



MVP Health Care

Medicare Member Notices

2011

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About the Medicare Customer Care Center

Medicare Customer Care Center representatives are ready to answer your questions, explain your benefits and resolve any issues.

If you are most comfortable speaking a language other than English, we can arrange to have an interpreter available at no cost to you.

When to contact Medicare Customer Care Center

- For the most up-to-date list of doctors, hospitals and other health care professionals in our network.
- To change your primary care physician (members can also do this on the Web—see Visit the MVP Health Care Web Site in this section).
- To learn more about your benefits.
- If your address or phone number changes.
- If you receive a bill, other than for copayments, from a physician or other health care professional or facility.
- If you lose your Preferred Gold HMO, GoldValue HMO or GoldAnywhere PPO card or need to update the information on your card.
- When you want to express a concern, make a suggestion or ask a question about your coverage or treatment.
- For information on allowing a family member, friend, or lawyer to help you with questions about your health care plan.
- For help with an appeal or complaint.
- For more detailed information about physician offices and other health care professionals (for example, to find a doctor's office where another language is spoken).

How to contact the Medicare Customer Care Center

By phone:

1-800-665-7924 (toll free)

1-800-662-1220 (toll free TTY)

Representatives are available Monday—Friday from 8 am to 8 pm Eastern Time and on Saturday from 8 am to 4 pm Eastern Time. From October 15 – February 14, call seven days a week from 8 am to 8 pm at the above numbers.

If you have an urgent concern after hours, please call the Medicare Customer Care Center number listed above and follow the prompts. You also may find answers to many of your questions on our Web site.

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In writing:

You can write Medicare Customer Care Center at the following address:

MVP Health Care
Attention: Medicare Customer Care Center
220 Alexander Street
Rochester, NY 14607

By fax:

You can send Medicare Customer Care Center a fax at 585-327-2298. Write on the fax: Attention Medicare Customer Care Center.

Visit the MVP Health Care Web site

You can use MVP Health Care's Web site to help manage your health plan and take charge of your health. These resources and information are available 24 hours a day at **www.mvphealthcare.com**. Click the *Medicare Members* tab to find valuable information.

About our network of doctors and hospitals

An important part of being a **Preferred Gold HMO or GoldValue HMO** member is selecting a Primary Care Physician (PCP). Your PCP will work with you to manage your health. You may choose from MVP's network of more than 15,000 doctors and health care professionals (nurse practitioners, therapists and others), and all the hospitals and urgent care centers in our service area. They have agreed to provide your care and follow specific quality of care practices.

If you are a **GoldAnywhere PPO** member, you may go outside of the network to get covered services. However, it may cost more to do so for services other than emergency or urgently needed care, or renal dialysis.

The Primary Care Physician (PCP) you choose:

- Understands your medical history and what is normal for you.
- Coordinates all of your medical care.
- Will arrange for follow-up care after a hospitalization or surgery, even if you are out of the service area.

You can feel confident in the health care professionals in our network. Each physician has been initially screened and is reviewed at least every three years for:

- New York State licensure
- Basic educational credentials, including Continuing Medical Education credits
- Malpractice insurance and malpractice claims (if any)
- Legal actions in any state
- Current drug enforcement agency license
- Sanctioning by CMS (the Centers for Medicare & Medicaid Services)

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No referral needed for specialists

If you are a **Preferred Gold** or **GoldValue** member, you will not need to call your primary care doctor for a referral to see a specialist in the MVP Health Care network, such as a podiatrist, rheumatologist, dermatologist, cardiologist or specialists in behavioral health services. You may call directly to make your appointment when the specialist is part of the MVP Health Care network.

If you are a **GoldAnywhere PPO** member, you can see any doctor in the United States any time. It is important that your primary care doctor is aware of all doctors who care for you to assure care is coordinated appropriately.

If a medical service is not available within our network

If you are a **Preferred Gold or GoldValue member** and need a medical service not available within our network, you will be referred to another physician or hospital for your medically necessary care. For example, members needing certain types of organ transplants are referred to a Medicare-approved transplant center. MVP covers this medically necessary care.

If you are a **GoldAnywhere member** and need or want a medical service not available within our network, you may see a doctor or receive services outside of the network. Remember that it may cost you more to receive medical services outside of the MVP network. Some services may have pre-authorization rules that apply either in or out of network.

MVP will help you find a provider

You can use our Web site — www.mvphealthcare.com — to look for a doctor. From our home page, click on the “Provider Search” feature. The site is updated regularly. You can search for a doctor by name, location or specialty. You also can choose to search for doctors who:

- Are currently accepting new patients
- Admit to the hospital nearest you
- Speak or understand other languages, such as Spanish or French

Or you can call us at the number on the back of your member ID card to ask for a listing of all the doctors in our network.

About your primary care physician (PCP)

Preferred Gold and GoldValue members must select a PCP to join our plan (not required for GoldAnywhere).

An important part of being a **Preferred Gold HMO or GoldValue HMO** member is selecting a Primary Care Physician (PCP). If you do not select a PCP, one may be assigned to you. Your PCP will work with you to manage your health.

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Your PCP is the internist, family practitioner, or general practitioner you choose to provide or arrange all of your care. Women may also choose an obstetrician / gynecologist in addition to their PCP.

Your PCP should be the first person you contact when you need medical care, except in an emergency or for out-of-area urgently needed care. It is very important that you choose a PCP and list your choice on your enrollment form. Your application cannot be processed without a PCP selection. This may cause delays in getting your member ID card.

GoldAnywhere members may choose to get most or all of their care from the doctors, hospitals and other health care professionals in our network; or they may choose to use non-plan health care professionals to get covered services. However, it may cost more.

The role of your PCP

The Primary Care Physician (PCP) you choose:

- Understands your medical history and what is normal for you.
- Coordinates all of your medical care.
- Will arrange for follow-up care after a hospitalization or surgery, even if you are out of the service area.

You can expect your Primary Care Physician to:

- Provide treatment in a timely manner.
- Inform you of your health condition and the full range of treatment options regardless of cost or benefit coverage.
- Obtain your consent, or the consent of someone you authorize, for all treatment.
- Maintain confidentiality about your care.
- Be accessible 24 hours a day, 365 days a year and have a backup (or on-call) physician.

