MVP New York Small Group Plan

Thank you for considering MVP Health Care® (MVP) for you and your employees' health insurance needs. The enclosed information provides an overview of MVP's New York Small Group plans, but you may also visit **mvphealthcare.com**, select *Shop for a Plan*, and then *Employers*. After you choose your plan(s), please complete and return the following materials:

- *HMO Plans Product Application* **and/or** *EPO/PPO Plans Product Application*
- *HMO Health Plan Enrollment or Change* form **and/or** EPO/PPO *Health Plan Enrollment or Change* form (for covered employees and their dependents)

Completed materials must be received by the 15th of the month to guarantee an effective date of coverage for the first of the next month. They should be sent via mail or email:

Mail: MVP Health Care
Small Business & Individual Service Unit
625 State Street
Schenectady, NY 12305

Email: SBIU@mvphealthcare.com
Fax: 518-386-7595

Additional Required Employer Eligibility Documentation

- Form NYS-45 Quarterly Combined Withholding, Wage Reporting, and Unemployment Insurance Return or comparable documentation listing all currently enrolled employees
- Certificate of Incorporation and payroll records for newly formed business
- A copy of the most recent 1065 K-1 with income amount stricken (for partnerships)
- New York State Certificate of Assumed Name for groups using a Doing Business As (DBA)

MVP Vision and Dental Plans

MVP vision plans, powered by EyeMed®, and dental plans are available for purchase. MVP vision plans must be purchased with an MVP medical plan. Visit **mvphealthcare.com/shop** for vision and dental plan options.

We're here to help!

If you have questions or need additional assistance, please contact our Small Business & Individual Service Unit at **1-844-865-0250**, email **SBIU@mvphealthcare.com**, or visit our website at **mvphealthcare.com**.

HMO Plans Product Application
for New York State Small Groups

Please complete all pages of this form. Some sections may not apply to your group.

Section 1: Group Information *(please print, and include Company Name and Tax ID No. on all pages)*

Group/Business Name or DBA Name *(if applicable)* | Tax ID No. *(required)*

Legal Entity Name *(if different than Group Name)* | SIC Code *(required)*

Nature of Business or Organization | **Effective Date of Coverage**

Business Physical Street Address | Phone No. ( ) | Fax No. ( )

City | State | Zip Code | County

Company Headquarters Street Address ☐ *Same as above* | Phone No. ( ) | Fax No. ( )

City | State | Zip Code | County

Group Health Benefits Administrator (HBA) Name | Group HBA Title

Group HBA Email | Group HBA Phone No. ( )

Group HBA Street Address ☐ *Same as above* | City | State | Zip Code

Who sponsors the group health coverage? *(check one)* ☐ Employer ☐ Union ☐ Association ☐ Other: _____

Organization Type ☐ C Corp ☐ S Corp ☐ Partnership ☐ Nonprofit ☐ Local Government ☐ State Government ☐ Church Group ☐ Trust ☐ Other: _____

List Owner(s)/Partner(s) of this Organization

Are the owners and their spouses the only policy holders on the group sponsored coverage? ☐ Yes ☐ No

This company is organized as: ☐ Stand Alone ☐ Parent ☐ Subsidiary ☐ Local Plant/Office/Division ☐ Other: _____

Do you, as an employer, offer a group medical plan in addition to the products offered through MVP Health Care®? ☐ **Yes** ☐ **No**

If ***Yes***, who is the plan carrier?

Continued on page 2

Company Name *Tax ID No.*

Section 2: Billing Information

☐ *Premium invoices should be sent to the Group Contact and Address listed in Section 1 (proceed to Section 3).*

Billing Contact Name | **Billing Contact** Title

Billing Contact Email | **Billing Contact** Phone No. ( ) | **Billing Contact** Fax No. ( )

Billing Street Address | City | State | Zip Code | County

Section 3: Regulatory Employer Information

Do you employ at least one employee who lives, works, or resides in the MVP service area?	☐ **Yes** ☐ **No**
Are all employees who are offered coverage working at least 20 hours per week?	☐ **Yes** ☐ **No**
Is there at least one common law employee enrolled as a contract holder?	☐ **Yes** ☐ **No**
Does your group have fewer covered employees outside the MVP service area than covered employees within the MVP service area?	☐ **Yes** ☐ **No**
If owners are enrolling in MVP coverage, do they all work at least 20 hours per week?	☐ **Yes** ☐ **No**

Section 4: Group Administration

Total Number of Part-Time and Full-Time Employees Over the Prior Calendar Year *(to determine Certification of Benefits for members 65 and older)*

Total Number of Full-Time Equivalent Employees[1] Over the Prior Calendar Year *(to determine if Small or Large Group)*

Note: Retirees and COBRA participants are not considered "employees" and should not be counted to determine group size.

[1] The *full-time equivalent* (FTE) employee counting method in 26 U.S.C. 4980H(c)(2) must be utilized to determine group size. This method is the same calculation used to determine employer liability under the *Shared Responsibility for Employers* provisions of the Affordable Care Act (ACA) and Internal Revenue Code.

To convert the number of part-time employees to a full-time equivalent, the aggregate number of hours worked for part-time employees is divided by 120. Part-time hours are capped at 120 hours per employee per month.

