

**MVP VERMONT  
HIGH DEDUCTIBLE HEALTH PLAN  
HMO CERTIFICATE OF COVERAGE**

MVP Health Plan, Inc.  
625 State Street  
Schenectady, New York 12305  
(800) 777-4793



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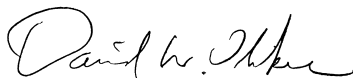
Issued by  
MVP Health Plan, Inc.  
625 State Street, Schenectady, New York 12305  
800/777-4793

Your employer or organization ("Group") has purchased a fully insured group health benefits plan from MVP Health Plan, Inc. ("MVP"). MVP is a health maintenance organization ("HMO").

This Certificate of Coverage ("Certificate") describes the health benefits you may get under a contract between MVP and your Group. This Certificate is not a contract between you and MVP. Amendments, riders or endorsements may be delivered with this Certificate or added thereafter.

**READ THIS ENTIRE CERTIFICATE AND ANY AMENDMENTS, RIDERS AND ENDORSEMENTS CAREFULLY. IT DESCRIBES: (1) THE HEALTH CARE SERVICES FOR WHICH MVP PROVIDES BENEFITS; (2) THE LIMITATIONS AND EXCLUSIONS REGARDING SUCH BENEFITS; (3) OTHER TERMS AND CONDITIONS OF COVERAGE; (4) THE RIGHTS AND RESPONSIBILITIES OF MVP; AND (5) YOUR RIGHTS AND RESPONSIBILITIES. IT IS YOUR RESPONSIBILITY TO UNDERSTAND AND COMPLY WITH ALL TERMS AND CONDITIONS IN THIS CERTIFICATE. YOU SHOULD KEEP THIS CERTIFICATE WITH YOUR OTHER IMPORTANT PAPERS SO THAT IT IS AVAILABLE FOR YOUR FUTURE REFERENCE.**

MVP Health Plan, Inc.



By:

David W. Oliker  
President

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## SECTION ONE – INTRODUCTION

This Certificate explains your coverage with MVP Health Plan, Inc. In this Certificate, “MVP”, “we,” “us,” “our” and “the Plan” mean MVP Health Plan, Inc. “You,” “your” and “yours” refer to you, the employee or group member to whom this Certificate is issued. Your eligible Dependents are referred to as “Members.” Use of the word “he” in this Certificate refers to he or she. Use of the word “his” refers to his or her.

### 1. Understanding Your Benefits

- A. Definitions. The capitalized words in this Certificate are defined in Section Two or within the Section that they are used.
- B. Covered Services and Exclusions. Covered Services means the services specified in this Certificate as eligible for Benefits. Covered Services are described in Sections Five through Twelve. Covered Services must be Medically Necessary. MVP has protocols to help determine if a service is a Covered Service and, if so, whether it is Medically Necessary. Exclusions are described in Section Thirteen.

Some Covered Services may be listed in more than one Section. These services are listed this way to make clear that they may be received in different settings. It does not mean that you get Benefits for additional services, such as additional days or visits.

If you receive services that are not Covered Services, MVP will not pay for those services. You will have to pay all Charges for those services. However, this Certificate applies to benefits only, and does not stop you from receiving services that are not, or might not be, eligible for Benefits.

### C. Health Care Providers.

- 1. Selecting a PCP and Getting Referrals to Participating Providers. When you enroll as an MVP member, you and your Dependents must each choose a Primary Care Physician (“PCP”) from MVP’s Participating Provider Directory. You may choose a family practitioner, general practitioner, internist, pediatrician or obstetrician/gynecologist as your PCP. You must notify MVP of your choice. You may change your PCP at any time, but you must notify MVP of your new choice before receiving services from that PCP. Your PCP is responsible for coordinating and overseeing your health care. Except as described below, all services must be provided either by your PCP or by MVP Participating Providers after getting a referral from your PCP. If not, the services will not be eligible for Benefits under this Certificate.

- a. No Referral Needed. You do not need a PCP to provide or refer you for the following services:

- (1) Emergency Services.
- (2) Certain gynecological services.
- (3) Members with certain serious conditions.
- (4) Members in their second or third trimester of pregnancy.
- (5) Mental Health Services and Substance Abuse Services. However, you must call [PrimariLink] at [1-800-320-5895] to get prior written approval before receiving these services.
- (6) Covered Preventive Dental Care for Children

These exceptions are described in detail in later sections in this Certificate. You should refer to those sections to make sure that you meet all requirements.

2. Receiving Services From Participating Providers. MVP will only provide Benefits for Covered Services provided by a MVP Participating Provider, except in the following cases:

- (A) Emergency Services (See Section Ten).
- (B) Urgently Needed Care (See Section Ten).
- (C) The Covered Services you need are not available through an MVP Participating Provider. In this case, your PCP must request a Pre-Service Review and MVP must approve this before you receive the services. The request must include information about your condition, a medical opinion as to why services cannot be provided by a Participating Provider, and the name and qualifications of the proposed Non-Participating Provider.
- (D) Covered Preventive Dental Care for Children. (See Section Eleven).

You may get a list of MVP Participating Providers by looking in your MVP Provider Directory. Or, you may call Member Services at 1-888-MVP-MBRS (1-888-687-6277), or visit MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com).

3. Specialty Networks. There are some services, including transplant services, pharmacy services and bariatric surgery services, that you can only get from MVP Specialty Network Providers for MVP to approve Benefits. These services are marked "**Specialty Network Only**" in bold. You may ask if a Provider is a Specialty Network Provider by calling MVP's Member Services Department. Call 1-888-MVP-MBRS (1-888-687-6277). It is up to you to make sure that a Provider is a Specialty Network Provider at the time you get services.

