MVP Health Care

www.mvphealthcare.com

Customer Care Center 1-888-687-6277

2016

A Health Maintenance Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

Serving: Upstate New York

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See pages 11-12 for requirements.

IMPORTANT

Enrollment codes for this plan:

Eastern Region
High Option – GA1 Self Only
High Option-- GA3 Self Plus One
High Option – GA2 Self and Family
Standard Option – GA4 Self Only
Standard Option -- GA6 Self Plus One
Standard Option – GA5 Self and Family

Mid- Hudson Region
High Option – MX1 Self Only
High Option -- MX3 Self Plus One
High Option – MX2 Self and Family
Standard Option – MX4 Self Only
Standard Option -- MX6 Self Plus One
Standard Option – MX5 Self and Family

Central Region
High Option – M91 Self Only
High Option -- M93 Self Plus One
High Option – M92 Self and Family
Standard Option – M94 Self Only
Standard Option M96 Self Plus One
Standard Option – M95 Self and Family

North Region
High Option – MF1 Self Only
High Option -- MF3 Self Plus One
High Option – MF2 Self and Family
Standard Option – MF4 Self Only
Standard Option -- MF 6 Self Plus One
Standard Option – MF5 Self and Family

Western Region
High Option – GV1 Self Only
High Option -- GV3 Self Plus One
High Option – GV2 Self and Family
Standard Option – GV4 Self Only
Standard Option -- GV 6 Self Plus One
Standard Option – GV5 Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from MVP Health Care About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that MVP Health Care's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. 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 cancel 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 Medicare Part D 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 will 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 (October 15 – December 7) 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): 1-877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of MVP Health Plan, Inc. contract (CS 2362) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-888-687-6277 or through our website: www.mvphealthcare.com. 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 verbal 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. Customer service may be reached at 1-888-687-6277 or through our website: www.mvphealthcare.com

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. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 13. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- 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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- 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

877-499-7295

OR got to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- 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)
  - Your child age 26 or over (unless he/she was disabled and incapable of self support prior to age 26).

- 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.

- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.

- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- 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 or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. 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.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use MVP Health Care preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance 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 that 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 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
  - 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. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 or Self Plus One 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 Plus One or 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 Plus One or 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 of changes in family member status including your marriage, divorce, annulment, or when your child reached age 26.

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.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below:

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self -support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but NOT their spouses or their own children) are covered until their 26th birthday..
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer- provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **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 Plus One or 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 Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, 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. Similarly, you cannot change to Self Plus One in the court/administrative order identifies more than one child. 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 2016 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 2015 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.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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 additional information about your coverage choices. You can also visit OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **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 or Tribal 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.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

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 2016. 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. Preventive care services are generally paid as first coverage and are not subjected to copayments, deductibles or annual limits when received from a network provider.

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.

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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 website (www.opm.gov/healthcare-insurance) 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, New Hampshire 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 website at www.mvphealthare.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

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, Columbia, Fulton, Greene, 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, Tioga and Tompkins.

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

North Region: The New York counties of Clinton, Essex, St. Lawrence and Franklin.

Western Region: The New York counties of Monroe, Genesee, Livingston, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, and Yates

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. Changes for 2016

Do not rely only 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.

Program Wide Changes

- Self Plus One enrollment type has been added effective January 1, 2016
- We have removed the exclusion of serives, drugs or supplies related to sex transofrmations

Changes to the High and Standard Option Coverage

- Your share of the premium will increase for Self only and increase for Self and Family. Please see the applicable rates on pages 78-80.
- Westchester County is now inside the MVP Service Area
- Speciality Drugs are covered as tier 4 on the formulary

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 website 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 website.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

MVP Health Care expects primary care physicians to prescribe and coordinate comprehensive care plans and treatment of our members.

You will be required to select a primary care physician for your HMO coverage. You should see your primary care physician for most of your care, such as routine well care, preventive care and basic health screenings. These services may not be covered under your contract unless they are performed by your primary care physician.

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**

Here are some other things you should know about specialty care:

- If you need specialty care, please tell your primary care physician. Your primary care physician can help you select a participating specialist and work with the specialist to develop a plan of treatment.
- If you need help selecting a participating specialist, please contact us by calling our Customer Care Center at 1-888-687-6277 or by visiting our website www.mvphealthcare.com
- 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 can 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;
- 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 Care Center 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;
- 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.

You need prior Plan approval for certain services

- **Inpatient hospital admission**
- **Other services**

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Precertification** is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.
- Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us via precertification. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.
  - Inpatient Hospital Admissions
  - Organ/Tissue Transplants
  - Bariatric surgery
  - Cardiac rehabilitation programs
  - Pulmonary rehabilitation programs
  - Skilled nursing facility care
  - Home health care
  - Elective inpatient, and certain outpatient procedures
  - Mental health and substance abuse treatment
  - Certain medications administered in your providers office or in an outpatient facility require prior authorization.

- Certain self-administered medications. See Section 5(f) Prescription Drug Benefits.

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.