Choose a PCP who's right for you

Choosing a Primary Care Physician is one of the most important decisions you can make about your health care. Your doctor is your partner in health. He or she will work with you to manage all your health care needs. Think about the qualities you want in a health care professional and in the doctor-patient relationship. You need to feel comfortable with your doctor. You also need to feel secure with his or her expertise and level of experience.

You may want to consider the following when deciding on a PCP:

- The PCP's location and office hours
- The age and/or gender of the PCP
- The PCP's hospital affiliations

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Here are some suggestions to help you choose the PCP who best meets your health care needs:

Do your research

The key to choosing a Primary Care Physician (PCP) is good research. Make sure that you have as much information as possible before selecting your PCP. The more you know about a doctor, the better the chances are that you will choose one who meets your health care needs. Some things to consider:

Education and Training

- Where did the doctor train?
- When looking at educational background, you may want to consider the medical school attended and where the doctor completed his or her residency.
- How long has he or she been practicing?
- Does the doctor have an area of expertise?
- Does the doctor belong to any professional organizations?

Certification

- Make sure that the doctor is licensed.
- Is the doctor board-certified?
- You also may want to check to see if any complaints have been filed against the doctor and/or whether he or she has had any disciplinary actions.

Hospital Affiliations

Some doctors have privileges to admit to certain hospitals. You may want to ask the doctor where he or she may admit patients.

Office Policies

The policies for a doctor's office may be important in making a decision about your PCP:

- How long does it typically take to get an appointment?
- How are payments handled?
- Is the office staff friendly and well-trained?
- Is there enough staff?

Access to Care

- What type of access to care does the doctor provide?
- Does he or she belong to a group practice where you may access other doctors in the group?
- Is he or she a sole practitioner?
- How does the office handle emergency care and weekend appointments?

Confidentiality

- How does the doctor handle confidentiality?
- Are your medical discussions done in private?
- Is the outer office sensitive to patients' confidential concerns?

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Recommendations are a good source of information

Sometimes the best sources of information come from family, friends, and co-workers. Another good source is the medical community in your area. If you know someone in the medical field, he or she might be able to recommend a doctor to you.

Call or visit the doctor's office

Try calling the doctor's office to set up a telephone interview or talk to the office staff. You also can try to meet with the doctor in person. Doctors are often willing to set up an initial visit with new or prospective patients. You'll be able to use first-hand knowledge to decide if that PCP is right for you.

Make a personal connection

- Do you and your doctor "click"?
- Your PCP will manage all your health care needs. You will need to feel comfortable with him or her. How are you treated?
- Do you prefer a male or female doctor?
- Do you like the doctor's "style?"
- Is the doctor "tough and straightforward" or more gentle and nurturing? Which do you prefer?
- Do you feel that you can speak openly and honestly about your health concerns?

Other resources

Other resources available to help you choose your PCP include:

- American Medical Association (AMA) – Provides an online service that you can use to research doctors. The Web site address is www.ama-assn.org. You can write to them to get up to five physician profiles. Profiles include information such as education, board certifications, and disciplinary actions. Call the AMA at 1-312-464-5199 for more information.
- New York State Department of Education Office of the Professions – Lets you search its Web site for physician licensing information. It also gives you general information on requirements for licenses. Visit its Web site at www.op.nysed.gov or contact the office at 1-518-474-3817.
- New York State Department of Health – Lets you search its Web site for information on misconduct and physician discipline from 1992 to the present. The Web site address is www.health.state.ny.us/nysdoh/opmc/main.htm, or call the department at 1-800-663-6114.
- Go to **www.mvphealthcare.com** on the Web for a full listing of our directory of health care professionals.

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How to change your PCP

You may change your PCP at any time. Simply confirm that your new PCP is accepting patients. Then call the Medicare Customer Care Center (at the phone numbers on the back of your member ID card) with the name of your new PCP. If possible, let us know of your new PCP at least 30 days before your first appointment. You also may change your PCP by going to www.mvphealthcare.com on the Web.

How to choose an OB/GYN

An OB/GYN doctor cannot be selected as a PCP. However, he or she is considered a “primary care professional” who can treat and refer non-OB/GYN conditions (for example, high blood pressure). The OB/GYN also will inform your PCP of any non-OB/GYN treatment you receive. **Please note:** Even if your OB/GYN serves as your PCP, you will still need to select a PCP.

MVP recognizes the importance of the relationship between a woman and her OB/GYN. All female members may see their OB/GYN (within the MVP network) whenever they choose for routine and preventive services, without a referral from their PCP.

No referral needed for specialists

If you are a **Preferred Gold** or **GoldValue** member, you will not need to call your primary care doctor for a referral to see a specialist, such as a podiatrist, rheumatologist, dermatologist, cardiologist or specialists in behavioral health services. You may call directly to make your appointment. The specialist must be part of the MVP Health Care network. To check to see if a specialist is a part of our network, visit www.mvphealthcare.com or call Medicare Customer Care Center. If you are a **GoldAnywhere** member, you can see any doctor, anywhere, any time. It is important that your primary care doctor is aware of all doctors who care for you to assure care is coordinated appropriately.

GoldAnywhere PPO members may go outside of the network to get covered services. However, it may cost more to do so for services other than emergency or urgently needed care, or renal dialysis.

For behavioral health concerns

For any chemical dependency or mental health issue, call the MVP Medicare Customer Care Center number on the back of your ID card. A representative will assist you with getting services. You can also refer to your Evidence of Coverage for further information regarding chemical dependency and mental health benefits and services.

How to seek emergency or urgently needed care

To get the best care when you need *immediate* medical attention, ask yourself, “What is the danger to my health?”

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- Choose **urgently needed care** if you need medical attention right away for an unplanned illness or injury, like a sprain, the flu, or a bad cut, but your health is not in serious danger.
- You should get **emergency care** if you believe that your health is in serious danger and every second counts, with severe pain, a bad injury, a serious illness or medical condition that is quickly getting much worse.

About urgently needed care

Many health care professionals report that a significant number of people in emergency rooms could be better and more quickly cared for in a doctor's office or an urgent care center. That is why an urgent care center may be a convenient, appropriate, and lower cost option to emergency room care when your doctor is unavailable.

- Urgent care is not designed to treat sudden, serious health problems. Rather, urgent care is designed to treat minor illnesses or injuries such as sprains, strains, minor cuts or burns, or the flu.
- You should follow up with your doctor within 48 hours after receiving urgent care.