4. Transition Care.

- A. Termination of Participating Providers. A Provider's participation with MVP may be terminated at any time by MVP or the Provider. In such case, MVP shall give notice to affected Members within fifteen (15) days after: (i) we get a notice of termination without cause or (ii) the date of a termination for cause. Covered Services the Provider gave to Members between the date of notice of termination or the date of termination and ten (10) business days after notice is mailed, shall continue to be Covered Services. After that, we will not provide Benefits for services given by the terminated Provider. If the Member's PCP is the terminated Provider, the Member must choose another PCP. If a non-primary care physician is the terminated Provider, the Member must be referred by his PCP to another Participating Provider. It is up to you to make sure that a provider is a Participating Provider at the time you get services. However, we will continue to provide Benefits for otherwise Covered Services for Members with life threatening, disabling or degenerative conditions who are receiving an ongoing course of treatment from the terminated Provider until the earlier of: (1) up to ninety (90) days from the date of the notice of termination or (2) the date the Member is accepted by a Participating Provider. We will also continue to provide benefits for Covered Services for Members in their second or third trimester of pregnancy who are getting services from the terminated Provider until the end of postpartum care. We will provide these Benefits only if the terminated Provider agrees to MVP's payment rates, quality of care standards and protocols, and to provide MVP with any clinical information it needs.
- B. Use of Non-Participating Providers by New Members. Except as provided below, we will not provide Benefits for use of Non-Participating Providers by new Members; however we will provide benefits for use of Non-Participating Providers by new Members for otherwise Covered Services to:
- (a) Members who are receiving an active course of treatment for an acute episode of chronic illness or acute medical condition from the terminated provider; and
  - (b) Members with life threatening, disabling or degenerative conditions who are receiving an ongoing course of treatment from the terminated provider.

These benefits will be provided for sixty (60) days from the date of the Member's enrollment, consistent with written transition plan goals developed and agreed to by MVP and the provider. We will

also continue to provide benefits for Covered Services for Members in their second or third trimester of pregnancy who are receiving services from the Non-Participating Provider until postpartum care is complete. We also will provide these benefits only if the terminated provider agrees:

- (a) to continue to treat the member for an appropriate period of time based on the written transition plan goals;
- (b) to abide by MVP's payment rates, quality of care standards and protocols, including utilization management protocols;
- (c) to provide MVP with any clinical and treatment plan information it needs; and
- (d) to not charge the member for amounts beyond any required Deductible and Coinsurance.

D. Utilization Management and Claims Filing. MVP must review some services before you get them in order for us to approve Benefits. In most cases, your MVP Participating Provider will take care of getting this review when it is needed. MVP must also receive a claim, after you have received services, in order to pay Benefits. In most cases, your MVP Participating Provider will file claims on your behalf. See Section Four for more information.

## 2. Your Payments under this Certificate.

A. Deductible. This Certificate requires you to pay a Deductible for all Covered Services except for Preventive Care Services and Preventive Dental Care Services for Children to Age 19. The Deductible amount is listed on your Schedule. If you have Single Person Coverage, you must meet the Single Person Coverage Deductible each Calendar Year. The amount of the Subscriber's Deductible Expenses will apply toward the Single Person Coverage Deductible. If you have Family Coverage, the Subscriber and/or his Dependents must meet the Family Coverage Deductible each Calendar Year. The Deductible Expenses of the Subscriber and his Dependents will apply toward the Family Coverage Deductible. Except for Covered Preventive Care, described in Section Eleven, the applicable Deductible must be met before MVP will pay any Benefits under this Certificate. If the applicable Deductible has been met, no further Deductible payments will be required for the rest of that Calendar Year. You must still pay any applicable Copayments and Coinsurance.

i. The following **DO NOT** Count Toward the Deductible.

a. Any Copayments and Coinsurance.

b. Any Charges you incur if you have exhausted any Benefit maximums or that are otherwise incurred for non-Covered Services.

- B. Coinsurance. This Certificate requires you to pay a Coinsurance for all Covered Services except for Preventive Dental Care for Children to Age 19. These amounts are listed on your Schedule.
  - C. Copayments. This Certificate requires you to pay a Copayment for Preventive Dental Care for Children to Age 19.
  - D. Annual Out of Pocket Maximum. This Certificate has the following Out of Pocket Annual Maximums: Single Person Coverage and Family Coverage. This is the maximum amount of Expenses that must be paid during any one Calendar Year. The amount is listed on your Schedule. If you have Single Person Coverage, you must meet the Single Person Annual Out of Pocket Maximum each Calendar Year. The amount of the Subscriber's Annual Out of Pocket Maximum Expenses will apply toward the Single Person Out of Pocket Maximum. If you have Family Coverage, the Subscriber and/or his Dependents must meet the Family Coverage Annual Out of Pocket Maximum each Calendar Year. The Annual Out of Pocket Maximum Expenses of the Subscriber and his Dependents will apply toward the Family Coverage Annual Out of Pocket Maximum.
    - i. The following **DO NOT** Count Toward the Annual Out of Pocket Maximum.
      - a. Any Charges you incur if you have exhausted any Benefit maximums or that are otherwise incurred for non-Covered Services.
3. MVP's Payments under this Contract.
- A. Benefits. When a Member receives Medically Necessary Covered Services, MVP will pay the Allowable Charge for the Covered Service minus any applicable Copayment or Coinsurance and Deductibles. Benefits are further limited to each Member's Annual and Lifetime Benefit Maximum, described below.
    - i. Participating Providers. MVP will pay the Allowable Charge directly to the Provider. These Providers will accept MVP's payment, plus any applicable Copayment or Deductibles and Coinsurance paid by you, as payment in full.
    - ii. Non-Participating Providers. If MVP approves Benefits for services provided by a Non-Participating Provider, MVP may reimburse you or pay the Provider. You must still pay any applicable Copayment or Deductible and Coinsurance.
  - B. Annual Benefit Maximums. These are the maximum amounts of days, visits or dollar amounts payable by MVP for a Covered Service for each Member during

any one Calendar Year under the Contract. Covered Services that are subject to an Annual Benefit Maximum are marked in **bold**. **After we have paid the Annual Benefit Maximum for a Covered Service in any Calendar Year, you must pay all Charges for that service. Such Charges in excess of the Annual Benefit Maximum will not count toward your Deductible or toward your Annual Out of Pocket Maximum.**

## SECTION TWO – DEFINITIONS

1. The following terms have special meanings in this Certificate.
  - A. Acute Services. This means services that are expected to provide significant, measurable clinical improvement within a period of time not to exceed two (2) months.
  - B. Allowable Charge. This means the maximum Benefit available under this Certificate. The Allowable Charge is established by MVP in accordance with a Fee Agreement; Usual, Customary and Reasonable Charges; or by law. The Allowable Charge for prescription drugs and prescription contraceptive devices you get at a Participating Pharmacy means the negotiated rate charged to MVP by the Participating Pharmacy
  - C. Benefits. This means payments made by MVP to you or a Provider for Covered Services.
  - D. Calendar Year. This means the twelve (12) month period beginning at 12:01 a.m. on January 1 and ending at 12:00 midnight on December 31. However, if you were not covered under this Certificate for this entire period, Calendar Year means the period from your effective date until 12:00 midnight on December 31.
  - D. Charges. This means the total amount billed by a Provider for a service. A charge is incurred on the date the service was provided to you.
  - E. Coinsurance. This means a dollar amount, expressed as a stated percentage of the Allowable Charge and listed on your Schedule, that you must pay, in addition to the premium, for Covered Services. You must pay any Coinsurance directly to the Provider.
  - F. Copayment. This means a fixed dollar amount, listed on your Schedule, which you must pay, in addition to the premium, for Covered Preventive Dental Care Services for Children to Age 19. You must pay any Copayment directly to the Provider.