How to request precertification for an admission or get prior authorization for other services

First, your physician, your hospital, you, or your representative, must call us at 888-687-6277 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-888-687-6277. You may also call OPM's Health Insurance x at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-888-687-6277. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Complete maternity (obstetrical) care is covered for : (prenatal care , delivery and postnatal care)

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

To file an appeal with OPM

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

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

Cost-Sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (for example, coinsurance, and copayments) for the covered care you receive.

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 $25 per office visit when you see your PCP or specialist. Under the Standard Option coverage, your office visit copay is $30 for visits to your PCP or $50 per visit to a specialist.

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. Copayments do not count toward any deductible.

This plan does not have a deductible for medical expenses. The calendar year deductible is $250 per person for brand name prescription drugs only under the High Option and $500 per person under the Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $250 under the High Option and $500 under the Standard Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the deducitble for your enrollment reach $500 under the High Option and $1000 under the Standard Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable to all family members when the combined covered expenses applied to the calendar year deductible for family members reach $500 under the High Option and $1000 on the Standard Option.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan, If you change plans at another time during the year, you must begin a new deductible under the plan.

If you change options in this plan during the year, we will credit the amount paid toward your deductible to the new plan option as applicable. More information on the prescription drug deductible can be found on pages 49-52.

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.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

Your catastrophic protection out-of-pocket maximum

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $13,200 for Self Only, or $6600 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $6600 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $6600 Self Only maximum out-of-pocket limit and a $13,200 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $6600 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $13,200, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $13,200 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

When Government Facilities Bill Us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 14 for how our benefits changed this year. Pages 76-77 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 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 *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 filing advice, or more information about High and Standard Option benefits, contact us at 1-888-687-6277 or on our website at www.mvphealthcare.com.

Each option offers unique features.

High Option

- No referrals needed for participating specialists
- The office visit copay is $25 whether you see your PCP or specialist.
- You pay nothing for laboratory tests such as blood tests, urinalysis, and pap tests.
- You pay $25 for radiology services such as X-ray, CT Scan/MRI, or Ultrasound.
- The copay for covered inpatient hospital care is $500 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.
- You pay $100 copay for ambulance
- Prescription drug copays (per 30-day supply) are $5 for generic formulary, $35 brand formulary, $70 non-formulary, and $70 Speciality. Brand name is subject to a $250 Deductible (per person)
- Mail order (per 90-day supply) is 2.5 times retail copay. Brand name is subject to deductible (per person)

Standard Option

- No referrals needed for participating specialists
- The office visit copay is $30 per visit to your PCP or $50 per visit to a specialist.
- You pay nothing for laboratory tests such as blood tests, urinalysis, and pap tests.
- You pay $50 for radiology services such as X-ray, CT Scan/MRI, or Ultrasound.
- The copay for covered inpatient hospital care is $750 per admission.
- The outpatient facility copay is $150 for surgery in the outpatient department of a hospital or ambulatory surgery center.
- Your copay for surgery is $150 for the physician's charge for surgery.
- The copay is $150 per visit for accidental injury or medical emergency treatment at a hospital.
- Prescription drug copays (per 30-day supply) are $5 for generic formulary, $45 name brand formulary, $90 non-formulary, and $90 Specialty. Brand name is subject to $500 deductible (per person).
- Mail order (per 90-day supply) is 2.5 times retail copay. Brand name is subject to deductible (per person).

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 • In physician's office, including office medical consultations and second surgical opinions • Initial examination of a newborn child under a family enrollment	$25 per office visit to your PCP or specialist	$30 per office visit to your PCP or $50 per visit to a specialist
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing	Nothing
Professional services of physicians • At home • In an urgent care center	$25 per visit	$30 per visit
Not covered: • *Dental treatment of temporomandibular joint (TMJ) syndrome* • *Costs for which a member fails to keep an appointment*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound	$25 per office visit to your PCP or specialist Nothing for lab tests at a participating freestanding laboratory $25 per visit for radiology at a participating freestanding radiology center	$30 per office visit to your PCP or $50 per office visit to a specialist. Nothing for lab tests at a participating freestanding laboratory $50 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**
• Electrocardiogram and EEG	$25 per office visit to your PCP or specialist Nothing for lab tests at a participating freestanding laboratory $25 per visit for radiology at a participating freestanding radiology center	$30 per office visit to your PCP or $50 per office visit to a specialist. Nothing for lab tests at a participating freestanding laboratory $50 per visit for radiology at a participating freestanding radiology center
Preventive care, adult	**High Option**	**Standard Option**
Routine physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including • Fecal occult blood test • Sigmoidoscopy screening – every five years starting at age 50 • Colonoscopy screening – every ten years starting at age 50	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence.	Nothing	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 49, one every calendar year • At age 50 and older, one every calendar year	Nothing	Nothing
BRCA Testing	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-carebenefits		
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges.*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 26)	Nothing	Nothing
• Examinations, such as: - Eye exams through age 19 to determine the need for vision correction - Ear exams through age 19 to determine the need for hearing correction	Nothing	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-carebenefits		
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk at no cost sharing. Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.	$25 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 $500 inpatient hospital copay applies to all inpatient admissions. Please see section 5 (c).	$30 for the initial office visit to your PCP or $50 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 $750 per admission. Please see section 5 (c).