New Hire Eligibility Policy

☐ Date of hire ☐ First of the month following date of hire

☐ First of the month following _____ day(s) of employment *(may not exceed 90 days)*

Section 5: Enrollment Class/Subgroup Assignment

Class Description *(example: All employees working more than 20 hours per week)*

Select a separate Class/Subgroup, if your Group requires one:

☐ Medicare ☐ Salary ☐ COBRA ☐ Union ☐ Hourly ☐ Other: _____

Section 6: Product Selection

☐ Platinum Plan No.	☐ Silver 4 with Embedded HRA	☐ MVP Dental PPO® for Adults	☐ MVP Vision 1
☐ Gold Plan No.	☐ Dependent through Age 29	☐ MVP Dental PPO® for Families	☐ MVP Vision 2
☐ Silver Plan No.	☐ Unlimited Skilled Nursing	☐ MVP Dental PPO for Kids®	☐ MVP Vision 3
☐ Bronze Plan No.		☐ Delta Dental Pediatric PPO Plan	
☐ Medicare Gold			

Continued on page 3

Company Name *Tax ID No.*

Section 7: Information About Individuals Not Listed on NYS-45-ATT or Other State Equivalent

Please list below the individuals eligible for coverage who are not listed on the NYS-45-ATT, *Quarterly Combined Withholding, Wage Reporting, and Unemployment Insurance Return form*, or other state equivalent. Eligible individuals include partners or owners of the business if actively engaged in the business, COBRA/New York State continuants, new employees, retirees, and spouses of retirees when it is the consistent policy of the business owner to cover retirees and spouses of retirees.

The group attests that the individual(s) listed below work at least 20 hours per week at the employer named on page 1 or are otherwise eligible for coverage under a group health insurance plan to be issued by MVP. For each employee listed, indicate their employment status.

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Section 8: Separate Entities with Multiple Tax ID Numbers

Only complete this section if you have separate entities with multiple Tax ID numbers.

Group size for groups under common ownership is determined based upon the total Full-Time Equivalent Employees (FTEs) for all entities. In order to combine separate groups into one employer group for group insurance purposes, MVP will require documentation showing 80% of each entity is owned by the same person or set of people.

Please check if any of the following conditions apply:

☐ Multiple Tax ID numbers are listed above
☐ This/These groups are owned by another entity
☐ This group owns another entity
☐ This group is one of multiple groups that are owned by the same entity/entities

If any of the above conditions apply, tax documentation certifying that at least 80% common ownership must be submitted. Acceptable tax forms are (1) IRS Form 851 (Affiliations Schedule) with names of all entities or (2) Schedule K-1 (IRS Form 1065).

Section 9: Small Business Health Options Program (SHOP) Attestation

Have you completed the New York State SHOP eligible employer verification process and found that the Group named on page 1 of this application is SHOP eligible? ☐ **Yes** ☐ **No**

Section 10: Broker Information

☐ *I understand that the agency below may be entitled to a base and/or bonus compensation for our business. This broker information will remain in effect until we notify MVP Health Care otherwise.*

Broker Name	Agency Name		
Street Address	City	State	Zip Code
Billing Contact Email	Phone No. ( )	Fax No. ( )	

Continued on page 4

Company Name *Tax ID No.*

Section 11: Private Exchange Information

Is this group to be enrolled through a private exchange (other than the NY State of Health Marketplace)? ☐ **Yes** ☐ **No**

If ***Yes***, please provide the name of the private exchange: _____

Section 12: MVP Representative Information

The information provided in this application is true to the best of my knowledge.

MVP Representative Name (print) *Signature* *Date*

Section 13: Authorization

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

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I have read and agree to the details outlined in *MVP's Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

I have read and agree to this authorization.

Signature *Date*

Name (print) *Title*

Health Plan Enrollment or Change
for New York State Small Group HMO Plans

Action Requested: ☐ **Enrollment** ☐ **Change** ☐ **Termination** *Please complete both sides of this form.*

To be Completed by Employer *(Include Group Name, Group No., and Applicant Name on page 2)*

Group Name	Group No.	Subgroup No.	Effective Date

Product ID No.	Employee Class

Section 1: Information About Yourself *(please print)*

Applicant Name *(First, Middle Initial, Last)* | Marital Status ☐ Single ☐ Married

Street Address	City	State	Zip Code	County

Email	Home Phone No. ( )	Mobile Phone No. ( )

Are you and/or your spouse eligible for Medicare? ☐ **Yes** ☐ **No**

If ***Yes***, provide your Medicare Member ID No(s). (Yourself) (Spouse, if eligible)

If ***Yes***, provide Medicare Parts A and B Effective Dates

(Yourself) Part A Part B (Spouse) Part A Part B

Section 2: Enrollment/Change/Termination Information

Enrollment or Change *(check all that apply)*

☐ New Applicant ☐ Add Dependent ☐ Name Change

☐ Transfer to Another Plan ☐ Address Change ☐ COBRA

Requested Effective Date

Reason

☐ New Hire (Date of Hire:) ☐ Open Enrollment

☐ Qualifying Event *(explain)*

☐ Other

Termination

☐ Terminate from Plan

☐ Remove Dependent(s) only *(specify name or member ID no.)*

Requested Effective Date

Reason for Termination

☐ Termination of Employment ☐ Opting for Other Coverage

☐ Moved from Service Area

☐ Other

Section 3: Coverage Selection (Enrollments and Changes)

Medical Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

Medical Plan Name (e.g., Gold 2 HDHP)

Optional Vision Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

Vision coverage must be equal to or less than medical coverage.

Optional Vision Plan (select one) ☐ MVP Vision 1 ☐ MVP Vision 2 ☐ MVP Vision 3

If scanning this form for submission, be sure to scan and return both pages of this form.

Continued on page 2

Group Name *Group No.* *Applicant Name*

Section 4: Information About All Family Members You Want to Enroll in Your Plan *(Complete for Enrollments and Changes)*

Please use a separate form for additional individuals.