Urgently needed care coverage for GoldValue HMO and Preferred Gold HMO members

In the service area

To get urgently needed care in the plan's service area, call your doctor or go to an urgent care center. In most cases, MVP will not pay for urgently needed care that you get from a non-plan health care professional while in the service area unless the care meets the definition of urgently needed care.

Outside the service area

When you are outside the service area and cannot get care from a network provider, MVP will cover urgently needed care that you get from any provider, as long as it meets the definition of urgently needed care. Some services may have pre-authorization rules that apply either in- or out-of-network.

Urgently needed care coverage for GoldAnywhere PPO members

If you are a **GoldAnywhere PPO** member and need urgent care, you should call your doctor first, whenever possible. MVP covers urgent and follow-up care that you get from any provider as long as the care you are getting still meets the definition of "urgently needed care." Some services may have pre-authorization rules that apply either in- or out-of-network.

Preferred Gold HMO, GoldValue HMO, and GoldAnywhere PPO plans do not cover urgently needed care outside of the United States.

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About medical emergencies

- In an emergency, get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. You do **not** need to get permission first from your physician or other doctor.
- Make sure that your doctor knows about your emergency, because he or she will need to be involved in following up on your emergency care. You or someone else should call to tell your doctor about your emergency care as soon as possible, preferably within 48 hours.
- When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, you receive post-stabilization care.

What is covered?

- You can get covered emergency medical care whenever you need it, anywhere in the world.
- Ambulance services are covered in situations where other means of transportation would endanger your health.
- Your post-stabilization care will be covered according to Medicare guidelines. In general, your doctor will try to arrange for plan health care professionals to take over your care as soon as your medical condition and the circumstances allow.
- **GoldAnywhere PPO** members pay more for post-stabilization care if they get their care from non-plan doctors.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger.

- If you get any additional care after the doctor says it is not a medical emergency, we will pay our portion of the covered additional care if you get it from a health care professional in our network.
- **Preferred Gold HMO** and **GoldValue HMO** members who get any additional care from a non-plan health care professional after the doctor says it was not a medical emergency will usually not be covered for the additional care. There is an exception: we will pay our portion of the covered additional care from a non-plan health care professional if you are out of our service area, as long as the additional care you get meets the definition of “urgently needed care” that follows; or if the care qualifies under your travel benefit.
- **GoldAnywhere PPO** members may pay more for additional care if they get their care from non-plan doctors.

What if you need medical care when your PCP's office is closed?

In an emergency, you should get care immediately. You do **not** have to contact your doctor or get permission in an emergency. You can dial 911 for immediate help by phone or go directly to the nearest emergency room, hospital or urgent care center.

How to change your PCP

You may change your PCP at any time. Simply confirm that your new PCP is accepting patients. Then call MVP's Medicare Customer Care Center (at the phone numbers on the back of your member ID card) with the name of your new PCP. If possible, let us know of your new PCP at least 30 days before your first appointment. You also may change your PCP by going to **www.mvphealthcare.com** on the Web.

How to choose an OB/GYN

An OB/GYN doctor cannot be selected as a PCP. However, he or she is considered a "primary care professional" who can treat and refer non-OB/GYN conditions (for example, high blood pressure). The OB/GYN also will inform your PCP of any non-OB/GYN treatment you receive. **Please note:** Even if your OB/GYN serves as your PCP, you will still need to select a PCP.

MVP recognizes the importance of the relationship between a woman and her OB/GYN. All female members may see their OB/GYN (within the MVP network) whenever they choose for routine and preventive services, without a referral from their PCP.

Hospitalization

Your doctor or a specialist will decide if you need treatment in a hospital. This might happen, for example, if you need tests or routine procedures that cannot be performed in a doctor's office or to treat a serious illness or other medical problem. If you do require a hospital stay, your primary care physician will contact MVP Health Care before you are admitted and make all the necessary arrangements. He or she also will explain everything you need to know and answer all your questions.

With very few exceptions, all medically necessary hospital services are covered for as many days as medically necessary in a semi-private room. The length of your stay will be based on medical need, as determined by your primary care physician and any specialist involved in your treatment, together with MVP Health Care's Medical Director.

Your pre-admission testing is a covered service, and the appropriate copayment applies.

There are many medical conditions that cannot be treated on an outpatient basis, but do not require hospitalization. Your doctor may arrange for you to be cared for in a subacute unit at a skilled nursing facility or intermediate care facility, or even through home care. Your doctor has agreed to refer you to the most appropriate setting for your care and may believe that your best care will be in a setting other than a traditional

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hospital unit. All facilities used by MVP Health Care have met our credentialing standards and are qualified to meet your medical needs.

Specialized medical care over a prolonged period of time

If you have a very serious degenerative or disabling condition or disease that requires specialized care over a prolonged period of time (for example, cancer) you may request that your specialist becomes your primary care physician. You also may request care at a specialty care center, if appropriate, for the same reason. All requests for this type of specialty care must be made through your primary care physician to MVP Health Care's Utilization Management Department. We will inform you of the decision made on your request.

Transitional care for new members

If you are a new member and your doctor from your previous plan is not part of the MVP Health Care network, you may ask to continue seeing your former doctor for up to 60 days after you become a member if you are living with a life-threatening, deteriorating or disabling condition or disease. The doctor must:

- Agree to accept MVP Health Care's reimbursement as payment in full (minus any copays or deductibles)
- Maintain our quality assurance requirements
- Share medical information with MVP Health Care
- Follow our policies and procedures for prior authorization of services

To ask for this type of transitional care or help with choosing a new doctor, call our Medicare Customer Care Center.

Medical bills

Preferred Gold HMO and GoldValue HMO members must receive their care from MVP network health care professionals (except for emergency and urgently needed care and renal dialysis outside of the service area), or it will not be covered by MVP or Medicare. **GoldAnywhere PPO** members may use non-plan health professionals to get covered services. However, your out-of-pocket costs may be higher than if you use our plan health care professionals (except for emergency and urgently needed care and renal dialysis). All network health care professionals have agreed to provide care to our members at negotiated prices. **Your doctor will not bill you for unpaid balances or charge you any extra fees for covered services.** You are responsible for your copayments or coinsurance.