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• 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 Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	$25 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 $500 inpatient hospital copay applies to all inpatient admissions. Please see section 5 (c).	$30 for the initial office visit to your PCP or $50 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 $750 per admission. Please see section 5 (c).
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing
Family planning	**High Option**	**Standard Option**
MVP covers a range of voluntary family planning services, such as: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Contraceptive counseling on an annual basis • Voluntary sterilization (e.g. tubal ligation, see surgical procedures Section 5(b)) Note: We cover oral and injectable contraceptives and diaphragms under the prescription drug benefit subject to the applicable formulary tier.	Nothing	Nothing
• Voluntary sterilization (e.g. vasectomy, see surgical procedures Section 5(b))	$25 per office visit to your PCP or specialist Nothing for surgery Note: The $75 facility copay will apply to surgery in the outpatient department of a hospital or in an ambulatory surgery center. See Section 5 (c).	$30 per office visit to your PCP or $50 per office visit to a specialist $150 per surgery Note: The $150 facility copay will apply to surgery in the outpatient department of a hospital or in an ambulatory surgery center. See Section 5 (c).
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling, embryo transfer, GIFT, ZIFT, in-vitro fertilization*	*All charges*	*All charges*

Benefit Description	You pay	
Infertility services	**High Option**	**Standard Option**
Basic infertility services include those services provided for the initial evaluation and testing for infertility. Advanced infertility services such as: • Semen analysis • Post-coital examinations • Hysterosalpingograms • Varicocele surgery • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Note: We cover infertility services for members between twenty-one (21) and forty-four (44) years of age. 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	$25 per office visit to your PCP or specialist Nothing for lab tests at a participating freestanding laboratory 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).	$30 per office visit to your PCP or $50 per office visit to a specialist $150 per surgery Nothing for lab tests at a participating freestanding laboratory Note: The $150 facility copay will apply to surgery in the outpatient department of a hospital or in an ambulatory surgery center. See Section (c).
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm or sperm banking* • *Cost of donor egg* • *Gender selection* • *External pump for administration of infertility drugs* • *Reversal of vasectomy or tubal ligation*	*All charges.*	*All charges.*

Benefit Description	You pay	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$25 per office visit to your PCP or specialist	$30 per office visit to your PCP or $50 per office visit to a specialist
• Allergy Injections • Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 38-39. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder • Growth hormone is covered under the prescription drug benefit. 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. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other Services under You Need Prior Plan Approval for certain services on page 11.	$25 per office visit	$25 per office visit
Not covered:Treatment that is not authorized or provided by a plan doctor	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**
Physical and occupational therapy are limited to one course each for two consecutive months for each specific diagnosis and related conditions per calendar year: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider orders the care. Applicable for both rehabilitative and habilitative services.	$25 per office visit Nothing per visit during covered inpatient admission	$50 per office visit Nothing per visit during covered inpatient admission

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.	$25 per office visit	$50 per office visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
60 visits per calendar year for both habilitative and rehabilitative	$25 per office visit Nothing per visit during covered inpatient admission	$50 per office visit Nothing per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$25 per office visit	$50 per office visit
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for hearing aids*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
Routine eye refractions, covered once every 24 months	$25 per office visit	$50 per office visit
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
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. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts	$25 per office visit	$30 per office visit to your PCP or $50 per office visit to a specialist
Not covered:	*All charges*	*All charges*

Foot care - continued on next page

Benefit Description	You pay	
Foot care (cont.)	**High Option**	**Standard Option**
• *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotic devices such as arch supports and shoe inserts*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes; • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Note: For information on the professional charges for the surgery to insert an implant, see Section 5 (b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	50% of charges	50% of charges
Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy.	Nothing	Nothing
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Wigs and other hair prosthesis* *Prosthetic replacements unless authorized by MVP Health Care*	*All charges*	*All charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; 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.	50% of charges	50% of charges
• Blood glucose monitors • Insulin pumps	$25 per item for services and equipment necessary for the treatment of diabetes	$30 per item for services and equipment necessary for the treatment of diabetes
Not covered: • *Exercise equipment* • *Car or Van Lifts* • *Hearing aids* • *Personal comfort items* • *Home modifications (ie. ramps for wheel chairs)*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• 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.	$25 per office visit	$25 per office visit
• Services include oxygen therapy, intravenous therapy and medications.	Nothing	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*	*All charges*

Benefit Description	You pay	
Chiropractic	**High Option**	**Standard Option**
• Manipulation of the spine only Note: You must obtain a prescription from your primary care physician.	$25 per office visit	$50 per office visit
Alternative treatments	**High Option**	**Standard Option**
We do not cover alternative treatments including but not limited to: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: • Tobacco Cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for four (4) counseling sessions and up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for four (4) counseling sessions and up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Diabetes self management Childhood obesity education 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.	$25 per office visit	$50 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g. vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery (per procedure) Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.
Voluntary sterilization (e.g. tubal ligation)	Nothing	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All Charges*	*All Charges*