1 Applicant ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

2 Name *(First, Middle Initial, Last)* ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Relationship to Applicant ☐ Spouse ☐ Dependent | Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

3 Name *(First, Middle Initial, Last)* ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Relationship to Applicant ☐ Dependent | Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

4 Name *(First, Middle Initial, Last)* ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Relationship to Applicant ☐ Dependent | Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

Section 5: Authorization *(Your signature is required for Enrollments, Changes, or Terminations)*

On behalf of myself and any members of my family for whom I have enrollment authority and have listed on this enrollment form, I (we) hereby apply for membership in MVP. I hereby consent to the release, use, and disclosure of any medical information about me and any members of my family for whom I can give consent:

- By my primary care provider, any other health care provider, or the New York State Department of Health ("NYSDOH") to MVP and any health care providers involved in caring for me or my family, as reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations functions, or other functions permitted by, and in accordance with, applicable laws, regulations, and rules. This may include pharmacy and other medical claims information needed to help manage my care;
- By MVP and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administering health programs to the extent permitted by, and in accordance with, applicable laws, regulations, and rules; and
- By MVP to my providers or other persons or organizations, as reasonably necessary for MVP or my providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules.

At any time, I can take away the permission I gave to release information. All I have to do is call the MVP Customer Care Center at the phone number listed on the back of my MVP Member ID card.

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

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP's *Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

☐ Yes ☐ No

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

I have read and agree to this authorization.

Signature *Date*

EPO/PPO Plans Product Application
for New York State Small Groups

Please complete all pages of this form. Some sections may not apply to your group.

Section 1: Group Information *(please print, and include Company Name and Tax ID No. on all pages)*

Group/Business Name or DBA Name *(if applicable)* | Tax ID No. *(required)*

Legal Entity Name *(if different than Group Name)* | SIC Code *(required)*

Nature of Business or Organization | **Effective Date of Coverage**

Business Physical Street Address | Phone No. ( ) | Fax No. ( )

City | State | Zip Code | County

Company Headquarters Street Address ☐ *Same as above* | Phone No. ( ) | Fax No. ( )

City | State | Zip Code | County

Group Health Benefits Administrator (HBA) Name | Group HBA Title

Group HBA Email | Group HBA Phone No. ( )

Group HBA Street Address ☐ *Same as above* | City | State | Zip Code

Who sponsors the group health coverage? *(check one)* ☐ Employer ☐ Union ☐ Association ☐ Other: _____

Organization Type ☐ C Corp ☐ S Corp ☐ Partnership ☐ Nonprofit ☐ Local Government ☐ State Government ☐ Church Group ☐ Trust ☐ Other: _____

List Owner(s)/Partner(s) of this Organization

Are the owners and their spouses the only policy holders on the group sponsored coverage? ☐ **Yes** ☐ **No**

This company is organized as: ☐ Stand Alone ☐ Parent ☐ Subsidiary ☐ Local Plant/Office/Division ☐ Other: _____

Do you, as an employer, offer a group medical plan in addition to the products offered through MVP Health Care®? ☐ **Yes** ☐ **No**

If ***Yes***, who is the plan carrier?

Continued on page 2

Company Name *Tax ID No.*

Section 2: Billing Information

☐ ***Premium invoices should be sent to the Group Contact and Address listed in Section 1 (proceed to Section 3).***

Billing Contact Name	Billing Contact Title
Billing Contact Email	Billing Contact Phone No. ( )
Billing Street Address	Billing Contact Fax No. ( )

City	State	Zip Code	County

Section 3: Regulatory Employer Information

Do you employ at least one employee who lives, works, or resides in the MVP service area?	☐ Yes ☐ No
Are all employees who are offered coverage working at least 20 hours per week?	☐ Yes ☐ No
Is there at least one common law employee enrolled as a contract holder?	☐ Yes ☐ No
Does your group have fewer covered employees outside the MVP service area than covered employees within the MVP service area?	☐ Yes ☐ No
If owners are enrolling in MVP coverage, do they all work at least 20 hours per week?	☐ Yes ☐ No

Section 4: Group Administration

Total Number of Part-Time and Full-Time Employees Over the Prior Calendar Year *(to determine Certification of Benefits for members 65 and older)*	Total Number of Full-Time Equivalent Employees[1] Over the Prior Calendar Year *(to determine if Small or Large Group)*

Note: Retirees and COBRA participants are not considered "employees" and should not be counted to determine group size.

[1] The *full-time equivalent* (FTE) employee counting method in 26 U.S.C. 4980H(c)(2) must be utilized to determine group size. This method is the same calculation used to determine employer liability under the *Shared Responsibility for Employers* provisions of the Affordable Care Act (ACA) and Internal Revenue Code.

To convert the number of part-time employees to a full-time equivalent, the aggregate number of hours worked for part-time employees is divided by 120. Part-time hours are capped at 120 hours per employee per month.