If you receive a medical bill from a physician or other health care professional **other than for your required coinsurance or copayment**, do not pay it. This is true for both MVP participating and non-contract health care professionals.

1. Review the bill to verify that you did receive the stated services.

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2. Submit the bill for processing to: Claims Submission, MVP Health Care, P.O. Box 2207, Schenectady, NY, 12301.
3. Our Claims Department will determine if you have any financial liability for this care.
4. If you decide that the bill contains services that you did not receive, please notify Medicare Customer Care Center immediately so it can be reviewed. Call Medicare Customer Care Center at the phone numbers on the back of your member ID card.

Prior authorization

For Preferred Gold and GoldValue members

There are certain procedures and services that require “prior authorization”, which is a process in which MVP works with you and your doctor to make sure you receive medically necessary, high-quality medical treatment at a reasonable cost. It’s a process in which MVP responds orally or in writing to a request for authorization before you receive specified non-emergency services.

Services needing prior authorization are covered only if determined to be medically necessary. In most cases, your doctor will start the process and request authorization whenever it is needed. Please note that you are ultimately responsible for ensuring the prior authorization is obtained from MVP for specified services. We encourage you to talk with your doctor about the process to ensure that prior authorization is obtained.

A few examples of services that need prior authorization include:

- Admissions (to hospitals, transitional care units, acute rehabilitation, skilled nursing facilities, partial hospitalization programs)
- Durable medical equipment / prosthetics
- Home care services
- Implants and internal prosthetics
- Dental services
- Prescription drugs

If you wish to receive services that need prior authorization, you should work with your doctor. Your doctor should contact MVP at least seven days in advance of the planned service or procedure. You and your doctor will be notified within three business days of receipt of all necessary information. If the request involves urgent or continued treatment, the notification will be made within one business day of receipt of all necessary information.

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For GoldAnywhere members

Some services require “**prior authorization**” by MVP regardless of whether these services are given in-network or out-of-network. Prior authorization is a process in which MVP works with you and your doctors to make sure you receive medically necessary, high-quality medical treatment at a reasonable cost. Some examples of services needing prior authorization include:

- Admissions to transitional care units, acute rehabilitation, skilled nursing facilities
- Durable medical equipment
- Home care services
- Implants and internal prosthetics
- Medically necessary dental services
- Certain prescription drugs

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

If you need or want a medical service not available within the MVP health care professional network, you may do so. Remember that it may cost you more to receive medical services outside of the MVP health care professional network.

Evaluating medical technology

MVP Health Care medical policies are developed and reviewed annually and as needed when medical technology changes. If appropriate, new policies are established as new medical technologies arise.

Requests may come from different sources, including providers, members, and regulatory agencies. Careful consideration and research go into each request for consideration of a new technology as a covered benefit. Decisions are made from the most recent evidence-based medical literature and research available.

MVP Health Care medical directors, community physicians on MVP Health Care’s specialty health care teams, medical services departments, claims administration, and product management make up the team that reviews each request. For more explanation of this process, call Medicare Customer Care Center.

Physician incentive program regulation

As Medicare Advantage health plans, Preferred Gold, GoldValue and GoldAnywhere must provide you with the following information if you request it:

- Whether we use a physician incentive plan that affects the use of referral services
- The type of incentive arrangement
- Whether stop-loss protection is provided

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Fraud

Fraud is stealing. Fraudulent health insurance claims increase health care costs. Who pays for this costly crime? We all do. Common forms of fraud include accepting:

- Payments made for services not rendered
- Payments made for services previously covered by another insurance carrier
- Payments made to or for someone who was not an eligible subscriber or dependent

All of these situations are serious crimes — punishable by law.

Report suspected insurance fraud

At MVP Health Care, we're tough on insurance fraud. We work closely with our health care providers and other insurance companies to identify potential fraud. We rely on you to help us fight insurance fraud by reporting any suspicious activity similar to the situations described above.

If you suspect fraud in the health care system, please call our confidential Special Investigations Unit fraud hotline at **1-877-TELL-MVP (1-877-835-5687)**.

How to submit a claim

MVP Health Care is dedicated to prompt and accurate claim payments to our plan participants. If you have paid for services that are covered by your plan, fill out the Medical Reimbursement Claim Form completely and send it to:

Claims Submission
MVP Health Care
P.O. Box 2207
Schenectady, NY 12301

For additional claim forms, you can download and print a copy at **www.mvphealthcare.com** or call the Medicare Customer Care Center at the phone number on the back of your member ID card.

So that we can process your claim promptly, please refer to the following guidelines:

- Use a separate claim form for different calendar years. A separate claim form must accompany each bill. Original bills must be submitted with your claim form. **Keep copies for your own records.**
- Make sure your bills include:
 - Name and address (on letterhead) of the provider of service or supply (hospital, doctor, etc.) including tax ID.
 - Patient's full name and health plan identification number.
 - Type of service or supply (office visits, chest x-ray, etc.), including CPT or HCPCs code.
 - Place of service (inpatient or outpatient hospital, office etc.).
 - Date and charge, for each service or supply provided.

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- Patient's diagnosis codes (the medical condition for which the patient was treated), or ICD-9-CM diagnosis code.
- Cash register receipts, cancelled checks, money orders, credit card vouchers and personal lists of services or bills stating only 'balance forward' are not acceptable as substitutes for bills.
- If another insurance carrier has made payment on this service, an explanation of benefits from the other insurance carrier must be attached.
- Payment will be made directly to provider, unless proof of payment is attached, in which case reimbursement will be sent directly to the subscriber.

Your Explanation of Benefits (EOB)

Whether you receive care from an in-network or out-of-network provider, we may send you an "Explanation of Benefits." This form cites all the care for which we have received claims on your behalf. It is not a bill. We ask that you review any Explanation of Benefits you receive to be sure we are being billed only for the services you actually received. If you see any errors, please call Medicare Customer Care Center right away.

Quality Improvement Program

MVP is dedicated to providing quality health care and services to our members. Our Quality Improvement (QI) program sets standards for the care and services that are provided to our members by MVP and by participating providers. MVP reports on its progress toward achieving the QI program goals in an annual Quality Improvement Evaluation report. You are welcome to participate in the development, implementation, or evaluation of the quality improvement system, and/or you may comment on MVP's Quality Improvement process. If you are interested in participating or commenting, please call our Quality Improvement department.