G. Covered Services. This means the services specified in this Certificate as eligible for Benefits. MVP maintains protocols to assist in determining whether a service is a Covered Service.

D. Creditable Coverage includes:

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|---|--|
| (1) Coverage provided under a group health plan such as an employer plan. | (6) Government-sponsored health benefit programs such as CHAMPUS/TRICARE, Peace Corps, or Indian Health Service. |
| (2) A health insurance policy or contract.                                | (7) Federal Employees Health Benefits Program.   |
| (3) Self-insured group health benefit plans.                              | (8) A State health benefits risk pool.   |
| (4) Medicaid.   | (9) Coverage under any health insurance plan sponsored by a state, county or other political subdivision.        |
| (5) Medicare.   |  |

Creditable coverage does not include:

- |   |  |
|---|--|
| (1) Accident-only coverage.                     | (4) Limited scope dental or vision benefits.               |
| (2) Worker's compensation or similar insurance. | (5) Long-term care benefits provided in a separate policy. |
| (3) Automobile medical payment insurance.       |  |

H. Custodial Services. This means services mainly for maintenance or designed to help you in your daily living activities. Custodial Services include, but are not limited to:

- |   |   |
|---|---|
| (1) assistance in walking, bathing and other personal hygiene, toileting, getting in and out of bed | (6) routine changing of dressings             |
| (2) dressing  | (7) child care                                |
| (3) feeding   | (8) adult day care                            |
| (4) preparation of special diets  | (9) residential care                          |
| (5) administration of oral medications  | (10) care not requiring skilled professionals |

This term also means services that, according to generally accepted professional standards, are not expected to provide significant, measurable clinical improvement within a period of time, not to exceed two (2) months.

I. Deductible. This means a dollar amount, listed on your Schedule, which must be paid each Calendar Year, in addition to the premium, before we provide Benefits under this Certificate. You must pay any Deductible directly to the Provider.

- J. Dependent. This means a person other than the Subscriber, listed on the Subscriber's enrollment application who meets all eligibility requirements, and for whom the required premium has been received and accepted by MVP.
- K. Diagnostic Services, Supplies and Equipment. This means supplies and equipment used in and provided by the Provider when performing Diagnostic Services ordered by a physician to determine a definite condition or disease. Diagnostic Services includes radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scans, electroencephalograms (EEG), electrocardiograms (ECG), organ scans, allergy testing (percutaneous, intracutaneous, patch and RAST testing) and other medical and surgical diagnostic services.
- L. Effective Date. This means the date your coverage under this Certificate begins. Coverage begins at 12:01 a.m., Eastern Time, on that date.
- M. Eligible Individual. This is defined by federal law to mean a person on his Effective Date under this Certificate:
- i. who has eighteen (18) or more months of Creditable Coverage,
  - ii. whose most recent prior Creditable Coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with such plans;
  - iii. who is not eligible for coverage under a group health plan, Medicare, Medicaid or any successor program, and does not have other health insurance coverage;
  - iv. whose most recent prior Creditable Coverage was not terminated based upon nonpayment of premiums or fraud; and
  - v. who has elected and exhausted any COBRA or state continuation coverage, if available.
- N. Emergency Medical Condition. This means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:
- i. placing the member's physical or mental health in serious jeopardy; or
  - ii. serious impairment to bodily functions; or
  - iii. serious dysfunction of any bodily organ or part.
- O. Emergency Services. This means Covered Services provided to diagnose and treat an Emergency Medical Condition.

- P. Expenses. There are two types of Expenses: Deductible Expenses and Annual Out of Pocket Maximum Expenses. Deductible Expenses mean expenses incurred by you, up to the Allowable Charge, for Medically Necessary Covered Services. Deductible Expenses do not include any Copayments or Coinsurance. Annual Out of Pocket Expenses means Deductible Expenses plus Coinsurance and Copayments. Expenses do not include premium payments, out of pocket costs for Non-Covered Services, and expenses incurred by you prior to your Effective Date and/or after the termination of your coverage under this Certificate.
- Q. Experimental or Investigational Services. This means services that are either generally not accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.
- R. Fee Agreement. This means an arrangement between MVP and Providers to provide Covered Services to Members.
- S. Medical or Scientific Evidence. This means the following sources:
- i. peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
  - ii. peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
  - iii. medical journals recognized by the federal Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act;
  - iv. the following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and the United States Pharmacopoeia-Drug Information;
  - v. findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Center for Medicare and Medicaid Services (CMS), and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and peer-reviewed abstracts accepted for presentation at major medical association meetings;

- vi. peer-reviewed abstracts accepted for presentation at major medical association meetings.

T. Medically Necessary or Medical Necessity. This means that a Covered Service is:

- i. Appropriate, in terms of type, amount, frequency, level, setting and duration, for the diagnosis or treatment of your condition;
- ii. Consistent with generally accepted practice parameters as recognized by health care providers in the same or similar specialty as typically treat or manage the diagnosis or condition;
- iii. A Covered Service which:
  - a. helps restore or maintain your health;
  - b. prevents deterioration of or palliate your condition; or
  - c. prevents the reasonably likely onset of a health problem or detect an incipient problem.

MVP has protocols to help determine if a service is Medically Necessary. Even though a Provider prescribes, performs, orders, recommends, or approves a service, that does not mean that the service is Medically Necessary or that we must provide Benefits for the service.

U. Member. This means the Subscriber or his Dependents.

V. Mental Health Condition. This means a condition or disorder involving mental illness that falls under a diagnostic category listed in the Mental Disorders Section of the International Classification of Disease (ICD-CM-9), as periodically revised, and the following conditions listed in the “V Codes” Section of the International Classification of Disease:

- i. Personal history of mental disorder (ICD-9-CM codes V11.00 through V11.99);
- ii. Psychological trauma (ICD-9-CM code V15.40);
- iii. Psychiatric condition (ICD-9-CM code V17.00);
- iv. Other family circumstances and other psychosocial circumstances (ICD-9-CM codes V61.00 through V62.99, except V61.10 (marital counseling)); and
- v. Observation for suspected mental condition (ICD-9-CM code V71.00).