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• 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. 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. Note: The qualified candidate should: 1) be between the ages of ≥18 or ≤ 60 and ; 2) have a body mass index (BMI) greater than 40 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.	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay.
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow stem cell transplant donors in addition to the testing of family members.		
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect. • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance; and - The condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - 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)	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay. 50% copay (External Prosthetic Devices)	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay. 50% copay (External Prosthetic Devices)

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
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.	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay. 50% copay (External Prosthetic Devices)	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5 (c) for information on the applicable inpatient or outpatient facility copay. 50% copay (External Prosthetic Devices)
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All Charges*	*All Charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • 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.	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Any dental care involved in the treatment of temporomandibular joint pain dysfunction syndrome)*	*All charges*	*All charges*

Benefit Description	You pay	
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intenstine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Autologous tandem transplants for • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Chronic inflammatory demyelination polyneuropathy (CIPD) • Hemoglobinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma • Pineoblastoma • Neuroblastoma	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.
• Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed)	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.
These blood or marrow stem cell transplants are 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. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic - lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.
• Mini-transplants (non-myeloblative allogenic , reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	$25 per office visit to your PCP or specialist Nothing for the physician's charge for surgery Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	$30 per office visit to your PCP or $50 per office visit to a specialist $150 for the physician's charge for surgery Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.
Not covered: • *Travel, food, and lodging costs* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*	*All Charges*

Benefit Description	You pay	
National Transplant Program (NTP) -	**High Option**	**Standard Option**
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.		
Not covered: • *Travel, food, and lodging costs* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (Inpatient) • Hospital outpatient department • Ambulatory surgical center • Skilled nursing facility	Nothing Note: The outpatient facility copay is $75 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $500. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.	Nothing Note: The outpatient facility copay is $150 for surgery in a hospital or ambulatory surgery center. The inpatient hospital copay is $750 per admission. See Section 5(c) for information on the applicable inpatient or outpatient facility copay.
• Office	$25 per office visit to your PCP or Specialist.	$30 per office visit to your PCP or $50 per office visit to a specialist

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 FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets • Physical Rehabilitation Care Note: Physical rehabilitation care is covered for 60 days per member per year Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$500 per admission (limited to one copay per person or three copays per family, per year)	$750 per admission Note: The admission copay applies to all hospital confinements separated by 90 days. Note: There is a $150 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: • 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

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care (unless medically necessary)*	*All Charges*	*All Charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• 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 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.	$75 copay per surgery	$150 copay per surgery Note: There is a $150 copay for the physician's charge for surgery. See Section 5(b) for information on copays that apply to the physician's charges
• Pre-surgical and diagnostic laboratory testing and pathology	Nothing	Nothing
• X-rays and radiology services	$25 per visit	$50 per visit
Not covered: • *Blood and blood derivatives not replaced by the member* • *Personal and comfort items such as telephone and television*	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
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: • 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.	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**
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.	Nothing	Nothing
Not covered: • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
We cover up to 210 days of hospice care for a terminally ill member in the home or a hospice facility. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. Covered services must be billed by the hospice and include: • Inpatient hospice care • Outpatient care, including drugs and medical supplies • Five visits for bereavement counseling of the immediate family	Nothing	Nothing
Not covered: • *Independent nursing* • *homemaker services*	*All Charges*	*All Charges*
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate	$100 per trip	$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	
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$25 per office visit	$30 per office visit to the PCP or $50 per office visit to a specialist
• Emergency care at an urgent care center	$25 per visit	$30 per visit
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the emergency room copay if you are admitted to the hospital.	$50 per hospital emergency room visit See Section 5(c) for information on the inpatient hospital copay.	$150 per hospital emergency room visit See Section 5(c) for information on the inpatient hospital copay.
Not covered: • *Elective care or non-emergency*	*All Charges*	*All Charges*

Emergency outside our service area - continued on next page

Benefit Description	You pay	
Emergency outside our service area (cont.)	**High Option**	**Standard Option**
• *Follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges*	*All Charges*
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$25 per office visit	$30 per office visit to the PCP or $50 per office visit to a specialist
• Emergency care at an urgent care center	$25 per visit	$30 per visit
• Emergency care in the outpatient at a hospital, including doctors' services Note: We waive the emergency room copay if you are admitted to the hospital.	$50 per hospital emergency room visit See Section 5(c) for information on the inpatient hospital copay.	$150 per hospital emergency room visit See Section 5(c) for information on the inpatient hospital copay.
Not covered: Elective care or non-emergency care	*All Charges*	*All Charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	$100 per trip	$100 per trip
Not covered: Air ambulance if not medically necessary	*All Charges.*	*All Charges.*

Section 5(e). Mental health and substance abuse 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.
- 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.
- **NOTIFICATION MAY BE REQUIRED FOR THESE SERVICES.** See the instructions after the benefits description below.
- **Preauthorization:** To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: Call the Behavioral Health Access Center at 1-800-568-0458 before seeking treatment.
- **Limitation:** We may limit your benefits if you do not obtain a treatment plan.