To receive a summary of the program description document and the Executive Summary of the Annual Evaluation, please call our Quality Improvement department at 1-800-777-4793, ext. 2602 or visit www.mvphealthcare.com on the Web.

Utilization management – we may review the care you receive

Utilization management is a process that MVP uses to review the health care services our members receive. The process makes sure you get the right care for your health needs — effective care that you are able to get in a timely manner and at a place that best meets your specific health care needs.

MVP asks certain questions when reviewing a service or making coverage decisions, such as:

- What is the quality of the care like?
- Do the benefits of getting this care outweigh its risks?
- Is this care appropriate for your specific medical condition?
- Is this the only service that is available or are there other more cost-effective treatments?

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- Does your health plan cover this type of care?

Not all the care you get will be reviewed by MVP. Visits to a specialist's office do not require approval by MVP. A visit to a specialist who is not in the MVP network requires approval from MVP unless it is an urgent or emergent situation. It is still important for you to work with your PCP to coordinate care. Types of care that may be reviewed include services that are high cost (such as gastric bypass surgery) or services often considered not medically necessary (such as cosmetic surgery).

MVP wants to make sure you know:

- that decisions are based on appropriateness of care and service and existence of coverage;
- that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage;
- that financial incentives for UM decision makers do not encourage decisions that result in underutilization or encourage barriers to care and service.

MVP will generally speak to your provider if there are questions about your care.

Your doctor has the right to ask MVP to reconsider its coverage decision if he or she does not agree with that decision. MVP will reconsider the request and provide a response within one business day after the request is received. This timeline does not apply if you have already received the care.

You and your doctor will make all final decisions on your health care. MVP cannot stop you from getting medical care. These utilization management policies are used to determine if, and to what degree, your care will be covered by your MVP health plan.

There are three basic types of review:

Pre-service review (before treatment)

A "pre-service review" is a review that takes place before you get care. Your doctor will contact MVP to request approval for coverage of care. We will review your request before you get the treatment. We will contact your primary care physician and the doctor treating you with the result of the review, and will let you know whether your care will be covered under your health plan.

Types of services that may be reviewed before you get care include elective hospital admissions. An elective admission is a planned admission to the hospital — such as knee replacement surgery. This type of care is not an urgent or emergency admission. Your health will not be at risk if you do not get immediate care.

MVP will review elective admission requests and other pre-service requests within two business days after the request is received. You and your doctor will be informed of the decision within three business days of the request. Urgent referrals will be reviewed as

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soon as possible. You and your doctor will be told of the decision within one business day after the request is received.

You and your doctor will be informed of the MVP decision — by phone and in writing. If you have chosen a person to represent you (member designee), that person will also be notified. MVP also uses this review to find out if you may benefit from our care management programs. You also may get help with planning once you are ready to leave the hospital.

Concurrent review (during treatment)

A “concurrent review” is a review that takes place while you are getting care. This happens when your doctor asks for additional services while you are going through a course of treatment. Examples include ongoing physical therapy and care received while you are in the hospital.

A decision on this type of review will be made within one business day after the request is received. You and your doctor will be informed of the MVP decision about whether this care will be covered under your health plan — by phone and in writing. If you have chosen a person to represent you (“member designee”), that person will also be notified.

Examples of services reviewed during treatment include mental health care, rehabilitation care, and chemical dependency care.

MVP also uses this review to find out if you may benefit from care management programs. You may also get help with planning once you are ready to leave the hospital.

Post-service review (after treatment)

A “post-service review” takes place *after* you receive care. This type of review includes things such as the reason for an inpatient admission, member complaints, appeals, and claims review.

MVP will make a decision and provide a written notice to you and your doctor on this type of review within 30 calendar days after the request is received. The decision will include information about whether this care will be covered under your health plan. If you have chosen a person to represent you, that person will also be notified.

MVP will make a decision on every request. If a decision is not made within the stated timeframe, you may consider this a denial and appeal the MVP decision.

MVP has a medical team — nurses, medical directors, pharmacists, social workers, and physical therapists — on staff. This medical team will help answer questions you may have about your care.

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Call Medicare Customer Care Center at the phone number on the back of your member ID card if you have questions about a review of your medical care. You will be put in contact with someone on our medical team who can answer your questions.

Utilization management for prescription drugs

There are certain prescription drugs that require MVP's review and authorization. This review needs to take place before the prescription can be filled in order for the prescription to be covered under your health plan.

If you have Medicare Part D prescription drug coverage through MVP, please check your Evidence of Coverage booklet for more information. You also may go to **www.mvphealthcare.com** for a list of medications that may require prior authorization under your Part D coverage. Or call Medicare Customer Care Center at the phone numbers on the back of your member ID card for answers to your questions.

About the Formulary and your pharmacy benefit

The *MVP Health Care Medicare Part D Formulary* is a list of drugs that MVP covers for members enrolled in our Medicare Part D benefit. The list has been reviewed by a team of doctors and pharmacists, and has been approved by Medicare. In general, MVP will cover these drugs as long as:

- the drugs are medically necessary (meaning reasonable and necessary to treat your illness or injury and is an accepted treatment for your condition),
- the prescriptions are filled at an MVP Health Care network pharmacy, and
- all other plan rules are followed. Check your Evidence of Coverage (your contract) to read these rules.

As you look through the formulary, you will see that MVP has additional requirements for certain drugs. These restrictions ensure that our members use these drugs in the safest and most effective way, which keeps your drug coverage more affordable. If you notice that a drug that you are taking has a restriction or limit, you should talk with your doctor to determine if an alternative drug might work just as well for you. If your doctor says you have a medical reason to remain on your current therapy, you or your doctor may request an exception for coverage.

