MVP HEALTH CARE VERMONT OFFICE

Enrollment/Change Form

ACTION REQUESTED: ☐ Enroll ☐ Change ☐ Cancel

TO BE COMPLETED BY EMPLOYER	Group #	Subgroup #	Effective Date	Product #	Product #
Employee Class	Employee Dept. (if applicable)		Approved by		

1 INFORMATION ABOUT YOURSELF

INSTRUCTIONS TO EMPLOYEE: Please print or type and complete Sections 1 through 5.

Employee Name *(Last, First, Initial, Suffix)* Marital Status ☐ Single ☐ Married

Address City State Zip County

Phone Employer Date Employed ☐ Active ☐ Retiree

Do you or any other family members have health insurance? ☐ Yes ☐ No If yes, by whom? Spouse's health insurance carrier *(if other than yours)* Coverage level ☐ Individual ☐ Family Spouse's health insurance ID#

Eligible for Medicare? ☐ Yes ☐ No Employee ID# Spouse ID#

Employee ☐ A Effective Date ☐ B Effective Date Spouse ☐ A Effective Date ☐ B Effective Date

2 ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call **1-800-318-8575** or visit **www.mvphealthcare.com.**

A

- ☐ New Applicant
- ☐ Name Change
- ☐ COBRA
- ☐ Add Dependent
- ☐ Plan Transfer
- ☐ Address Change

Reason:

- ☐ New Hire
- ☐ Open Enrollment
- ☐ COBRA/State Continuation
- ☐ Qualifying Event *(describe)* _____
- ☐ Other _____

B

- ☐ Termination
- ☐ Remove Dependent(s) only *(please specify)* _____

Reason:

- ☐ Termination of Employment
- ☐ Moved From Area
- ☐ Opting for Other Coverage
- ☐ Other _____

3 CHOOSE COVERAGE

- ☐ HMO*
- ☐ PPO
- ☐ Indemnity
- ☐ Dental
- ☐ Other
- ☐ POS*
- ☐ EPO
- ☐ Prescription Drug Only
- ☐ High Deductible HMO
- ☐ High Deductible EPO
- ☐ High Deductible PPO
- ☐ TriVantage *(choose an option)*:
  - ☐ Active Lifestyles
  - ☐ Family Focus
  - ☐ Healthy Alternatives

**Please choose a Primary Care Physician—for each family member—in Section 4.*

4 INFORMATION ABOUT ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

If you are applying for HMO or POS coverage, you and each of your dependents must designate your choice of Primary Care Physician in order for MVP to initiate coverage.

1. Name (First, MI, Last) Relationship to Employee self

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary Care Physician (PCP) (First, Last) PCP Number

2. Name (First, MI, Last) Relationship to Employee ☐ spouse/civil union partner ☐ Domestic Partner

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary Care Physician (PCP) (First, Last) PCP Number

3. Name (First, MI, Last) Relationship to Employee Check all that apply: ☐ Disabled ☐ Current Patient ☐ Full-time Student over 18

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ *If applicable:* College Name

Primary Care Physician (PCP) (First, Last) PCP Number Expected Graduation Date

4. Name (First, MI, Last) Relationship to Employee Check all that apply: ☐ Disabled ☐ Current Patient ☐ Full-time Student over 18

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ *If applicable:* College Name

Primary Care Physician (PCP) (First, Last) PCP Number Expected Graduation Date

For additional dependents, please list on a separate form.

5 SIGNATURE

I have read and agree to the authorization of the reverse side of this form. Late entrant? ☐ Yes ☐ No

SIGNATURE _____ **DATE** _____

AUTHORIZATION

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and, may also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP.

I authorize my employer to deduct from my earnings the necessary contribution, if any, required of me.

I hereby authorize any licensed physician, hospital or other health care provider to furnish MVP with such medical information about myself and my minor eligible dependents listed on the application that may be required to allow MVP to administer my benefits. This authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC, and further precludes the insurer from forwarding new HIV testing information except as specifically permitted under 8VSA §4724(20) and Department Bulletin I-92.