New Hire Eligibility Policy

☐ Date of hire ☐ First of the month following date of hire

☐ First of the month following _____ day(s) of employment *(may not exceed 90 days)*

Section 5: Enrollment Class/Subgroup Assignment

Class Description *(example: All employees working more than 20 hours per week)*

Select a separate Class/Subgroup, if your Group requires one:

☐ Medicare ☐ Salary ☐ COBRA ☐ Union ☐ Hourly ☐ Other: _____

Section 6: Product Selection

☐ Platinum Plan No. _____	☐ Silver 4 with Embedded HRA	☐ MVP Dental PPO® for Adults	☐ MVP Vision 1
☐ Gold Plan No. _____	☐ Dependent through Age 29	☐ MVP Dental PPO® for Families	☐ MVP Vision 2
☐ Silver Plan No. _____	☐ Unlimited Skilled Nursing	☐ MVP Dental PPO for Kids®	☐ MVP Vision 3
☐ Bronze Plan No. _____		☐ Delta Dental Pediatric PPO Plan	
☐ Medicare Gold			

Continued on page 3

Company Name *Tax ID No.*

Section 7: Information About Individuals Not Listed on NYS-45-ATT or Other State Equivalent

Please list below the individuals eligible for coverage who are not listed on the NYS-45-ATT, *Quarterly Combined Withholding, Wage Reporting, and Unemployment Insurance Return form*, or other state equivalent. Eligible individuals include partners or owners of the business if actively engaged in the business, COBRA/New York State continuants, new employees, retirees, and spouses of retirees when it is the consistent policy of the business owner to cover retirees and spouses of retirees.

The group attests that the individual(s) listed below work at least 20 hours per week at the employer named on page 1 or are otherwise eligible for coverage under a group health insurance plan to be issued by MVP. For each employee listed, indicate their employment status.

Name

☐ New Employee *(Date of hire: __________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ________________________

Name

☐ New Employee *(Date of hire: __________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ________________________

Name

☐ New Employee *(Date of hire: __________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ________________________

Name

☐ New Employee *(Date of hire: __________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ________________________

Name

☐ New Employee *(Date of hire: __________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ________________________

Name

☐ New Employee *(Date of hire: __________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ________________________

Section 8: Separate Entities with Multiple Tax ID Numbers

Only complete this section if you have separate entities with multiple Tax ID numbers.

Group size for groups under common ownership is determined based upon the total Full-Time Equivalent Employees (FTEs) for all entities. In order to combine separate groups into one employer group for group insurance purposes, MVP will require documentation showing 80% of each entity is owned by the same person or set of people.

Please check if any of the following conditions apply:

☐ Multiple Tax ID numbers are listed above
☐ This/These groups are owned by another entity
☐ This group owns another entity
☐ This group is one of multiple groups that are owned by the same entity/entities

If any of the above conditions apply, tax documentation certifying that at least 80% common ownership must be submitted. Acceptable tax forms are (1) IRS Form 851 (Affiliations Schedule) with names of all entities or (2) Schedule K-1 (IRS Form 1065).

Section 9: Small Business Health Options Program (SHOP) Attestation

Have you completed the New York State SHOP eligible employer verification process and found that the Group named on page 1 of this application is SHOP eligible? ☐ **Yes** ☐ **No**

Section 10: Broker Information

☐ *I understand that the agency below may be entitled to a base and/or bonus compensation for our business. This broker information will remain in effect until we notify MVP Health Care otherwise.*

Broker Name	Agency Name		
Street Address	City	State	Zip Code
Billing Contact Email	Phone No. ( )	Fax No. ( )	

Continued on page 4

Company Name *Tax ID No.*

Section 11: Private Exchange Information

Is this group to be enrolled through a private exchange (other than the NY State of Health Marketplace)? ☐ Yes ☐ No

If ***Yes***, please provide the name of the private exchange: _____

Section 12: MVP Representative Information

The information provided in this application is true to the best of my knowledge.

MVP Representative Name (print) *Signature* *Date*

Section 13: Authorization

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

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I have read and agree to the details outlined in *MVP's Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

I have read and agree to this authorization.

Signature *Date*

Name (print) *Title*

Health Plan Enrollment or Change
for New York State Small Group EPO/PPO Plans

Action Requested: ☐ **Enrollment** ☐ **Change** ☐ **Termination** *Please complete all pages of this form.*

To be Completed by Employer *(please include Group Name, Group No., and Applicant Name on pages 2 and 3)*

Group Name	Group No.	Subgroup No.

Employee Class	Product ID No.	Effective Date

Section 1: Information About Yourself *(please print)*

Applicant Name *(First, Middle Initial, Last)* | Marital Status ☐ Single ☐ Married

Street Address | City | State | Zip Code

County | Home Phone No. ( ) | Mobile Phone No. ( )

Email

Are you and/or your spouse eligible for Medicare? ☐ Yes ☐ No | If ***Yes***, provide your Medicare Member ID No(s). (Yourself) (Spouse, if eligible)

If ***Yes***, provide Medicare Parts A and B Effective Dates
(Yourself) Part A Part B (Spouse) Part A Part B

Section 2: Enrollment/Change/Termination Information

Enrollment or Change *(check all that apply)*

☐ New Applicant ☐ Add Dependent ☐ Name Change
☐ Transfer to Another Plan ☐ Address Change ☐ COBRA

Requested Effective Date

Reason

☐ New Hire (Date of Hire:) ☐ Open Enrollment
☐ Qualifying Event *(explain)*
☐ Other

Termination

☐ Terminate from Plan
☐ Remove Dependent(s) only *(specify name or member ID no.)*

Requested Effective Date

Reason for Termination

☐ Termination of Employment ☐ Opting for Other Coverage
☐ Moved from Service Area
☐ Other

Section 3: Coverage Selection (Enrollments and Changes)

Medical Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

Medical Plan Name (e.g., Gold 2 HDHP)

Optional Vision Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family
Vision coverage must be equal to or less than medical coverage.

Optional Vision Plan (select one) ☐ MVP Vision 1 ☐ MVP Vision 2 ☐ MVP Vision 3

If scanning this form for submission, be sure to scan and return all pages of this form.