Types of Restrictions

Request	Why you would request it	How we determine our response
PA: Prior authorization B/D: B vs. D review	MVP requires a review of certain drugs. The review helps to ensure that the most appropriate medication was selected. Reviews also are done to determine if a drug is covered by	Approval will be granted if your request meets certain criteria which can be found in our Medicare Part D policies (posted on the Web site or available by calling our

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	<p>Medicare rules, or to determine which benefit a drug falls under.</p> <p>For example, some drugs such as albuterol nebulizer solution, could be covered under Part B (medical services) or Part D (pharmacy benefit) depending on your medical condition. MVP must review your specific request to determine which benefit (Part B or Part D) your drug would be covered under. Your cost sharing will be based on this determination.</p> <p>If you fill your prescription before you get approval -- the drug may not be covered.</p>	<p>Medicare Customer Care Center). Our Medicare Part D policies are reviewed by a team of doctors and pharmacists, and approved by Medicare.</p>
<p>QL: Quantity Limit</p>	<p>In some cases, MVP limits the amount of the drug that you can get per prescription or for a defined period of time. For example, MVP will provide up to 30 capsules per month for Nexium®.</p> <p>If you and your doctor believe you need more of a drug than what's typically covered, you can ask for an exception.</p>	<p>Approval will be granted for a quantity limit exception request if the allowed quantity has not been effective in treating your condition and other formulary drugs are not appropriate.</p>
<p>ST: Step Therapy</p>	<p>MVP requires you to first try one drug to treat your medical condition before we will cover another drug. For example, MVP may require the use of a generic medication before using a brand name medication in the same medication class.</p> <p>If you and your doctor believe that taking the first drug will not help your medical condition, you can ask for an exception.</p>	<p>Approval will be granted if you had previously tried the first drug and it was not effective or caused a side effect, or if your doctor does not believe the first drug would be effective in treating your medical condition.</p>
<p>What if my drug is not</p>	<p>If your medication is not on the MVP Formulary, you should talk</p>	<p>Approval will be granted if you tried drugs on the MVP</p>

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<p>listed on the MVP Formulary?</p>	<p>with your doctor to see if you should switch to a medication on the MVP Formulary.</p> <p>If your doctor does not feel that another medication on the formulary is right for you, you or your doctor may submit a request for MVP to cover a non-formulary drug.</p> <p>Please note that some medications are not on our formulary because Medicare has determined that they are not Medicare Part D benefits. MVP cannot approve a formulary exception request to cover a drug that the federal Medicare program does not allow us to cover.</p>	<p>Formulary and they were not effective or caused side effects, or if your doctor does not believe that the drugs on the formulary would treat your medical condition as well as the non-formulary drug.</p> <p>If we grant your request, the drug will be covered in Tier 3 (or Tier 4 if it meets certain cost requirements). You can not ask us to cover the drug in a lower tier.</p>
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Submitting a request for an exception

- You or your doctor must complete the *Request for Medicare Prescription Drug Coverage Determination* form.

The form is available on our Web site at www.mvphealthcare.com. (Click the Medicare Member tab, select your county if prompted, and then click Find a Form under the Forms and Publications column. On the Forms and Publications page, select Coverage Determination Form in the Pharmacy column).

You can also call our Medicare Customer Care Center at the phone number on the back of your member ID card to obtain a form.

- Make sure the form includes:
 - Physician's or prescriber's signature,
 - Supporting information (medical documentation (chart notes) and/or supporting statement) from your doctor,

Timeframe for a decision

- Generally, we must make our decision within **72 hours** of getting your physician's or prescriber's supporting information.
- You can request an **expedited** (fast) exception if you or your physician or prescriber believe that your health could be seriously harmed by waiting up to 72 hours for a decision.

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If your request to expedite is granted, we must give you a decision no later than **24 hours** after we get your prescribing physician's or prescriber's supporting information.

If your physician or prescriber does not provide us with the supporting information, we will wait up to 28 days to make our decision. **If we don't receive the supporting information within 28 days, we will make the decision with the information that we have.**

Obtaining Formulary information

The Formulary and other information about your pharmacy benefit is on our Web site. Go to **www.mvphealthcare.com**, click on the Medicare Members tab, and on the Medicare Members home page click *Part D Prescription Information*. You can also call the Medicare Customer Care Center at the phone number on the back of your member ID card with questions or for information.

How to voice your concerns to MVP

You have rights as an MVP Health Care member and as someone who is getting Medicare. MVP is committed to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

You have the right to voice concerns, to make complaints, or to ask MVP Health Care to reconsider decisions we have made about your coverage.

If you have a problem or concern, please call us first. Your health and satisfaction are important to us. We will work with you to try to find a satisfactory solution to your problem. You may call the Medicare Customer Care Center at the numbers on the back of your MVP member ID card.

If you do not wish to call, or you called and were not satisfied, you can put your complaint in writing and send it to us at:

MVP Health Care
ATTN: Appeals Dept.
220 Alexander St.
Rochester, NY 14607

Two ways to deal with concerns

Sometimes you might need to use a more formal process to address a concern or problem you are having as a member of our plan. There are two ways to formally handle these issues:

- For some issues you need to use the process for making a **complaint**, also called a **grievance**.

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- For other issues, you need to use the process to question or challenge a coverage decision, also called an **appeal**.

Which process should you use? That will depend on the type of problem you are having. Please call MVP first for help, or refer to the chapter of your Evidence of Coverage (your contract with MVP) entitled, “What to do if you have a problem or complaint (coverage decisions, appeals, complaints)” to help you decide which process to use and to find more details about grievances and appeals.

Let’s look more closely at each process.

Filing a grievance

A grievance is a complaint about the way your Medicare health plan is giving care or service. Issues that might lead to you file a grievance include concerns with:

- The service you receive from MVP’s Member Services.
- The quality of care you receive from a doctor, hospital or other health care provider in MVP’s network.
- Getting appointments when you need them, or waiting too long on the phone or to be seen.
- Cleanliness or conditions of doctors’ offices, clinics, or hospitals.

To file a grievance, you must contact MVP within 60 days after the incident occurred.

Filing an appeal

An appeal is a complaint you make if you disagree with certain kinds of decisions made by MVP. Issues that might lead to you file an appeal include:

- A claim being denied for a service you already received and which you believe is covered by your MVP contract.
- MVP not approving medical care that you believe is covered by your contract.
- You are asking MVP to cover a Part D drug that is not on our list of Medicare-approved covered drugs.

To file an appeal, you must contact MVP within 60 days from the date on the denial letter that we send you.