Mental Health Condition does *not* include:

- i. Substance Abuse Conditions;

- ii. Hyperkinetic Syndrome of Childhood (ICD-9-CM codes 314.00 through 314.99); provided however that we will provide Benefits for Acute Mental Health Services when other diagnoses are present;
  - iii. Specific Delays in Development (ICD-9-CM codes 315.00 through 315.99);
  - iv. Psychic Factors associated with diseases classified elsewhere in the ICD-9-CM (ICD-9-CM code 316.00); and
  - v. Mental retardation (ICD-9-CM codes 317.00 through 319.99), Autistic Disease of Childhood (ICD-9-CM Code 299.00) provided however that we will provide Benefits for Acute Mental Health Services when other diagnoses are present.
- W. Mental Health Services. This means services to diagnose or treat a Mental Health Condition.
- X. Non-Participating Provider. This means a Provider who does not have an agreement with MVP to provide Covered Services to Members and/or who has not been credentialed by MVP as a Participating Provider.
- Y. Participating Provider. This means a Provider who has a Fee Agreement with MVP to provide Covered Services to Members and who has been credentialed by MVP as a Participating Provider.
- Z. Primary Care Physician. This means a Participating Provider who is licensed as a family practitioner, general practitioner, internist, pediatrician or obstetrician/gynecologist and who has been credentialed by MVP to provide covered primary health care services to Members.
- AA. Provider. This means properly licensed or certified physicians and health care professionals performing services within their licensure or certification. It also means Hospitals, ambulatory surgery centers, birth centers, Skilled Nursing Facilities, federally qualified mental health or substance abuse treatment facilities, Home Health Agencies, Hospices, Durable Medical Equipment and External Prosthetic Device suppliers, Ambulance services, and retail, mail and specialty pharmacies. Some Providers must be Specialty Network Providers for their services to be covered.
- BB. Resident. This means a person who is domiciled in Vermont, as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent.
- CC. Schedule. This means the document attached to this Certificate that describes the applicable Copayments, Deductible, Coinsurance, Annual Out of Pocket

Maximums, Annual Benefit Maximums, Lifetime Maximums and similar information.

DD. Spouse. This means the Subscriber's spouse under a legally valid marriage or civil union as defined by Vermont law.

EE. Subscriber. This means the person to whom this Certificate is issued, who meets and continues to meet all eligibility requirements, and for whom the required premium has been received by MVP.

FF. Substance Abuse Condition. This means the following disorders involving alcohol or substance abuse that falls as listed in the Mental Disorders Section in the International Classification of Diseases Manual (ICD-9-CM):

- i. Alcohol and drug psychoses (ICD-9-CM codes 291.00 through 292.99);
- ii. Alcohol dependence syndromes (ICD-9-CM codes 303.00 through 303.99);
- iii. Drug dependence (ICD-9-CM codes 304.00 through 304.99); and
- iv. Non-dependent abuse of drugs (ICD-9-CM codes 305.00 through 305.99), except tobacco use disorder (ICD-9-CM code 305.10) and other, mixed or unspecified drug abuse (ICD-9-CM code 305.90).

GG. Substance Abuse Services. This means services to diagnose or treat a Substance Abuse Condition.

HH. Surgery. This means generally accepted invasive, operative, and cutting procedures including, but not limited to specialized instrumentation, endoscopic examinations, and correction of fractures and dislocations, and the pre- and post-operative care usually rendered in connection with such procedures. Sterilization and abortion are included. Surgery does not include vaccination, collection of blood, drug administration, or injections.

II. Therapeutic Services means:

- a. Radiation Therapy. This means the use of x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes for treatment of disease.
- b. Chemotherapy. This means prevention of the development, growth, or multiplication of malignant diseases by chemical or biological agents, and includes growth cell stimulating factor injections taken as part of a chemotherapy regimen.

- c. Dialysis. This means removal of waste materials when a Member has acute kidney failure or chronic, irreversible kidney deficiency, and the use of equipment and disposable medical supplies. Alternatively, Dialysis may be provided at home. If provided at home, MVP will provide Benefits for the reasonable rental cost of equipment, as determined by us, plus Medically Necessary supplies for home dialysis treatment when ordered by your physician. MVP will not provide benefits for any furniture, electrical or other fixtures or plumbing to perform the dialysis treatments at home. For outpatient or home-based Dialysis to be covered, the treatments must be provided, supervised or arranged by your physician, and you must be a registered patient of an MVP approved kidney diseases treatment center. Benefits for Dialysis will continue until the Member becomes eligible for Medicare due to end stage renal disease, or until the Member's MVP coverage is otherwise terminated, whichever comes first.
  - d. Infusion Therapy. This means treatment of disease by continuous injection of curative agents.
  - e. Inhalation Therapy. This means inhalation of medicine, water vapor and/or gases to treat impaired breathing.
  - f. Therapeutic items used in and provided by the Hospital or facility when performing Therapeutic Services, such as prescribed drugs, medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items.
- JJ. Totally Disabled or Total Disability. This means an illness, injury or condition for which you are receiving Covered Services and which causes you to be incapable of engaging in any employment or occupation for which you are qualified or become qualified by reason of education, training or experience. You must not, in fact, engage in any employment or occupation for wage or profit.
- KK. Urgent Claim. This means any Claim for medical care or treatment with respect to which the application of the time periods for making Non-Urgent determinations: (1) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, as determined by MVP (this determination will be made by MVP applying the prudent layperson standard); (2) in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot adequately be managed without the care or treatment that is the subject of the Claim; (3) any Claim that a physician with knowledge of the Member's medical condition determines is an Urgent Claim. It does not include any claim made after services have been received.

- LL. Usual, Customary and Reasonable (UCR) Charges. These are established based on a percentile of national prevailing charge data compiled for a specific procedure and adjusted for geographic differences.