Continued on page 2

Group Name *Group No.* *Applicant Name*

Section 4: Information About All Family Members You Want to Enroll in Your Plan (Enrollments and Changes)

Please use a separate form for additional individuals.

1 Applicant ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Are you already a patient of this physician? ☐ Yes ☐ No | PCP No.

2 Name *(First, Middle Initial, Last)* | Relationship to Applicant ☐ Spouse ☐ Dependent

☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

3 Name *(First, Middle Initial, Last)* | Relationship to Applicant ☐ Dependent

☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

4 Name *(First, Middle Initial, Last)* | Relationship to Applicant ☐ Dependent

☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

5 Name *(First, Middle Initial, Last)* | Relationship to Applicant ☐ Dependent

☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

Section 5: Authorization *(Your signature is required for Enrollments, Changes, or Terminations)*

On behalf of myself and any members of my family for whom I have enrollment authority and have listed on this enrollment form, I (we) hereby apply for membership in MVP. I hereby consent to the release, use, and disclosure of any medical information about me and any members of my family for whom I can give consent:

- By my primary care provider, any other health care provider, or the New York State Department of Health ("NYSDOH") to MVP and any health care providers involved in caring for me or my family, as reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations functions, or other functions permitted by, and in accordance with, applicable laws, regulations, and rules. This may include pharmacy and other medical claims information needed to help manage my care;
- By MVP and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administering health programs to the extent permitted by, and in accordance with, applicable laws, regulations, and rules; and
- By MVP to my providers or other persons or organizations, as reasonably necessary for MVP or my providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules.

At any time, I can take away the permission I gave to release information. All I have to do is call the MVP Customer Care Center at the phone number listed on the back of my MVP Member ID card.

Continued on page 3

Group Name	*Group No.*	*Applicant Name*

*(**Section 5: Authorization** continued from page 2)*

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

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP's *Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

☐ Yes ☐ No

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

I have read and agree to this authorization.

Signature *Date*

Questions? We're here to help. Call **1-844-865-0250** Visit **mvphealthcare.com** Fax: **518-386-7595**

Return this completed application by mail to **MVP HEALTH CARE 625 STATE ST SCHENECTADY NY 12305-2111**

(Be sure to include all pages of the form)

A better value.
A better experience.

MVP Health Care® New York Small Group employer plans pair innovative extras with personal support.

MVP offers great benefits and services with every plan.

Network Strength

A regional network of top providers, hospitals, and pharmacies—and access to over a million providers nationwide with select plans.

24/7 Access to Quality Care, Plan Information & Cost Savings

The Gia by MVP mobile app can help reduce the overall cost of care and decrease employee absenteeism by giving your employees access to important care and plan information whenever and wherever they need it.

24/7 Virtual Primary Care

Same-day, high-quality virtual primary and multispecialty care from Galileo doctors via text or video chat—no appointments necessary.

$600 Well-Being Reimbursement

Members can get reimbursed up to $600 per contract, per calendar year for well-being items, programs, and activities.

Savings and Value

$0 preventive care, including physicals and immunizations, per recommended guidelines.

Save 20% on CVS Pharmacy® brand health-related items.

Get Rx delivered to your door with Simple Dose™ from CVS Pharmacy and PillPack by Amazon Pharmacy.

Embedded Pediatric Dental

All covered dependents, up to age 19, can receive preventive, routine, and major dental services from any licensed provider.

Preferred Providers

Members pay as little as $0 for laboratory, radiology, and ambulatory/outpatient surgery service, or pay a reduced cost-share for plans with an unmet annual deductible.*

Questions? Visit **mvphealthcare.com** or call the MVP Small Business & Individual Service Unit at **1-844-865-0250**.

*Preferred providers are not available in all counties.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

MVP Vision Plans

Powered by EyeMed

More convenience, more choices,
and more savings for your employees!

Making happier, healthier employees

MVP vision plans can be offered to your employees alongside an MVP medical plan.

Amazing savings

- $10 co-pay for an annual eye exam
- $25 co-pay for single vision lenses
- Additional lens options

Allowance for frames and contact lenses

- MVP Vision 1: $170 allowance every 12 months for frames and every 12 months for contact lenses
- MVP Vision 2: $150 allowance every 24 months for frames and every 12 months for contact lenses
- MVP Vision 3: $130 allowance every 24 months for frames and every 12 months for contact lenses

More

Vision Benefits **for Every Set of Eyes**

The vision network you want.

Every doctor in our vision network is carefully selected to ensure your employees have the flexibility to choose from the right mix of independent, national retail, and regional retail providers, including LensCrafters℠, Target Optical℠, and Pearle Vision℠. Plus, we offer online, in-network options through **LensCrafters.com**, **Ray-Ban.com**, **Glasses.com**, and **ContactsDirect.com**.

A more convenient experience.

Our member website gives your employees access to benefit details, claims, provider locations, and more. And, since many providers offer extended evening and weekend hours, they can get care when it works around their busy schedule.

Choices that fit your style.

You can choose nearly any frame, lens, or contact lens—including frames from popular designer brands such as Armani, Coach, Ray-Ban, DKNY, and more.[1]

More savings for your employees.

EyeMed offers even more savings for your employees with 40% off additional complete pairs of eyeglasses, 20% off non-prescription sunglasses, and 15% off standard prices on laser vision correction.[2]

Answers every step of the way.