The statements made are true and complete to the best of my knowledge and belief.

Vermont
$2,500/$5,000 **Aggregate** Deductible
100%/0% Coinsurance Option

MVP Preferred High Deductible EPO

Summary of Benefits

This Plan can be offered with a Health Savings Account (HSA); talk to your employer or local bank for details.

SERVICE CATEGORY[1]	COVERAGE INFORMATION[2]
Annual Deductible	$2,500 per Individual/$5,000 per Family[3]
Coinsurance	MVP covers at 100% of allowable charges
Lifetime Maximum Benefit Payable	No Maximum
Annual Out-of-Pocket Maximum (Includes the deductible and prescription drug Copayments)	$3,500 per Individual/$7,000 per Family per Contract Year[3]
Preventive & Well Care Services[4] Well Baby, Child Care & Immunizations Adult Physical (One Routine Physical/Contract Year) Mammography & Prostate Cancer Screening Annual Pap Test & Ob/Gyn Exam Immunizations for Adults Colonoscopy and Sigmoidoscopy Screening for Adults Bone Density Tests	Covered in Full
Hospital Hospital Inpatient Hospital Outpatient Surgery **Physician Inpatient Care** (Medical/Surgical) **Urgent Care Center** **Emergency Room (ER) Visit** **Ambulance** **Diagnostic X-ray & Other Imaging Services[5]** **High Tech Imaging Services[5]** (MRI, MRA, CT, etc.) **Laboratory Services** **Physician Office Visits** **Second Surgical Opinion** (Optional) **Chiropractic Benefit** **Physical/Occupational/Speech Therapy** (Combined 30 Visits per Member per Contract Year) **Maternity** Physician Services Hospital Services **Mental Health & Substance Abuse** Inpatient Outpatient **Durable Medical Equipment[6]** **Diabetic Supplies & Equipment** (Items limited to a 30 day supply) **Home Health Care**	MVP covers at 100% of allowable charges, after deductible
Prescription Drug Benefit[7] (Must use a participating pharmacy)	
Tier 1 (generally Formulary Generic)	$10 copay after deductible is met
Tier 2 (generally Formulary Brand)	$30 copay after deductible is met
Tier 3 (generally Non-Formulary)	$50 copay after deductible is met

[1]Some services are subject to notification requirements, e.g. Prior Authorization. See your Certificate of Coverage under Section Five Utilization Management & Claims Filing for details.

[2]A network provider must deliver all care. MVP's High Deductible Health Plan's include National Network coverage.

[3]How the family Aggregate deductible works: For this plan, one or more family members' covered expenses must meet the family deductible amount (outlined above) each Contract Year before MVP will make benefit payments for all the members of a family. All family members' expenses are subject to the Family annual out-of-pocket amount and, except for Preventive and Well Care Services, to the Family deductible amount.

[4]This represents a partial list of preventive services covered under this Plan. MVP will also cover all preventive services as required under the Patient Protection and Affordable Care Act of 2010 (PPACA). For a full listing of the PPACA preventive services, including any applicable limitations, please visit **www.healthcare.gov.**

[5]X-rays usually require two providers' services, one for taking the X-ray, the other for interpreting results. Payments for each may apply and are based on where the work was done.

[6]Artificial Limbs are covered separately, see your Certificate of Coverage for details.

[7]Certain prescription drugs require Prior Approval before dispensing. As a guide, visit **www.mvphealthcare.com**, and click on the *Member* tool bar, then click the *Pharmacy Tab* and look under Drug Coverage for the Formulary (covered drugs) chart. Drugs listed with the "#" indicator require Prior Approval.

This Summary of Benefits chart is intended to provide a general outline of MVP coverage. In the event of any conflict between this document and your Certificate of Coverage, Schedule and any applicable rider(s), your Certificate of Coverage, Schedule, and rider(s) will be controlling. For details, call 1-800-TALK-MVP (1-800-825-5687), option #2.