### **SECTION THREE – ENROLLMENT AND COVERAGE**

1. Who Is Eligible To Be Covered Under This Certificate.

- A. The Subscriber; subject to the Group's eligibility requirements.
- B. The Subscriber's Spouse, subject to the Group's eligibility requirements. A former Spouse is not eligible, even if a court orders the Subscriber to maintain coverage.
- C. The Subscriber's children, as described below, subject to the Group's eligibility requirements.
  - i. The Subscriber's unmarried children who are under age nineteen (19), live with the Subscriber, and are chiefly dependent upon the Subscriber for support and maintenance; and
  - ii. The Subscriber's unmarried children who are over age nineteen (19) and incapable of self-sustaining employment because of developmental disability, mental retardation, or physical disability, provided that the incapacity occurred before the child reached age nineteen (19). The child must live with the Subscriber and be chiefly dependent upon the Subscriber for support and maintenance. You must provide a physician's certification, within thirty-one (31) days after the child's nineteenth birthday in order for the child's coverage to continue under this section. We can require you to provide documentation verifying that the child is qualified and continues to qualify under this section.

2. Children Covered Under This Certificate. To be covered, the Subscriber's children must meet the requirements of 1(C)(i) or (ii) above. The Subscriber's children must also be related to the Subscriber in one of the following ways:

- A. The Subscriber's natural child;
- B. The Subscriber's legally adopted child;
- C. A child for whom the Subscriber is the legal guardian or has legal custody;
- D. The Subscriber's step child;
- E. A child under age eighteen (18) who has been placed with the Subscriber for adoption and for whom the Subscriber has assumed and retains a legal obligation to support;

- F. A child of the Subscriber's Dependent, limited to coverage from the moment of birth for thirty-one (31) days, and further limited to benefits for otherwise covered services for injury, sickness, necessary care and treatment of medically diagnosed congenital defects or birth abnormalities, or any combination of these, and well child care; or
- G. A child for whom the Subscriber has been ordered to provide dependent health insurance coverage pursuant to a qualified medical support order, even if the child does not live with the subscriber or in the State of Vermont.

Foster children and grandchildren (except as provided in paragraph (F) above) are not eligible to be covered under this Certificate.

- 3. Initial Enrollment. In order to be covered under this Certificate, you must complete an enrollment application and be accepted by MVP. You must follow your Group's instructions for enrollment. At the time of enrollment, each Member must choose a PCP as described in Section One. Your group will transmit your enrollment information to MVP in paper or electronic format. If on-line enrollment is available to you, you will complete an on-line enrollment form and transmit the form to MVP. If you have been enrolled electronically, MVP will also send you a paper form to sign. Your Spouse and your adult Dependents must also sign the paper form. By signing, you confirm your enrollment and provide written authorization for MVP to obtain your medical records and information so that we can administer your benefits, process your claims and conduct other health care operations as permitted by law.
- 4. Open Enrollment. You may enroll or add Dependents for any reason during your Group's open enrollment period. If we get your enrollment form before this period, your enrollment will be effective on the open enrollment date. If we get your enrollment form during the period in which your Group's open enrollment occurs, your enrollment will be effective on the first of the following month. If you belong to a Group of less than 50 Subscribers ("Small Group"), we do not impose open enrollment periods. However, your Group may do so. Check with your Group for information.
- 5. Enrollment of Subscriber's New Family Members.
  - A. To add a Spouse. You and your Spouse must fill out and return an enrollment form, any requested documentation, and any required premium. If you do so within thirty (30) days of the marriage or civil union, your Spouse will be added to your coverage effective as of the date of the marriage or civil union. If you do not, your Spouse will be added to your coverage as of the first of the month following the next premium due date after the next open enrollment period when we receive the completed form, requested documents and applicable premium.
  - B. To add a child.
    - i. If the Subscriber plus a Spouse, or the Subscriber plus a child or children are already covered under this Certificate the Subscriber's newborn child

will automatically be covered from the moment of birth for 31 days; and the Subscriber's adopted child or child placed with the Subscriber for adoption and will automatically be covered for 31 days from the date of the adoption or placement for adoption. Coverage is limited to benefits for otherwise Covered Services for injury, sickness, necessary care and treatment of medically diagnosed congenital defects or birth abnormalities, or any combination of these, and well child care. If you want the child to have coverage beyond the 31 days described above, you must comply with paragraph (iii) below. If you do not, we will not provide coverage beyond the 31 days.

- ii. If the Subscriber only is covered under this Certificate, the Subscriber's newborn natural child or a child placed with the Subscriber for adoption will not automatically be covered from the moment of birth or from the date of the adoption or placement for adoption. You must comply with paragraph (iii) below in order for the child to be covered from the moment of birth, adoption or placement for adoption. If you do not, we will not provide coverage for the child.
- iii. For coverage beyond the 31 days described in paragraph (i) above, or to begin coverage as described in paragraph (ii) above, you must complete and return an enrollment form, any requested documentation, and the required premium. If you do so within 31 days of the date of birth, adoption, placement for adoption, legal guardianship, or within 31 days of the date the child became the Subscriber's step child, the child will be added to your coverage effective as of the date of birth, adoption, placement for adoption, or legal guardianship, or as of the date the child became a step child. If you do not do so within 31 days of the events described, the child will be added to your coverage as of your Group's renewal date after the next open enrollment period when we receive the completed form, requested documents, and applicable premium. If you do not notify us, we will not provide coverage for the child.
  - a. We will coordinate benefits for a newborn child placed with the Subscriber for adoption if a natural parent of the child also has insurance coverage that has paid for these services.
  - b. If a notice of revocation of adoption is filed or one of the natural parents revokes their consent to the adoption, we will cease providing Benefits as of the date of the revocation.
- iv. To add a child for whom a court has ordered the Subscriber to provide dependent health insurance coverage pursuant to a qualified medical support order, you must mail us a copy of the order, by first class mail, postage prepaid. If the child is otherwise eligible for coverage, we will process the child's enrollment within ten (10) days of receiving the order.

The child will be added to your coverage three (3) days from the date you mailed the order to us or 3 days from our actual receipt of the order, whichever is sooner. You must pay us any required premium for coverage to be effective.