EyeMed offers access to one of America's highest-rated and award-winning customer call centers.[3]

Learn more about MVP vision plans, contact your broker or MVP sales representative, or visit mvphealthcare.com/visionplans.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION ESTD 1961 OPTICAL

POWERED BY eyemed

[1]All brands may not be available at all provider locations.
[2]Discounts only available at participating in-network providers. Does not apply to discount plans.
[3]Purdue University Benchmark Portal independent assessment of call centers nationwide, 2020.

MVP Vision Plans
For Small Groups

MVP Health Care® vision plans are powered by EyeMed, which means every doctor in our network is carefully selected to ensure our members have the flexibility to choose from the right mix of independent, national retail, and regional retail providers, including LensCrafters,® Target Optical,® and Pearle Vision.® Plus, we offer online, in-network options through LensCrafters.com, Ray-Ban.com, Glasses.com, and ContactsDirect.com.

To learn more about MVP vision plans, contact your Broker or MVP Sales Representative.

Benefit Summary

	MVP Vision 1		MVP Vision 2		MVP Vision 3	
	Par Provider (Member Responsibility)	**Non-Par Provider** (Reimbursement to Member)	**Par Provider** (Member Responsibility)	**Non-Par Provider** (Reimbursement to Member)	**Par Provider** (Member Responsibility)	**Non-Par Provider** (Reimbursement to Member)
Routine Eye Exam (one exam every 12 months)	$10 co-pay *Lenses or Contact Lenses every 12 months, Frames every 12 months*	Up to $25	$10 co-pay *Lenses or Contact Lenses every 12 months, Frames every 24 months*	Up to $25	$10 co-pay *Lenses or Contact Lenses every 12 months, Frames every 24 months*	Up to $25
Frames	20% off after $170 allowance	Up to $85	20% off after $150 allowance	Up to $75	20% off after $130 allowance	Up to $65
Lenses - Single Pair						
Single Vision	$25 co-pay	Up to $7	$25 co-pay	Up to $7	$25 co-pay	Up to $7
Bifocal	$25 co-pay	Up to $21	$25 co-pay	Up to $21	$25 co-pay	Up to $21
Trifocal	$25 co-pay	Up to $46	$25 co-pay	Up to $46	$25 co-pay	Up to $46
Standard—Progressive	$90 co-pay	Up to $21	$90 co-pay	Up to $21	$90 co-pay	Up to $21
Premium—Progressive (Tier 1/Tier 2/Tier 3/Tier 4)	$110/$120/$135/ $90 co-pay, then 20% off after $120 allowance	Up to $21	$110/$120/$135/ $90 co-pay, then 20% off after $120 allowance	Up to $21	$110/$120/$135/ $90 co-pay, then 20% off after $120 allowance	Up to $21
Lens Options - Per Pair						
Standard Polycarbonate (Adult/to age 19)	$40/$0	Not Covered/Up to $28	$40/$0	Not Covered/Up to $28	$40/$0	Not Covered/Up to $28
Scratch Resistant Coating	$0	Up to $11	$0	Up to $11	$0	Up to $11
UV Coating	$15	Not Covered	$15	Not Covered	$15	Not Covered
Solid or Gradiant Tint	$15	Not Covered	$15	Not Covered	$15	Not Covered
Standard AR Coating	$45	Not Covered	$45	Not Covered	$45	Not Covered
Other add-ons and sevices	20% off	Not Covered	20% off	Not Covered	20% off	Not Covered
Contact Lenses						
Conventional	15% off after $170 allowance	Up to $136	15% off after $150 allowance	Up to $120	15% off after $130 allowance	Up to $104
Disposables	$170 allowance	Up to $136	$150 allowance	Up to $120	$130 allowance	Up to $104

Rates

Effective January 1, 2023–December 31, 2023

	MVP Vision 1	MVP Vision 2	MVP Vision 3
Voluntary			
Single	$8.01	$6.70	$6.20
Single + Spouse	$15.22	$12.73	$11.78
Single + Child(ren)	$16.02	$13.40	$12.40
Family	$23.55	$19.70	$18.23
Non-Voluntary*			
Single	$6.58	$5.24	$4.84
Single + Spouse	$12.50	$9.96	$9.20
Single + Child(ren)	$13.16	$10.48	$9.68
Family	$19.35	$15.41	$14.23

*Employer contributes 80% or more to the premium for their employees.

POWERED BY EyeMed

No benefits will be paid for services or materials connected with or charges arising from: orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time. Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

These plan overviews are intended to provide a general outline of coverage. In the event of any conflict between this document and your Certificate of Coverage, Schedule, or any applicable Rider(s), your Certificate of Coverage, Schedule, or any applicable Rider(s) will be controlling.

MVPCOMM0245 (09/2022)

2023 MVP Vision Plan Selection

For MVP Health Care® NY Commercial Group Plans

MVP HEALTH CARE

Section 1: Group Information

(Please print)

Group Name

Group No. *(if applicable)*

Medical and Vision Plan Effective Date

Broker Agency Name

Section 2: MVP Vision Plan(s) Selection

Select the MVP Vision Plan(s) below you will offer your employees.

MVP Vision Plans	Routine Eye Exam	Frames	Lenses and Contact Lenses
☐ MVP Vision 1	**$10 co-payment** (One exam every 12 months)	**20% off after $170 allowance** (New frames every 12 months)	**Refer to the Schedule for cost-share** (New lenses or contact lenses every 12 months)
☐ MVP Vision 2	**$10 co-payment** (One exam every 12 months)	**20% off after $150 allowance** (New frames every 24 months)	
☐ MVP Vision 3	**$10 co-payment** (One exam every 12 months)	**20% off after $130 allowance** (New frames every 24 months)	

Section 3: Vision Coverage Level and Rates

Select one of the premium rate schedules below, and all tier levels you will offer your employees within that rate schedule.