Benefit Description	You pay	
Professional services	**High Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	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
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$25 per office visit to your PCP or specialist	$30 per office visit to your PCP or specialist

Benefit Description	You pay	
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$25 per office visit to your PCP or specialist Nothing for lab tests at a participating freestanding laboratory $25 per visit for radiology at a participating freestanding radiology center	$30 per office visit to your PCP or specialist Nothing for lab tests at a participating freestanding laboratory $50 per visit for radiology at a participating freestanding radiology center
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$500 per inpatient hospital admission or $75 copay per alternative care setting	$750 per inpatient hospital admission or $150 copay per alternative care setting
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment • Residential treatment services are covered in full	$25 per office visit	$30 per office visit
Not covered	**High Option**	**Standard Option**
Care that is determined not to be clinically appropriate to treat your condition.	All charges	All charges

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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting any unused medications.
- The calendar year deductible is $250 per person ($500 for Self Plus One and Self and Family coverage on the High Option and $500 per person ($1000 for Self Plus One and Self and Family coverage) on the Standard Option.
- 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 a 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 drugs is a preferred list that we selected to meet patient needs at a lower cost. To order a copy of our prescription drug formulary please call us at 1-888-687-6277or visit our website at www.mvphealthcare.com

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **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 Customer Care Center 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 coverage under your Plan. 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 Customer Care Center at 1-888-687-6277.
- **These are the days supply 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, you can obtain up to a 90-day supply of maintenance medications. You may contact our Customer Care Center 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.
- Ask your doctor to write two prescriptions when he/she 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 the CVS/Caremark Pharmacy. Complete and sign an order form and attach the 90-day prescription. Then, mail everything to CVS/Caremark P.O. Box 2110, Pittsburgh, PA 15230-2110
- Some medications are only available from a specialty pharmacy. Generally these are self- administered injectable drugs used to treat certain conditions. You may contact our Customer Care Center at 1-888-687-6277 or visit our website at www.mvphealthcare.com to find out if a certain drug must be obtained at a specialty pharmacy.

- **A generic equivalent will be dispensed if it is available,** unless your physician states that you specifically require a name brand. Under the Brand/Generic Difference Program, if there is an A-rated generic drug, and you receive the brand name drug, you will be responsible for the difference in cost between the generic and the brand name drug plus your generic copayment.
- **Why use generic drugs?** Generic drugs are typically lower priced drugs that are the therapeutic equivalent to more expensive name brand name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand name product. Generics cost less than the equivalent brand name drug.
- Certain drugs are subject to prior authorization, step therapy or quantity limits. All new drugs require prior authorization for a minimum of six (6) months from when they become available on the market. To find out if the drug you take is subject to one of these management tools or if you must obtain your medication from a specialty pharmacy, check the formulary at www.mvphealthcare.com or call our Customer Care Center at 1-888-687-6277.
- We review policies and drug classes on a regular basis and may make changes to the formulary, prior authorization, step therapy or quantity limits based on the Pharmacy & Therapeutics committee recommendations. We will notify you in writing 30 (thirty) days prior to any change that will impact you. These changes are also posted on our website at www.mvphealthcare.com.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies when obtained from a Plan pharmacy or through our mail order program: • Food and Drug Administration (FDA) approved drugs that require a physician's prescription for their purchase, except those listed as *Not covered.* • Enteral Formulas when medically necessary (contact MVP Health Care for details). • Modified solid foods, when medically necessary, up to $2,500 per calendar year. • Drugs for sexual dysfunction (see note below concerning prior authorization and dose limits) 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 the Plan for quantity limits, step therapy and prior authorization. Note: You may obtain up to a 90-day supply of maintenance medication by mail order. Only maintenance drugs are available through mail order. Note: Infertility drugs will only be dispensed for members between twenty-one (21) and forty-four (44) years of age and may require prior authorization.	$5 per Generic prescription unit or refill from a participating Retail pharmacy $35 per Brand Name prescription unit or refill from a participating Retail pharmacy $70 per Non-Formulary prescription unit or refill from a participating Retail pharmacy $70 per Specialty prescription unit or refill from a participating specialty pharmacy $12.50 per Generic prescription for up to a 90-day supply by Mail Order $87.50 per Brand Name prescription for up to a 90-day supply by Mail Order $175.00 per Non-Formulary prescription for up to a 90-day supply by Mail Order $175.00 per Specialty prescription for up to 90-day supply by Mail Order	$5 per Generic prescription unit or refill from a participating Retail pharmacy $45 per Brand Name prescription unit or refill from a participating Retail pharmacy $90 per Non-Formulary prescription unit or refill from a participating Retail pharmacy $90 per Specialty prescription unit or refill from a participating specialty pharmacy $12.50 per Generic prescription for up to a 90-day supply by Mail Order $112.50 per Brand Name prescription for up to a 90-day supply by Mail Order $225.00 per Non-Formulary prescription for up to a 90-day supply by Mail Order $225.00 per Specialty precription for up to 90-day supply by Mail Order