6. When you Reject Initial Enrollment, But Do Not Need to Wait Until the Group's Open Enrollment Period to Enroll for Coverage ("Special Enrollment"). This paragraph applies only to Members of Large Groups and to Members of those Small Groups who have elected one or more open enrollment periods. If you and your Dependents do not initially enroll or enroll during an open enrollment period, you and/or your Dependents may enroll at other times if all of the following conditions are met:
- A. You and/or your Dependents were covered under another plan or contract when coverage was initially offered;
  - B. Coverage was provided in accordance with the continuation coverage required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you and/or your Dependents lost eligibility for one or more of the following reasons:
    - (1) termination of employment;
    - (2) termination of the other plan or contract;
    - (3) death of the Spouse;
    - (4) legal separation, divorce or annulment;
    - (5) reduction in the number of hours worked; or
    - (6) the employer or other group ceased its contribution toward the premium for the other plan or contract.
  - C. You and/or your Dependents apply for coverage under this Certificate within thirty (30) days after termination for one of the reasons set forth in Paragraph B above.

If you belong to a Large Group when enrolling pursuant to this paragraph, your coverage will begin at 12:01 a.m. Eastern Time on the first of the month following the next premium due date after loss of coverage. If you belong to a Small Group, coverage will begin as of the date MVP receives your completed enrollment form, any requested documents and applicable premium. You should check with your Group to determine whether your Group is a Large Group or a Small Group.

7. Obligation to Provide Information. You must give us information needed to determine your initial and continuing eligibility status. This information must be provided within 30 days of our request. We have the right to verify this information.
8. When you, your Spouse or your child is no longer eligible for coverage. You must notify us right away of any event that affects your coverage. Such events include, but are not limited to, divorce or annulment, death of your Spouse, Medicare eligibility or coverage under another policy or Certificate, a child marrying or reaching the age at which

coverage terminates, a change in residency and a change or termination of any medical support order.

9. Enrollment Changes. If you want to change your coverage to one with a lower premium, (such as a change from family to individual coverage), you must return a completed change form and any requested documentation to your Group within 30 days of such event so that the change in premium will be effective as of the date of the event. If you do not, or if your Group does not provide the information to MVP in a timely manner, your change in premium will not be effective until the first of the month following the next premium due date after the form and documentation are received. This paragraph only involves the effective date of changes in premiums.

#### **SECTION FOUR UTILIZATION REVIEW AND CLAIMS FILING**

MVP reviews services to determine whether they are Covered Services and, if so, whether they are Medically Necessary or Experimental or Investigational, whether MVP has qualified Participating Providers available to provide these services to you, and whether and to what extent Benefits are payable under this Certificate. We will review services that you are seeking (“Pre-Service Review”), services that you are now getting and want to continue (“Concurrent Review”), and past services (“Post Service Review”). This process is called Utilization Review and Claims Review. MVP's approval of services through these processes is not a guarantee of benefits. MVP may deny Benefits in cases where there is material misrepresentation or fraud by a Member, and as otherwise permitted by law.

1. Requesting Pre-Service Review. To request a Pre-Service Review, you need to:
  - A. Except as described below, consult with your PCP or MVP Participating Provider. Your PCP or MVP Participating Provider will ask for the approval from MVP when it is required. MVP gives Participating Providers a list of the services that need Pre-Service Review.
  - B. For Mental Health Services and Substance Abuse Services, you must call [PrimariLink] at [1-800-320-5895]. These services are marked in **bold**.
2. Pre-Service Review Decisions. MVP will decide about Pre-Service Review requests as follows:
  - A. Pre-Service Reviews for Urgent Care. If your request for Pre-Service Review is Urgent and you properly identify to MVP that the request is Urgent, we will tell you and your Provider, by telephone, what we decided within 24 hours of the time of the request. You and your Provider will be notified, in writing, within 24 hours of the telephone notice. Requests and claims for Post Service Review are excluded from this paragraph. If we deny Benefits, you must pay all Charges.

- B. Non-Urgent Pre-Service Requests. If your request for Pre-Service Review is not Urgent and all needed information is received at the time of the request, we will tell you what we decided within three (3) working days after we get the request. Except in cases involving Mental Health Services or Substance Abuse Services, in the event of an adverse determination, we will also tell your Provider, by telephone, what we decided. If all needed information is not received at the time of the request, we will tell you and your Provider within fifteen (15) days after we get the request of any missing information that is needed to decide the request. You and your Provider will then have forty-five (45) days from when you get our notice to get us with the missing information. In such cases, we will tell you and your Provider, in writing, what we decided: (a) within three (3) working days after we get the missing information; or (b) within fifteen (15) days after the end of the 45 days you had to give us the missing information, whichever is sooner. If we deny Benefits, you must pay all Charges.
3. Concurrent Notice. Concurrent Notice means the notice you or your Provider or other representative must give to MVP while you are receiving certain Covered Services. MVP does not review, approve or deny Benefits at this time. Your call is needed for MVP to establish a concurrent review schedule.
- A. When Concurrent Notice is Required. You must give Concurrent Notice for the following services.
- i. All Emergency Inpatient Admissions;
  - ii. Inpatient Maternity Care (call after delivery); and
  - iii. Detoxification Admissions.
- Covered Services that require Concurrent Notice Review are marked in **bold** in this Certificate.
- B. How to give Concurrent Notice. You or your Provider or other representative must call [us] at [1-800-568-0458] within 48 hours (or as soon as you can) after you start getting these services. You must tell us your name, MVP ID number, your Provider's name and address, services you are receiving, dates of service and your diagnosis.
- C. MVP's Response to Concurrent Notice. MVP will give you a written notice to confirm your call.
4. Concurrent Review. MVP and your Participating Providers will work together so that MVP can do concurrent review. If you have been getting inpatient care or treatment that should be continued, we will review the care proposed to be continued and decide within 24 hours after our receipt of the information.

5. Post Service Review. Post Service Review means our review, after you get services. This is done to determine if the services were Medically Necessary Covered Services and if Benefits are payable. We do Post Service Review on all claims.

A. How to get Post Service Review.

- i. Participating Provider Services. When you get Covered Services from MVP Participating Providers, the Provider will, in most cases, submit a claim for Benefits for you. MVP's timely receipt of a Participating Provider's properly completed and submitted bill or electronic claim will be deemed a proper filing of Proof of Loss on your behalf. In such cases, Benefits payable will be paid directly to the Participating Provider. We will subtract any applicable Deductible, Coinsurance and Copayments from MVP's Benefit payment. You must pay the Provider these amounts. In the unlikely event a Participating Provider bills you directly, please call the provider to identify yourself as a MVP member and give your plan information on your ID card. Or, you can follow the instructions in subsection iii, Claim Submission, below. For more help you can call MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).
- ii. Non-Participating Provider Services. When you get Covered Services from a Non-Participating Provider, in some cases, the Provider will submit a claim for Benefits on your behalf. In other cases, you must pay the Provider and then submit a claim for Benefits to MVP yourself. In either case, you or the Non-Participating Provider must submit a claim to MVP by following the Claims Submission instructions below.
- iii. Claim Submission.