☐ **Non-Voluntary Monthly Rates**
By selecting this rate schedule, the employer agrees to contribute 80% or more to the employees' vision premium.

	MVP Vision 1	MVP Vision 2	MVP Vision 3
☐ Single	$6.58	$5.24	$4.84
☐ Single + Spouse	$12.50	$9.96	$9.20
☐ Single + Child(ren)	$13.16	$10.48	$9.68
☐ Family*	$16.78 (2T) $18.36 (3T) $19.35 (4T)	$13.36 (2T) $14.62 (3T) $15.41 (4T)	$12.34 (2T) $13.50 (3T) $14.23 (4T)

☐ **Voluntary Monthly Rates**

	MVP Vision 1	MVP Vision 2	MVP Vision 3
☐ Single	$8.01	$6.70	$6.20
☐ Single + Spouse	$15.22	$12.73	$11.78
☐ Single + Child(ren)	$16.02	$13.40	$12.40
☐ Family*	$20.43 (2T) $22.35 (3T) $23.55 (4T)	$17.09 (2T) $18.69 (3T) $19.70 (4T)	$15.81 (2T) $17.30 (3T) $18.23 (4T)

*2T (2-Tier) Single/Family; 3T (3-Tier) Single/Single + Spouse, Family; 4T (4-Tier) Single/Single + Spouse/Single + Child(ren)/Family.

The plan overviews above are intended to provide a general outline of coverage. Comprehensive benefit details will be available in your Certificate of Coverage (COC), Schedule of Benefits, Summary of Benefits and Coverage (SBC), and any applicable Riders. Your COC, Schedule, SBC, and Rider(s) will be controlling. These documents will be available in your MVP online account, or by request.

Employer Signature

Date

Employer Name (print)

Title

No benefits will be paid for services or materials connected with or charges arising from: orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time. Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

2023 Dental Benefit Plans from MVP Health Care®

For Small Group Plans in New York State

MVP NY Small Group Plans Include Pediatric Dental

Preventive $25 co-pay, deductible applies to QHDHP plans
Routine 20% co-insurance, after deductible
Major 50% co-insurance, after deductible
Orthodontia 50% co-insurance, after deductible
(Medically necessary)

Medically necessary Orthodontia and Major Services require prior authorization.

- No additional monthly premium (included with medical plan premium)
- Covered dependents, up to age 19, have access to preventive, routine, major, and medically necessary orthodontia services
- No separate in-network/out-of-network benefits; members can choose any dentist they like
- Members simply use their MVP Member ID Card to obtain dental services
- Dental services are subject to the medical deductible and out-of-pocket maximum, with the exception of preventive services which are not subject to the deductible
- For even more coverage, the MVP standalone plans (administered by Healthplex) can be purchased alongside MVP Small Group plans; the embedded pediatric dental will be the primary benefit

MVP partners with Healthplex to ensure members have access to the most comprehensive oral care services through a network of fully credentialed dentists and specialists. All MVP dental plans with pediatric coverage meet the Affordable Care Act (ACA) requirements for dependent children up to age 19.

These plans can be purchased alongside your MVP medical plan, or as a standalone dental benefit.

	MVP Dental for Kids®		MVP Dental PPO®–Family		MVP Dental PPO®–Adults	
	In-Network	Out-of-Network[1]	Up to Age 19	Age 19 and Over	In-Network	Out-of-Network[1]
Annual Deductible	None	None	None	$50[2]	$100	$100
Annual Out-of-Pocket Maximum	$375 for one child, $750 for two or more children	None	**IN**: $375 for one child, $750 for two or more children **OUT**: None	None	None	None
Annual Maximum Benefit	None	None	None	$750	$1,000 (In- and out-of-network combined)	
Emergency and Preventive Dental	$25 co-pay	$25 co-pay	$25 co-pay	Covered in full	Covered in full	Covered in full
Routine Dental Exams, X-rays, Simple Extractions, Fillings	$25 co-pay	$25 co-pay	$25 co-pay	0%, after deductible	20%, after deductible	20%, after deductible
Oral Surgery	50%	50%	50%	20%, after deductible	20%, after deductible	20%, after deductible
Endodontics Root Canals	50%	50%	50%	20%, after deductible	50%, after deductible	50%, after deductible
Periodontics	50%	50%	50%	20%, after deductible	50%, after deductible	50%, after deductible
Prosthodontics[3] Partial Dentures, Crowns	50%	50%	50%	50%, after deductible	50%, after deductible	50%, after deductible
Orthodontics[3]	50%	50%	50%	Not covered	Not covered	Not covered

[1] Any charges of a non-participating provider that are in excess of the allowed amount do not apply toward the deductible or out-of-pocket maximum. If billed by your provider, you must pay the amount of the non-participating provider's charge that exceeds our allowed amount.

[2] Deductible applies to routine dental care, endodontics, periodontics, and prosthodontics.

[3] Service requires prior authorization, and must be medically necessary.

IN: In-Network **OUT:** Out-of-Network **QHDHP:** Qualified High-Deductible Health Plan

Predetermination of benefits available.

The embedded pediatric dental benefit does not apply to Healthy NY plans.

MVP Dental for Kids, MVP Dental PPO for Adults, and MVP Dental PPO for Families are administered by Healthplex, Inc.

This chart is intended to provide a general outline of MVP Dental coverage. In the event of any conflict between this document, and your Dental Contract and Schedule of Benefits, your Dental Contract and Schedule of Benefits will be controlling.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

Questions?