Both the grievance and the appeal processes have been approved by the Medicare program. To ensure fairness and prompt handling of your concerns, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Member Protections

MVP’s privacy notice — How we protect and keep your personal health information confidential

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

MVP Health Plan, Inc., MVP Health Services Corp., MVP Health Insurance Company, MVP Health Plan of New Hampshire, Inc. and MVP Health Insurance Company of New Hampshire, Inc., Rochester Area Health Maintenance Organization, Inc. and Preferred Care Assurance Company, Inc., (collectively "MVP") respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, provide you with this notice of our privacy practices and legal duties and to abide by the terms of this notice.

In compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and New York State laws and regulations regarding the confidentiality of health information, MVP provides this notice to explain how we may use and disclose your health information to carry out payment and health care operations and for other purposes permitted or required by law. "Health information" is defined as enrollment, eligibility, benefit, claim, and any other information that relates to your past, present or future physical or mental health.

MVP's duties regarding your health information

MVP is required by law to:

- Maintain the privacy of information about your health in all forms including oral, written, and electronic;
- Provide you with this notice of our legal duties and health information privacy rules; and
- Abide by the terms of this notice.

We reserve the right to change the terms of this notice at any time, consistent with applicable law, and to make those changes effective for health information we already have about you. Once revised, we will provide the new notice to you by mail and post it on our Web site. www.mvphealthcare.com.

How we use or disclose your health information

As a member, you agree to let MVP share information about you for treatment, payment, and healthcare operations. The following are ways we may use or disclose your health information:

For Treatment: We may share your health information with a physician or other health care provider in order for them to provide you with treatment.

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For Payment: We may use and disclose your health information to collect premium payments, determine benefit coverage, or to provide payment to health care providers who render treatment on your behalf.

For Health Care Operations: We may use or disclose your health information for health care operations that are necessary to enable us to arrange for the provision of health benefits, the payment of health claims, and to ensure that our members receive quality service. For example, we may use and disclose your health information to conduct quality assessment and improvement activities, case management and care coordination, licensing, credentialing, underwriting, premium rating, fraud and abuse detection, medical review and legal services.

Appointment Reminders: We may use or disclose your health information to send you a reminder that you have an appointment with your doctor for treatment or medical care.

Health-Related Benefits and Services: We may use or disclose your health information to tell you about alternative medical treatments and programs or about health related products and services that may be of interest to you.

Disclosures to a Business Associate: We may disclose your health information to other companies that perform certain functions on our behalf. These companies are called "Business Associates". These Business Associates must agree in writing to protect your privacy and follow the same rules we do.

Disclosures to a Plan Sponsor: We may disclose your health information to the plan sponsor of your group health plan (usually your employer) so that the plan sponsor may obtain premium bids, modify, amend or terminate your group health plan and perform enrollment functions on your behalf. If we obtain assurances as required by law from your plan sponsor, including an assurance that it will not use your health information for any employment related decisions, we may also disclose your health information to your plan sponsor so that it can carry out other administrative functions on behalf of your group health plan related to your treatment, payment of your claims and the health care operations of your group health plan.

Disclosures to a Third Party Representative: We may disclose to a Third Party Representative (family member, relative, friend, etc.) health information that is directly relevant to that person's involvement with your care or payment for care if we can reasonably infer that the person is involved in your care or payment for care and that you would not object.

Disclosures Authorized by You: We can accept an Authorization to Disclose Information Form if you would like us to share your health information with someone for a reason we have not stated above. Using this form, you can designate who you would like us to share information with, what information you would like us to share, and how long you want us to be able to share your information with that individual. A copy of this form is available by calling Medicare Customer Care Center at the phone numbers on

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the back of your member ID card, or logging on to the MVP Web site at www.mvphealthcare.com. You must complete this form and send it to the address or fax it to the fax number on the form. You can cancel this Authorization at any time in writing and per the requirements on the form.

Special use and disclosure situations

Under certain circumstances, as required by law, MVP would be required to share your information without your permission. Some circumstances include:

Uses and Disclosures required by law: We may use and disclose health information about you when we are required to do so by federal, state or local law.

Public Health: We may disclose your health information for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births or deaths; or reporting reactions to medications or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight: We may disclose your health information to a health oversight agency that monitors the health care system and government programs for designated oversight activities.

Legal Proceedings: We may disclose your health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and, in certain situations, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your health information, so long as applicable legal requirements are met, for law enforcement purposes.

Abuse or Neglect: We may disclose your health information to a public health authority, or other government authority authorized by law to receive reports of child abuse, neglect or domestic violence consistent with the requirements of applicable federal and state laws.

Coroners, Funeral Directors and Organ Donation: We may disclose your health information to a coroner or medical examiner to identify a deceased person, determine a cause of death or as authorized by law. We may also disclose your health information to funeral directors as necessary to carry out their duties. If you are an organ donor, we may release your health information for procurement, banking or transplantation.

Research Purposes: In certain circumstances, we may use and disclose your health information for research purposes.

Criminal Activity: We may disclose your health information when necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

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Military Activity: We may disclose your health information to authorized federal officials if you are a member of the military (or a veteran of the military).

National Security: We may disclose your health information to authorized federal officials for national security, intelligence activities and to enable them to provide protective services for the President and others.

Workers' Compensation: We may disclose your health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

What are your rights?

The following are your rights with respect to your health information. Requests for restrictions, confidential communications, accounting of disclosures, amendments to your health information or to inspect or copy your health information, can be made by using the contact information at the end of this notice.

Right to Request Restrictions: You have the right to request a restriction or limitation on your health information we disclose for payment or health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment for your care, like a family member, relative, or friend. While we will try to honor your request, we are not legally required to agree to restrictions or limitations. If we agree, we will comply with your request or limitations except in emergency situations.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information in a certain way or at a certain location if the disclosure of information could endanger you. We will require the reason for the request and will accommodate all reasonable requests.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us other than those necessary to carry out treatment, payment, and health care operations, disclosures made to you or authorized by you, or in certain other situations.

Right to Inspect and Obtain Copies of Your Health Information: You have the right to inspect and obtain a copy of certain health information that we maintain. In limited circumstances, we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing of the reason for the denial and if applicable the right to have the denial reviewed.

Right to Amend: If you feel that the health information we maintain about you is incomplete or inaccurate, you may ask us to amend the information. In certain circumstances we may deny your request. If we deny the request, we will explain your right to file a written statement of disagreement. If we approve your request, we will include the change in your health information and tell others that need to know about your changes.