You or the Non-Participating Provider must submit a properly completed MVP claim form, bill, and receipts to MVP at the address below. Claim forms, bills, and receipts for a particular service must be submitted together (collectively, such items are referred to as a "Claim") within 90 days of the date of service. MVP's timely receipt of a properly completed and submitted Claim, as described in this paragraph, will be deemed a proper filing of Proof of Loss by you or by a Non-Participating Provider on your behalf. Claims submitted after this time period will be denied and you will be responsible for all Charges unless it was not reasonably possible to submit the Claim within this time frame. If it was not reasonably possible to submit the Claim within 90 days after the date of service, you or the Non-Participating Provider must, except in the absence of legal capacity, do so not later than one year from the date of service. You may get claim forms by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). You may also visit MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com) to download the claim form or to ask for a copy

of the claim form. Mail your properly completed claim forms with all Provider bills and receipts by first class mail, postage prepaid, to MVP at:

MVP Health Plan, Inc.  
P.O. Box 2207  
Schenectady, NY 12301-2207

- B. MVP's Response to Post Service Review. If all necessary information is received at the time of the claim submission, we will notify you of any adverse determination, in writing, within thirty (30) days after our receipt of the claim. If all necessary information is not received at the time of the claim, we will notify you and your Provider within thirty (30) days after our receipt of the claim of any missing information that is needed to decide the claim. You and your Provider will then have forty-five (45) days from receipt of our notice to provide us with the missing information. In such cases, we will notify you of any adverse determination, in writing, within fifteen (15) days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide us with the missing information, whichever is sooner.
  - C. How and When Benefits are Paid. Benefits payable to you will be made within forty-five (45) days of our receipt of your properly submitted claim. We will subtract any applicable Deductible, Coinsurance and Copayment from MVP's Benefit payment. You must pay the Provider these amounts. Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted from the amount of Benefits otherwise payable. Any claim that has not been paid to you as of the date of your death will be paid to your estate. Up to one thousand (\$1,000) dollars of any Benefit payable to your estate, to someone who is a minor or someone who is not able to release MVP from its liability can be paid to any relative of yours whom MVP believes should be paid. Any payment made in good faith by MVP under this provision will relieve MVP of any additional liability for the claim so paid.
6. Filing Claims for Prescription Drug Benefits. You must receive your prescription from a Participating Provider and have your prescription filled at a Participating Pharmacy in order for MVP to provide Benefits.
- A. When you bring a prescription to a Participating Pharmacy, the pharmacist will be able to make an immediate benefit inquiry to MVP.
    - i. Prescription Filled by Pharmacy. If the pharmacist's benefit inquiry indicates that you have met all eligibility and coverage requirements, the pharmacist will fill your prescription and submit a claim to MVP for payment. You must pay any applicable Deductible and Coinsurance to the Pharmacy at the time the prescription is filled.
    - ii. Prescription Not Filled by Pharmacy. If the pharmacist's benefit inquiry indicates that you have not met all eligibility and coverage requirements,

the pharmacist will tell you the results of the benefit inquiry. You may then do one of the following:

- a. Ask the pharmacist to fill the prescription, pay the pharmacy's Charge for the prescription, and submit a Claim for Post Service Review, as described in paragraph 5(A)(iii) above. You must also have the pharmacist sign the claim form and attach the original receipt for the prescription. Mail the claim form to the address listed on the form.
- b. Decline to have the pharmacist fill the prescription and ask for Pre-Service Review as described in paragraph 1 above.

## SECTION FIVE – COVERED HOSPITAL INPATIENT SERVICES

1. To get Benefits for Hospital Inpatient Services, you must be a registered inpatient in a Participating Hospital and be under the care of a Participating Physician. We will only provide Benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible and Coinsurance.

Hospital means a duly licensed, short-term, acute care facility that primarily provides diagnostic and therapeutic services for diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians. It must have organized departments of medicine and major surgery. It must provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. The following are not Hospitals:

- Convalescent homes.
- Convalescent, rest or nursing facilities.
- Facilities primarily affording custodial or educational care.
- Health resorts, spas or sanitariums
- Infirmarys at schools, colleges or camps
- Facilities for the aged.
- Any military or veterans hospital or soldiers home, or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered for Emergency Medical Conditions, where a legal liability exists for charges made to the individual for such services.
- Residential Care Facilities and Long Term Care Facilities.

2. Inpatient Services. Inpatient Services mean the following:

- A. Room and Board, including special diet and nutritional therapy. Benefits will be paid for a semi-private room. **(If you have a private room, and such private room is not Medically Necessary, you will be responsible for any Charges in excess of the Allowable Charge for a semi-private room and such excess Charges will not be considered Covered Services. In addition, such excess**

**Charges will not count toward the Deductible or toward the Annual Out of Pocket Maximum.)**

- B. General, special and critical care nursing services, but not private duty nursing services.
  - C. Use of operating, recovery, delivery, endoscopic and treatment rooms and equipment.
  - D. Use of intensive care or special care units and equipment.
  - E. Dressings and casts.
  - F. Diagnostic Services, Supplies and Equipment.
  - G. Therapeutic Services.
  - H. Equipment, and supplies in connection with oxygen, anesthesia, and pathology services.
  - I. Laboratory services.
  - J. Medical and surgical supplies, including blood and blood plasma.
3. Skilled Nursing Facility Care. Care that is most appropriately provided in a Skilled Nursing Facility, but at MVP's discretion is provided on an inpatient basis in a Hospital, may be covered under and counted toward your Skilled Nursing Facility Benefits. You must pay any applicable Deductible and Coinsurance.
4. Maternity Care. **Concurrent Notice is required.** We will provide Benefits for Inpatient Services to a covered mother for childbirth for at least 48 hours after a non-caesarian delivery or for at least 96 hours after a cesarean delivery in a Participating Hospital or Participating birthing center. The attending physician, with the mother or mother's designated representative, may decide to discharge the mother sooner. We will also provide Benefits for Inpatient Services for pregnancy and complications of pregnancy. You must pay any applicable Deductible and Coinsurance.
5. Newborn Care. We will provide Benefits for Inpatient Services and routine inpatient nursery care and examinations for a covered newborn child for at least 48 hours after a non-caesarian delivery or for at least 96 hours after a caesarian delivery in a Participating Hospital or Participating birthing center. The attending physician, with the newborn's mother or the newborn's designated representative, may decide to discharge the newborn sooner. Subject to the requirements set forth in Section Three, paragraph 2(F) and 5(B), we will also provide Benefits for a covered newborn from the moment of birth through 31 days after birth for Covered Services for sickness, injury, and medically diagnosed congenital defects or birth abnormalities, or any combination of these, and well child care. You must pay any applicable Deductible and Coinsurance.