Continued on back

Here's how it works

Welcome to a new generation of health plans – built around the way you live your life. Each comes with unique features and valuable tools. From a company known for great customer service. Truly dedicated to helping you take on life and live well. All MVP Preferred EPO options come with these advantages:

- You can see any provider in-network with no referrals
- Access to our national network – more than 500,000 doctors, hospitals and specialists nationwide
- Comprehensive coverage – from preventive and sick care to emergency
- Great service for you and your family – the answers, expert guidance and personal support you need

Take advantage of our health management and wellness programs

Personalized Support *Condition Health and Case Management Programs*

If you are living with a physical or mental health concern, call **1-866-942-7966** for guidance and support. Working in partnership with your doctor, we can help you with:

- Asthma
- Cancer (Oncology)
- Chronic Obstructive Pulmonary Disorder (COPD)
- Depression
- Diabetes
- Dialysis
- Heart Events (heart attack or blockages)
- Heart Failure
- Low Back Pain

We also offer services to help members whose needs require different resources than those provided through our condition-specific programs.

- Acute Case Management for members who have complications or other serious health concerns
- Little Footprints℠ for high-risk pregnancies
- Social work services that help connect members to community resources and services

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.

Exclusive Member Discounts

From Massage Therapy to Gym Memberships

Enjoy savings on a wide range of health and wellness products and services.

Plus, WellStyle Extras:

Real Dollars for Living Well *$300 WellStyle Rewards*

You can earn up to $300 WellStyle Rewards, per subscriber per year – by completing milestone activities that show you are maintaining or improving your health. WellStyle Rewards are paid directly to members in the form of debit or gift cards.

Expert Guidance *Lifestyle Coaches*

Whether you want to lower your cholesterol or get a little more active, talk to our professional Lifestyle Coaches – to help guide, motivate and facilitate your positive lifestyle changes.

We are here for you

- Reach our Member Services Department at **1-888-MVP-MBRS.**
- Access **mvphealthcare.com** to find doctors, compare drug costs, look up benefits, change your address, research hospitals and many other time-saving services.

Medco By Mail Order Form
Benefits provided by MVP Health Care

MVP HEALTH CARE medco®

1 Member information: Please verify or provide member information below.

Member ID: _____
Group: MVPCOMM
Name: _____
Street Address: _____
Street Address: _____
Street Address: _____
City, ST, ZIP: _____

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
_____@_____._____
☐ New shipping address:

(Medco will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone: Evening phone:

FOLD HERE

2 Patient/doctor information: Complete one section for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name Last name

Birth date (MM/DD/YYYY) Sex ☐ M ☐ F Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name 1st initial Doctor's phone number

First name Last name

Birth date (MM/DD/YYYY) Sex ☐ M ☐ F Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name 1st initial Doctor's phone number

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders payable to Medco Health Solutions, Inc., and write your member ID number on the front. You can enroll for e-check payments and price medications at www.medco.com, or call 1 800 716-3752.

Number of prescriptions sent with this order:

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:
☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners

Credit card number

Expiration date
M M Y Y

X _____
Cardholder signature

☐ I authorize Medco to charge this card for all orders from any person in this membership.

☐ Rush the mailing of this shipment ($15, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

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Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at 1 800 716-3752. To verify Medicare Part B prescription coverage, call Medicare at 1 800 MEDICARE (1 800 633-4227).

Medco will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

☐ Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive brand or generic drug.**

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at **www.medco.com** or call Member Services at 1 800 716-3752. TTY/TDD users should call 1 800 759-1089.

FOLD HERE

Place your prescription(s), this form, and your payment in the envelope provided. Be sure the Medco address shows through the window. Do not use staples or paper clips.

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MEDCO HEALTH SOLUTIONS OF NETPARK, L.L.C.
PO BOX 30493
TAMPA FL 33630-3493