MVP HEALTH CARE
625 State Street, PO Box 2207
Schenectady, NY 12301-2207
mvphealthcare.com

RE: MVP Premier/Premier Plus Enrollment Materials

Dear Prospective Member,

Thank you for your interest in MVP Health Care® as your health insurance carrier for 2014. At MVP, all of our plans include quality care, great value and top-rated customer service.

Enclosed are MVP Premier/Premier Plus health plan enrollment materials:

- Enrollment Form
- One-Time Direct Payment Plan Authorization Form (unless the first month's premium is enclosed)

A check for the first month's premium OR a direct payment plan authorization form must be received by the **25th of the month to guarantee an effective date of coverage for the first of the next month**.

*Please note that included in this packet are benefit highlights and rates for the pediatric dental program offered along with our medical plans. Pediatric dental coverage is required under the Affordable Care Act (ACA) for all participants under the age of 19. If you do not currently have adequate pediatric dental coverage in compliance with ACA requirements your plan will automatically include this dental coverage with the additional rate.

Please email, fax or mail completed materials directly to our attention:

MVP Health Care
Attention: Direct Sales Team
220 Alexander St
Rochester, NY 14607
Email discoversales@mvphealthcare.com
Fax # (585) 325-3478

Thank you again for choosing MVP. For additional information, visit our website at **www.discovermvp.com** or contact us at 800-TALK-MVP.

Enclosures

MVP HEALTH CARE

INDIVIDUAL ENROLLMENT/CHANGE FORM

ACTION REQUESTED:
☐ **Enroll**
☐ **Change**
☐ **Cancel**

NEW YORK
625 State St. PO Box 2207
Schenectady, NY 12301-2207
518-370-4793 or 1-800-777-4793

1. INFORMATION ABOUT YOURSELF

INSTRUCTIONS: Please print or type and complete Sections 1 through 7.

Name *(First, MI, Last)* Marital Status ☐ Single ☐ Married

Address City State Zip County

Phone Email Address

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)* Spouse's health insurance ID#

Coverage level ☐ Subscriber ☐ Subscriber & Spouse ☐ Subscriber & Dependents ☐ Family

Eligible for Medicare? ☐ Yes ☐ No Member ID# Spouse/Dependent ID#

Member ☐ A Effective Date ☐ B Effective Date Spouse ☐ A Effective Date ☐ B Effective Date

2. ENROLLMENT/CHANGE

Group #_____ Sub-Group #_____

A. ☐ New Applicant ☐ Add Dependent **REASON:** ☐ Qualifying Event *(describe)*_____
☐ Name Change ☐ Plan Transfer _____
☐ Address Change ☐ Other_____
Effective Date of Change_____

B. ☐ Termination ☐ Remove Dependent(s) only *(please specify)*_____
REASON: ☐ Moved From Area ☐ Opting for Other Coverage
☐ Other_____
Effective Date of Change_____

3. CHOOSE COVERAGE

☐ Premier Plus Gold 1 ☐ Premier Plus Gold 2 ☐ Premier Plus Silver 1 ☐ Premier Plus Silver 2 ☐ Premier Plus Silver 3 ☐ Premier Plus Bronze 1
☐ Premier Plus Bronze 2 ☐ Premier Plus Bronze 3 ☐ Premier Platinum ☐ Premier Gold ☐ Premier Silver ☐ Premier Bronze
Other_____

A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ☐ Yes ☐ No

B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____ If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.

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

You and each of your dependents must designate your choice of Primary Care Physician. For help, visit MVP's website **www.mvphealthcare.com** or contact the MVP Customer Care Center. For additional dependents, please list on a separate form.

1. Self

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* PCP Number

Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you if you are under age 19.

2. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* PCP Number

Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you if you are under age 19.

3. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* PCP Number

Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you if you are under age 19.

4. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* PCP Number

Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you if you are under age 19.

5. SIGNATURE

I have read and agree to the authorization of the reverse side of this form.

SIGNATURE _____ **DATE** _____

By including an email address on this Enrollment/Change Form, you agree to accept electronic communication unless otherwise required by law.

6. 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 is a crime and, in New York, shall 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 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.

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

7. BROKER

If a broker assisted you with completing this application, please include:

Broker's Name	MVP Agency #	Agency Name
Agency Address	Phone	Email

MVP Health Care
One-Time Direct Payment Plan

MVP Health Care is pleased to offer the Direct Payment Plan.

Here's how the Direct Payment Plan works:

You authorize a **one time** scheduled payment to be made from your checking account. Proof of payment will appear on your statement. Your payment amount will be for the total amount due. To take advantage of this service, complete the authorization form and return it to us.

All you need to do is:

1. Complete the form
2. Fax or mail this form to MVP with your membership enrollment form
3. Please don't forget to sign and date the application.

If you have any questions, please contact your sales representative

Thank you for choosing MVP Health Care.