Existing MVP Dental plan members can call the MVP Customer Care Center at the number listed on the back of their Dental Member ID card.

Ready to purchase a dental plan?

For more information, call **1-800-TALK-MVP** (1-800-825-5687) or visit **mvphealthcare.com**.

MVPCOMM0004 (08/2022)

DELTA DENTAL®

MVP® HEALTH CARE

Pediatric Basic Plan for Small Businesses – 2023 rates

Delta Dental PPO™

A Delta Dental PPO plan makes it easy for your employees to find a dentist and control costs when visiting a Delta Dental 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. Monthly rates for the 2023 Pediatric Basic Plan for Small Businesses are listed below.

Subscriber (Age 19+)	Subscriber	Subscriber + spouse	Subscriber + children	Family
Albany Region **Counties:** Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	$0.00	$16.49	$31.33	$31.33
Buffalo Region **Counties:** Allegany*, Cattaraugus*, Chautauqua*, Erie, Genesee, Niagara, Orleans, Wyoming	$0.00	$15.44	$29.34	$29.34
Mid-Hudson Region **Counties:** Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster	$0.00	$18.45	$35.06	$35.06
New York City Region **Counties:** Bronx*, Kings*, New York*, Queens*, Richmond*, Rockland, Westchester	$0.00	$22.73	$43.19	$43.19
Rochester Region **Counties:** Livingston, Monroe, Ontario, Seneca, Wayne, Yates	$0.00	$16.01	$30.42	$30.42
Syracuse Region **Counties:** Broome, Cayuga, Chemung,Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins	$0.00	$16.22	$30.82	$30.82
Utica/Watertown Region **Counties:** Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence	$0.00	$16.12	$30.63	$30.63

*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.

Benefit Highlights
Delta Dental Individual

Delta Dental PPO™
Pediatric Basic Plan for Small Businesses – 2023 rates

Delta Dental is committed to being your partner in maintaining great oral health. A Delta Dental PPO plan can help you provide the coverage your employees need by offering options that balance maximum dentist choice while stretching your dental benefits budget. Plus, the cost savings provided by our PPO network can help keep your company's dental benefit costs stable. Plan highlights for the 2023 Pediatric Basic Plan for Small Businesses are listed below.

Deductibles & Maximums per calendar year	Pediatric benefits (up to age 19)
Deductible Enrollee	$65 per pediatric enrollee
Deductible waived Deductible does not apply to these services	n/a
Annual maximum Maximum the plan will pay each year for services per person	None
Out-of-pocket maximum After this amount is reached, the plan pays 100% of the remaining covered services for that year. Applies only to in-network services.	$375 one pediatric enrollee, $750 two or more pediatric enrollees

Covered services*	Delta Dental pays	Enrollee pays
Diagnostic and preventive services	100%	0%
Basic services	50%	50%
Major services	50%	50%
Orthodontics (Only medically necessary procedures)	50%	50%
Waiting periods	None	None

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement to dentists is based on contracted fees for all dental providers.

Delta Dental PPO™ is offered by MVP Health Care and administered by Delta Dental of New York, Inc.

Delta Dental is a registered mark of Delta Dental Plans Association.

NY O-V-15_2021

Non-Discrimination Notice

For MVP Commercial Plans

MVP Health Care® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sexual orientation and gender identity). MVP Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including sexual orientation and gender identity).

What MVP Health Care Provides

Free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If You Need These Services

If you need these services, contact Elona Charles-Wilson at **1-844-946-8009** (TTY: 1-800-662-1220).

How to File a Grievance or Complaint

If you believe that MVP has not given you these services or has treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with MVP by:

Mail: ATTN: ELONA CHARLES-WILSON
CIVIL RIGHTS COORDINATOR
MVP HEALTH CARE
625 STATE ST
SCHENECTADY NY 12305-2111

Phone: **1-844-946-8009**
(TTY/TDD: 1-800-662-1220)

In person: 625 State Street, Schenectady, NY

Email: **civilrightscoordinator@mvphealthcare.com**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

Online: **ocrportal.hhs.gov**

Mail: US DEPT OF HEALTH & HUMAN SRVS
200 INDEPENDENCE AVE SW
HHH BLDG ROOM 509F
WASHINGTON DC 20201

Phone: **1-800-368-1019**
(TTY/TTD: 1-800-537-7697)

Complaint forms are available by visiting **hhs.gov/regulations** and selecting *Complaints & Appeals*, then *Civil Rights: How to file a complaint*.

Multi-Language Interpreter Services

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-946-8010** (TTY: 1-800-662-1220).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-844-946-8010**（TTY：1-800-662-1220）。

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-844-946-8010** (телетайп: 1-800-662-1220).

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-844-946-8010** (TTY: 1-800-662-1220).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-844-946-8010** (TTY: 1-800-662-1220) 번으로 전화해 주십시오.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-844-946-8010** (TTY: 1-800-662-1220).

אידיש (Yiddish)
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט **1-844-946-8010** (TTY: 1-800-662-1220).

বাংলা (Bengali)
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-**844-946-8010** (TTY: ১- 800-662-1220)।

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-844-946-8010** (TTY: 1-800-662-1220).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-844-946-8010** (رقم هاتف الصم والبكم: 1-800-662-1220).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-844-946-8010** (ATS: 1-800-662-1220).

اُردُو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-844-946-8010** (TTY: 1-800-662-1220).

Tagalog (Tagalog-Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-946-8010** (TTY: 1-800-662-1220).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-844-946-8010** (TTY: 1-800-662-1220).

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-844-946-8010** (TTY: 1-800-662-1220).