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Women's contraceptive drugs and devices	Nothing for covered generic and single source brand name contraceptive drugs. Multi-source brand contraceptive drugs will require the member payment of the generic-brand difference in cost. We will only cover contraceptives that require a prescription for purchase, when prescribed by a participating physician and when purchased at a participating pharmacy.	Nothing for covered generic and single source brand name contraceptive drugs. Multi-source brand contraceptive drugs will require the member payment of the generic-brand difference in cost. We will only cover contraceptives that require a prescription for purchase, when prescribed by a participating physician and when purchased at a participating pharmacy.
Diabetic Drugs and Supplies- Includes insulin and oral medication, test strips and control solutions, urine testing strips, lancets and automatic lancing devices, insulin cartridges for the visually impaired, insulin syringes and injection aids and insulin pump supplies including but not limited to infusion sets and reservoirs.	$25 copay per 30 day supply	$25 copay per 30 day supply
Disposable needles and syringes for the administration of covered medications	20% copay for disposable needles and syringes needed to inject covered prescription medications	20% copay for disposable needles and syringes needed to inject covered prescription medications
Compounded prescriptions that require the mixing of two or more ingredients, at least one of which is a legend ingredient	$70 per Non-Formulary prescription unit or refill from a participating Retail pharmacy Not available through Mail Order	$90 per Non-Formulary prescription unit or refill from a participating Retail pharmacy Not available through Mail Order
Tobacco cessation medications (over the counter-OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for tobacco cessation medications (over the counter-OTC) and prescription drugs approved by the FDA to treat tobacco dependence. A prescription is required for coverage for OTC products. Not available through Mail Order	Nothing for tobacco cessation medications (over the counter-OTC) and prescription drugs approved by the FDA to treat tobacco dependence. A prescription is required for coverage for OTC products. Not available through Mail Order
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Non-prescription, vitamins, nutrients and food supplements even if a physician prescribes or administers them (except prenatal vitamins and Vitamin D for adults 65 and older)*	*All Charges*	*All Charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Over -the-counter medications (except insulin, smoking cessation medications and medically necessary enteral products)* • *Drugs that require a prescription, but have an exact equivalent that is available over the counter* • *Refills due to a lost or stolen prescription drug supply* • *Drugs used in connection with the provision of a non-covered service or benefit* • *Drugs determined to be not medically necessary* • *Drugs used for experimental and/or investigational purposes* • *Immunizations, vaccinations, oral drugs or other services taken solely as a precaution prior to travel within or outside the United States*	*All Charges*	*All Charges*

Section 5(g). 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 Desription	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
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	$25 per office visit to your PCP or specialist Note: Hospital services are subject to the $500 inpatient hospital copay or the $75 copay for outpatient services.	$30 per office visit to your PCP or $50 per office visit to a specialist Note: Hospital services are subject to the $750 inpatient hospital copay or the $150 copay for outpatient services and $150 physician surgical copay
Not covered: • *Dental services not shown as covered* • *Dental services that result from injury to teeth while eating*	*All charges.*	*All charges.*
Dental benefits for children up to age 19	**High Option**	**Standard Option**
The following preventive and diagnostic services are covered for Plan members under age 19: • One initial oral exam followed by periodic exams, once every six months • Bite wing x-rays, once every six months • Full mouth x-rays and panoramic x-rays, once every 36 months • Routine cleaning, scaling, and polishing of teeth, once every six months • Fluoride treatments, once every six months, to age 16 • Pulp vitality testing and diagnostic casts, as needed • Space maintainers and recementation thereof, as needed • Intra-oral and periapical x-rays, as needed	$25 per office visit	$25 per office visit

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

Benefit Desription	You Pay	
Dental benefits for children up to age 19 (cont.)	**High Option**	**Standard Option**
• Sealants once per tooth per child (only covered to age 16) 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: MVP Health Care P O Box 2207 Schenectady, NY 12301 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	$25 per office visit	$25 per office visit
Not Covered • *Other dental services not shown as covered* • *Services which are not approved by the Council of Dental Therapeutics of the America Dental Association (ADA)* • *Services rendered by a medical department, clinic, or similar facility of the child's employer, labor union, mutual benefits association, or other similar group* • *Charges for dental appointments that are not kept* • *Dental implants*	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Wellstyle Extras Program	• The Wellstyle Extras program is outcomes based, designed for members to take an active approach in managing their lifestyle by providing incentives for meeting health recommendations for identified biometric measures, for participating in telephonic health coaching and/or completing health related activities in an online portal. • Members can receive up to **$300** per Subscriber per calendar year. • Each point earned is equal to one dollar. • Points can be redeemed in $150 increments. • Rewards are available as gift cards or a reward checks. • Points are earned and tracked online. • Covered dependents eligible to earn points include the Subscriber's covered spouse or domestic partner and any dependent age 18 or older. • Only the Subscriber will be able to redeem points. • Points are earned and redeemed on a calendar year basis. • Points do not roll over from year to year and will expire at the end of each calendar year (by March 31) if not redeemed. • All activities must be completed by December 31st, and rewards redeemed by March 31st.
Services for deaf and hearing impaired	If you are hearing impaired and wish to speak with a Customer Care Center representative please first contact a relay operator at 1-800-662-1220 and then they will call our Customer Care Center (1-888-687-6277) and help you during your conversation with our representative.
High risk pregnancies	MVP's Little Footprints is a special program for women who have had a problem with a past pregnancy or who are at risk for having problems during their current pregnancy. You must have at least three months left in the pregnancy to be eligible to participate. As part of this program one of our prenatal nurses will call you every month to discuss the progress of your pregnancy and what can be done to help ensure a healthy pregnancy and to answer any questions she may have. You or your physician may contact us concerning this program. If you feel you might benefit from this program please contact our Customer Care Center at 1-888-687-6277.
Travel benefit/services overseas	As an MVP member you are covered for emergency care anywhere in the world. If you or your family member ever have a medical emergency, either outside of our service area or outside of the United States, please go to the nearest hospital or medical facility. Please contact our Customer Care Center 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	We offer extended out-of-area coverage for your dependent children up to age 26 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.

