	\$167.54	\$85.99
Standard Option Self and Family	VW5	\$321.89	\$333.06	\$697.43	\$721.63	\$380.01	\$274.94