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Your right to make recommendations

You have a right to member rights and responsibilities and to make recommendations to MVP Health Care about our members' rights and responsibilities policies. You may do so by:

- Calling Medicare Customer Care Center.
- Visiting **www.mvphealthcare.com** on the Web and clicking on "Medicare Customer Care Center."
- Contacting us at Living Well (your member newsletter) by email at **livingwell@mvphealthcare.com**, or by writing to MVP Health Care, 220 Alexander St., Rochester, NY 14607.

Right to a Copy of the Notice of Privacy Practices: You have the right to obtain a copy of this notice at any time.

Exercising your rights

Unless you provide us with a written authorization, we will not use or disclosure your health information in any manner not covered by this notice. If you authorize us in writing to use or disclose your health information in a manner other than described in this notice, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your authorization; however, we will not reverse any uses or disclosures already made in reliance on your authorization before it was revoked.

You have a right to receive a paper copy of this notice at any time. You can also view this notice on our Web site at **www.mvphealthcare.com**.

If you believe your privacy rights have been violated, you may file a written complaint by contacting the Quality Coordinator at the address or number indicated on the contact information at the end of this notice.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must:

1. Be in writing;
2. Contain the name of the entity against which the complaint is lodged;
3. Describe the relevant problems; and
4. Be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request.

We will not take any action against you for filing a complaint.

We will not retaliate in any way if you choose to file a complaint in good faith with us or with the U.S. Department of Health and Human Services. We support your right to the privacy of your medical information.

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Exclusions and non-covered services

Preferred Gold, GoldAnywhere, and GoldValue do not cover such services as cosmetic surgery, custodial care, non-standard and unevaluated treatments and services provided in conjunction with a non-covered service, among others. Unless expressly indicated in the contract, all non-medically-necessary services are not covered.

Preventive care guidelines

These guidelines are recommendations for healthy adults over age 65. Call the Medicare Customer Care Center for information on health care guidelines for people under age 65. It is important to work with your physician to develop a schedule that is appropriate for your health care situation.

Visits are recommended every 1 to 3 years and should include:

	Women ages 65 and older	Men ages 65 and older
Health history and lifestyle assessment	Complete or update assessment, including family history, activity, tobacco, alcohol, drug use and sexual practices	Complete or update assessment, including family history, activity, tobacco, alcohol, drug use and sexual practices
Physical Exam	<ul style="list-style-type: none"> • Height and weight (Body Mass Index) • Blood pressure • Clinical breast exam • Hearing and vision* screening 	<ul style="list-style-type: none"> • Height and weight (Body Mass Index) • Blood pressure • Hearing and vision* screening
Tests**	<ul style="list-style-type: none"> • Screen for lipid disorders • Colonoscopy once every 10 years or flexible sigmoidoscopy once every 5 years with fecal occult blood test once every 3 years (follow up as recommended by physician) • Pap test is optional after age 65; discuss with your doctor whether you should have this test screening 3 times in 10 years • Mammogram every 1-2 years until age 74; then as 	<ul style="list-style-type: none"> • Screen for lipid disorders • Colonoscopy once every 10 years or flexible sigmoidoscopy once every 5 years, with fecal occult blood test once every 3 years (follow up as recommended by physician) • TB screening by PPD test as indicated • Screen for Type 2 diabetes if blood pressure >135/80

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	<p>indicated after age 74</p> <ul style="list-style-type: none"> • Annual osteoporosis screening after age 65 • TB screening by PPD test as indicated • Screen for Type 2 diabetes if blood pressure >135/80 	
Immunizations	<ul style="list-style-type: none"> • Td booster every 10 years • Influenza vaccine annually • Pneumococcal vaccine once in a lifetime from age 65 • Booster as recommended • Zoster vaccine unless contraindicated 	<ul style="list-style-type: none"> • Td booster every 10 years • Influenza vaccine annually • Pneumococcal vaccine once in a lifetime from age 65 • Booster as recommended • Zoster vaccine unless contraindicated
Counseling / Screening	<ul style="list-style-type: none"> • Diet: discuss calcium and vitamin D • Exercise promotion • Menopause management • Smoking cessation • Alcohol/substance abuse prevention • Sexuality concerns • Dental health • Sun exposure • Bladder control problems • Injury prevention (including seat belt, helmet use and falls) • Life stage issues (bereavement) • Depression • Health Care Proxy/Advance Directives 	<ul style="list-style-type: none"> • Diet and exercise • Smoking cessation • Alcohol/substance abuse prevention • Sexuality concerns • Dental health • Sun exposure • Bladder control problems • Injury prevention (including seat belt, helmet use and falls) • Life stage issues (bereavement) • Depression • Health Care Proxy/Advance Directives

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High Risk Individuals	<ul style="list-style-type: none">• Aspirin therapy should be considered for adults at risk for coronary heart disease• HIV Screening***• Meningococcal, Varicella, Hep B, MMR and Hep A immunizations for those at risk• Screen for Abdominal Aortic Aneurysm (AAA) x 1 in men ages 65 to 75 who are smokers or who ever smoked
<p>*If you have a family history of glaucoma talk to your doctor about whether screening may be right for you</p> <p>**Prostate Cancer Screening: The United States Preventive Services Task Force (USPSTF) has determined that for men younger than age 75 years, evidence is inadequate to determine whether prostate cancer screening improves health outcomes. The balance of harms and benefits cannot be determined. If you are a man younger than 75 years, talk with your doctor to determine if you are at risk for prostate cancer and if prostate cancer screening is right for you.</p> <p>***HIV Screening: The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.</p>	

Guidelines adapted from the U.S. Preventive Services Task Force. Talk to your doctor about what preventive services are right for you. Your benefits may allow for services more frequently than what is listed here.

Advance care planning

Advance Care Planning is a process of planning for future medical care in case you are unable to make your own decisions. It is a continual process and not merely a document or isolated event. Advance Care Planning assists you in preparing for a sudden unexpected illness from which you expect to recover, as well as the dying process and ultimately death.

MVP provides a brochure, *Advance Care Planning*, that explains the process of determining your directives and completing the correct forms.

This booklet is on our Web site. Go to www.mvphealthcare.com, click on the Medicare Members tab, and on the Medicare Members home page click Publications. Under Publications, click on Advance Care Planning Booklet. You can also call the MVP Medicare Customer Care Center at the phone number on the back of your member ID card for a copy.