MVP Health Care
One-Time Direct Payment Plan Authorization Form

MEMBER INFORMATION:

_____
Member Name (Please Print)

_____
Street Address

_____
City / State / Zip

_____
Daytime phone number

_____
Subscriber number/Group number (if applicable)

AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize **MVP Health Care** to withdraw a **one time** amount due to MVP Health Care for the provision of health benefits. That in the case of an automatic bank debit form of payment it shall be the Customer's responsibility to verify whether these payments are properly debited to their bank account. I acknowledge that the origination of the ACH transaction to my account must comply with the provisions of U.S. law.

_____
Financial Institution Name (Please Print)

_____
Account Number at Financial Institution

_____
Financial Institution Routing/Transit Number

$_____
Dollar Amount

_____
Financial Institution City and State

_____
Print Name

_____
Signature / Date

PLEASE KEEP A COPY OF THE AUTHORIZATION FOR YOUR RECORDS

Delta Dental PPO[SM]

2014 Individual Rates

The Delta Dental PPO plan makes it easy for members to find a dentist and control costs when visiting a Delta network provider.

Delta Dental also offers competitive rates and access to one of the largest dentist networks in the U.S. – making quality dental care accessible and affordable for members.

2014 monthly rates for pediatric coverage are listed below ▼

	Subscriber + Child(ren) and Family Coverage (subscriber must be 19 or older)
ALBANY REGION **Counties:** Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	$30.51
BUFFALO REGION **Counties:** Allegany#, Cattaraugus#, Chautauqua#, Erie#, Genesee, Niagara#, Orleans, Wyoming	$28.60
MID HUDSON **Counties:** Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster	$32.68
NEW YORK CITY **Counties:** Bronx#, Kings#, New York#, Queens#, Richmond#, Rockland, Westchester#	$41.46
ROCHESTER **Counties:** Livingston, Monroe, Ontario, Seneca, Wayne, Yates	$30.61
SYRACUSE **Counties:** Broome, Cayuga, Chemung#, Cortland, Onondaga, Schuyler#, Steuben, Tioga, Tompkins	$29.56
UTICA/WATERTOWN **Counties:** Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	$28.67

MVP is not licensed to sell in this county

Rates listed above are for **Pediatric** coverage only. Eligible members must be under the age of 19 to qualify. For subscribers under the age of 19, contact your MVP Health Care® Representative for additional rates.

You must purchase an MVP medical plan in order to qualify for this pediatric dental coverage.

DELTA DENTAL®

Delta Dental PPO℠ – Easy, Friendly, Accessible

We'll do whatever it takes and then some.

Greatest potential savings when you visit a Delta Dental PPO dentist

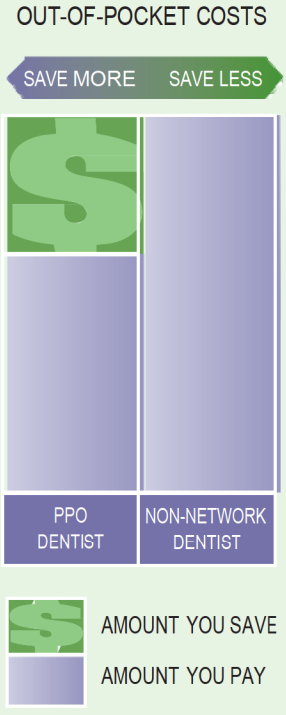

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- Save money with a Delta Dental PPO dentist. Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental PPO dentists won't balance bill you the difference between the contracted amount and their usual fee.
- Visit the dentist of your choice. Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- Many network dentists to choose from. Since Delta Dental offers access to one of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Many dentists nationwide are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at deltadentalins.com to search our dentist directory by location or specialty.
- Easy to use your benefits. When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- Delta Dental's Online Services make getting information quick and easy. Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

* In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

DELTA DENTAL®

WE KEEP YOU SMILING®

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Plan Benefit Highlights for: MVP Health Care

Group No: 16317 **Effective Date:** 1/1/2014

Delta Dental PPO℠

Benefit Highlights

Eligibility	Pediatric enrollees are covered to age 19
Deductibles	$40 per person each plan year
Out of Pocket Maximums	**PPO Dentist:** One Child: $700 per person each plan year Family: $1,400 each plan year
	Non-PPO Dentist: One Child: N/A per person each plan year Family: N/A per person each plan year

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-PPO dentists** (Delta Dental Premier® & Non-Delta Dental Dentists)
Diagnostic & Preventive Services Exams, cleanings, x-rays, sealants	100 %	100 %
Basic Services Fillings	50 %	50 %
Endodontics (root canals)	50 %	50 %
Periodontics (gum treatment)	50 %	50 %
Oral Surgery	50 %	50 %
Major Services Crowns, inlays, onlays and cast restorations, TMJ	50 %	50 %
Prosthodontics Bridges and dentures	50 %	50 %
Orthodontic Benefits	50 % Covered for Medical Necessity Only	50 % Covered for Medical Necessity Only

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

Delta Dental of New York
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783
(Business Hours: 8 am to 8 pm ET)

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-2105

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.