	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 Customer Care Center at 1-888-687-6277.

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. These programs & materials are the responsibilities of the plan and all appeals must follow their guidelines. For additional information contact the Plan at 1-888-687-6277 or visit their website at www.mvphealthcare.com

Answers and Advice*24/7 Nurse Advice Line*

Expert advice on non-emergency questions is just a phone call away, even on weekends, when you call our *24/7 Nurse Advice Line* at **1-888-MVP-MBRS (1-888-687-6277).**

Online Wellness Tools and Activities

This dynamic site features a Personal Health Assessment, which provides a customized health action plan to target your modifiable risk factors, as well as a variety of interactive tools, including meal planners and grocery lists, personalized cardio and resistance exercise routines, and online coaching classes that can be tailored to your unique interests and lifestyle goals.

Section 6. General exclusions – services, drugs and supplies we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of the brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For more information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except when authorized or for 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 you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

This section primarily deals with post -service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1-888-687-6277, or at our website at : www.mvphealthcare.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number 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 payor – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.
- Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills

Submit your claims to:

MVP Health Care

625 State Street

Schenectady, NY 12305

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. Once we pay the benefits, there is a 3 year limitation on the re-issuance of uncashed checks.

Dental Services

For children's preventive dental benefit, the dentist may have you pay the cost of the entire visit. If so, please call our Customer Care Center 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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Section 3, 7 and 8 of this brochure, please visit www.mvphealthcare.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post service claim (a claim where services, drugs or supplies have already been provided). In section 3, *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services , referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Care Center by writing MVP Health Care, 625 State Street, Schenectady, NY 12305 or calling 1-888-687-6277.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial claims decision. You must: : a) Write to us within 6 months from the date of our 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 claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by providing your email address, you may receive our decision more quickly. We will provide you , free of charge and in a timely manner, with any new or additional evidence considered, relied upon or generated by us or at our discretion in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post- service claim, we have 30 days from the date we receive your request to : a) Pay the claim or b) Write to you and maintain our denial or

	c) Ask you or your provider for more information 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.
3	If you do not agree with our decision, you ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us--if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at : United States Office of Personnel Management, Healthcare and insurance, Federal Employees Insurance Operations, Health Insurance 3, 1900 E Street NW, Washington DC 20415. Send OPM the following information: • A statement about why you beleive our decision was wrong, based on specific benefit provisions in this brochure; • 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. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM"s decision more quickly. 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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	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 file a lawsuit. If you decide to file a lawsuit, 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 file a lawsuit 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-888-687-6277. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p. m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at www.NAIC.org.

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

When we are the secondary payor, 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.

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 (or a covered family member) 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgement, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your illness or injury. However, we will cover the cost of treatment that exceeds the amount of the payments you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgement, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, 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 or by phone at 1-877-888-3337, (TTY 1-877-889-5680), 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.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

1. Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
2. Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
3. Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

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

- 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 1-800-633-4227, (TTY: 1-877-486-2048) 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. 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. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **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, (TTY: 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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 payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-888-687-6277 or see our website at www.mvphealthcare.com.

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

You can find more information about how our plan coordinates benefits with Medicare at www.mvphealthcare.com.

Benefit Description	Member Cost without Medicare	Member Cost without Medicare	Member Cost with Medicare Part B	Member Cost with Medicare Part B
Benefit Description	**High Option**	**Standard Option**	**High Option**	**Standard Option**
Deductible	$0	$0	$0	$0
Out-of- Pocket Maximum	$6,600 Self Only/ $13,200 Self Plus One or Self and Family	$6,600 Self Only/ $13,200 Self Plus One or Self and Family	$6,600 Self Only/ $13,200Self Plus One or Self and Family	$6,600 Self Only/ $13,200 Self Plus One or Self and Family
Primary Care Physician	$25	$30	$25	$30
Specialist	$25	$50	$25	$50
Inpatient Hospital	$500 copay per admission	$750 copay per admission	$500 copay per admission	$750 copay per admission
Outpatient Hospital	$75	$150	$75	$150
Rx	Level 1 -$5 Level 2 -$35 Level 3 - $70 Level 4 – $70 Specialty (30-day supply)	Level 1 -$5 Level 2 -$45 Level 3 - $90 Level 4 – $90 Specialty (30-day supply)	Level 1 -$5 Level 2 -$35 Level 3 - $70 Level 4 – $70 Specialty (30-day supply)	Level 1 -$5 Level 2 -$45 Level 3 - $90 Level 4 – $90 Specialty (30-day supply)
Rx – Mail Order (90 day supply)	2.5x retail copay	2.5x retail copay	2.5x retail copay	2.5x retail copay

You can find more information about how our plan coordinates benefits with Medicare in the 'Medicare and You' booklet on the CMS web site at https://www.medicare.gov/supplement-other-insurance/how-medicare-works-with-otherinsurance/who-pays-first/which-insurance-pays.html.

- **Tell us about your Medicare Coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under medicare , if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary /secondary status of this Plan and Medicare.

- **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), (TTY: 1-877-486-2048) 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). However, 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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
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.

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.
Clinical Trials Cost Categories	• Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
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.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs(e.g. coinsurance and copayments) for the covered care you received.
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	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 us being recommended. We will only provide coverage for these type of services if the proposed treatment has shown promising results in treating the underlying condition through a nationally recognized program, and a group of experts has reviewed the proposed treatment and thinks that it is appropriate. If an appeal agent, outside of our Plan approves coverage for experimental or investigational services for you, and you would be part of a scientific trial or test, than our Plan would only provide limited benefits for these services, and you would be responsible for the rest.
Group health coverage	Coverage you are eligible to receive through your employer. This Plan is offered as group health coverage to you, and all other eligible employees of the Federal Government.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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.
Post Service Claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits
Pre Service Claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Us/We	Us and We refer to MVP Health Care
You	You refers to the enrollee and each covered family member.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at : MVP Health Care 1-888-687-6277. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitve group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one , or self and family coverage for your self and any eligible dependents.

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB and FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **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 out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income tax return who is mentally or physically incapable of self-care. You (and your spouse, if married) must be working, looking for work (income must be earned during the year), or attending a school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	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.

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

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including : • 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 up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888- 3337, (TTY: 1- 877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It 's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

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

Summary of Benefits for the High Option of MVP Health Care - 2016

- **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 treament services provided in the office	$25 per office visit	23
Services provided by a hospital		
• Inpatient	$500 per admission copay (limited to one copay per person or three copays per family per year)	42
• Outpatient	$75 copay at outpatient facility	43
Emergency benefits:		
• In-area	$25 per office visit or urgent care center visit; $50 per visit to hospital emergency room	46
• Out-of-area	$25 per office visit or urgent care center visit; $50 per visit to hospital emergency room	45-46
Mental health and substance abuse treatment	Regular cost sharing	47-48
Prescription drugs:		
• Retail pharmacy	$5 Generic/$35 Name brand/$70 Non-formulary/$70 Specialty per prescription unit or refill. (Brand name is subject to a $250 deductible, per person)	50
• Mail-order	$12.50 Generic/$87.50 Name brand/$175 Non-formulary/$175 Specialty per prescription unit or refill (Brand name is subject to a $250 deductible, per person)	50
Dental care: Preventive care for children up to age 19 only	$25 per office visit	53-54
Vision care:	$25 per office visit (one covered eye exam every 24 months)	29
Special features: Wellstyle Extras**,** Little Footprints; Out-of-Area student benefit; travel benefit/overseas benefit		55-56

Summary of benefits for the Standard Option of MVP Health Care - 2016

- **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	$30 per primary care office visit; $50 per office visit to a specialist	23
Services provided by a hospital:		
• Inpatient	$750 per inpatient admission; $150 for the physician's charge for surgery	42
• Outpatient	$150 copay at outpatient facility; $150 for the physician's charge for surgery	43
Emergency benefits:		
• In-area	$30 per visit to urgent care center; $150 per hospital emergency room visit	46
• Out-of-area	$150 per hospital emergency room visit	45-46
Mental health and substance abuse	Regular cost sharing	47-48
Prescription drugs:		
• Retail pharmacy (30 day supply)	$5 Generic/$45 Name Brand/$90 Non-Formulary/$90 Specialty per prescription unit or refill. (Brand name is subject to a $500 deductible, per person)	50
• Mail-order (for a 90 day supply)	$12.50 Generic/$112.50Name Brand/$225.00 Non-Formulary/$225 Specialty per prescription unit or refill. (Brand name is subject to a $500 deductible, per person)	50
Dental care: Preventive care for children up to age 19 only	$25 per office visit	53-54
Vision care: One covered eye exam every 24 months	$50 per office visit	29
Special features: Wellstyle Extras**,** Little Footprints; Out-of-area-student benefit; Travel benefit/services overseas		55-56

Notes

2016 Rate Information for MVP Health Care

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.