6. Breast Cancer Care. We will provide Benefits for Inpatient Services in connection with an inpatient stay at a Participating Hospital following a mastectomy, lymph node dissection or lumpectomy for the treatment of breast cancer. We will also provide Benefits for physical complications of mastectomy, including lymphedemas. We will also provide Benefits for Inpatient Services in connection with an inpatient stay at a Participating Hospital following reconstruction of the breast on which a mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. These surgical services will be performed in the manner that your attending physician, in consultation with you, determines is appropriate. We will also provide Benefits for breast prostheses required as a result of covered Breast Cancer Care. You must pay any applicable Deductible and Coinsurance.
7. Mental Health Services. **You must request a Pre-Service Review for Mental Health Services.** We will provide Benefits for Inpatient Services and Mental Health Services for Mental Health Conditions only when such services are provided in a mental health facility qualified pursuant to rules adopted by the secretary of human services that is a Participating Provider or in an institution approved by the secretary of human services that is a Participating Provider and such facility or institution provides a mental health treatment program pursuant to a written plan. You must pay any applicable Deductible and Coinsurance.
8. Substance Abuse Services. **You must request a Pre-Service Review for Substance Abuse Services. You must also give Concurrent Notice for Detoxification Admissions.** We will provide Benefits for Inpatient Services and Substance Abuse Services only when such services are provided pursuant to a written treatment plan in an institution approved by the secretary of human services that provides a program for the treatment of alcohol or substance dependency and is a Participating Provider. You must pay any applicable Deductible and Coinsurance.
9. Inpatient Physical Rehabilitation Care. We will provide Benefits for Inpatient Services for physical rehabilitation up to sixty (60) days per Member per Calendar Year only when such services are Acute Services and are provided by a Participating facility licensed to provide such services or by a unit of a Participating Hospital designated as providing such services. **Subject to Annual Benefit Maximum.** You must pay any applicable Deductible and Coinsurance.

## SECTION SIX – COVERED OUTPATIENT SERVICES

1. Outpatient Services. We will provide Benefits for the Outpatient Services listed below. Such services must be provided to you in the outpatient department of a Participating Hospital or a Participating free-standing facility. We will only provide Benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible and Coinsurance for each service/visit.
  - A. Pre-admission testing. We will provide benefits for tests given to you before your admission to a Hospital if:

- i. A Participating Physician has ordered the tests;
- ii. The tests are necessary for the diagnosis and treatment of your condition;
- iii. An operating room and inpatient bed at the Hospital have been reserved;
- iv. You are physically present at the Hospital for the tests.

You must pay any applicable Deductible and Coinsurance.

- B. Outpatient Surgery. You must pay any applicable Deductible and Coinsurance.
- C. Therapeutic Services. You must pay any applicable Deductible and Coinsurance.
- D. Diagnostic Services. You must pay any applicable Deductible and Coinsurance.
- E. Mental Health Services. **Pre-Service Review is required.** Services must be provided by a Hospital or a facility that is a licensed or certified mental health provider and that is a Participating Provider. You must pay any applicable Deductible and Coinsurance.
- F. Substance Abuse Services. **Pre-Service Review is required.** Services must be provided by a Hospital or a facility that is a licensed or certified substance abuse provider and that is a Participating Provider. You must pay any applicable Deductible and Coinsurance.
- G. Mammography Screenings. We will provide the following Benefits:
  - (a) for Members under age 50, we will provide Benefits for mammography screening when recommended by a Participating physician; and
  - (b) for Members age 50 and older, we will provide Benefits for an annual mammography screening.

You must pay any applicable Coinsurance.

- H. Laboratory Services. You must pay any applicable Deductible and Coinsurance.
- I. Physical, Occupational and Speech Therapy. We will provide Benefits for up to a combined 30 visits per Member per Calendar Year for physical therapy, occupational therapy, and speech therapy only when such services are Acute Services and are provided under the direction of a Participating physician in a Participating Hospital or facility or in a Participating Provider's office as described in Section Twelve. You must pay any applicable Deductible and Coinsurance. **Subject to Annual Benefit Maximum. If you incur Charges for**

**these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**

- J. Cardiac Rehabilitation Care. We will provide Benefits for up to 36 visits per Calendar Year only when such services are Acute Services and are provided under the direction of a Participating physician in a Participating Hospital or facility. You must pay any applicable Deductible and Coinsurance. **Subject to Annual Benefit Maximum. If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**

## **SECTION SEVEN – COVERED SKILLED NURSING FACILITY SERVICES**

1. We will only provide Benefits if a Covered Service is Medically Necessary. The services must be provided by a Participating Provider. You must pay any applicable Deductible and Coinsurance. **Subject to Annual Benefit Maximum. If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**
2. What is a Skilled Nursing Facility (SNF)? – A Skilled Nursing Facility is a licensed facility that provides 24 hour inpatient skilled nursing care and related services. It is certified as a participating SNF by Medicare or accredited as an SNF by the Joint Commission on Accreditation of Healthcare Organizations. A SNF is not, other than occasionally, a place that provides minimal, custodial, ambulatory or part-time care services. The SNF must be a Participating Provider.
3. Conditions For Skilled Nursing Facility Services. We will provide Benefits for Skilled Nursing Facility Care if:
  - A. You are under the supervision of a licensed Participating physician;
  - B. Hospitalization would otherwise be needed.
4. Skilled Nursing Facility Services. We will provide Benefits for the inpatient Skilled Nursing Facility Services listed below for up to forty-five (45) days per Member per Calendar Year. However, the days shall be consecutive. You may not select the day or days for which we will provide Benefits. We will provide Benefits for the day you are admitted. We will not provide Benefits for the day you are discharged. If you are admitted and discharged on the same day, we will provide Benefits for that day.
  - A. Room and board in a semiprivate room. **(If you have a private room, and such private room is not Medically Necessary, you will be responsible for any Charges in excess of the Allowable Charge for a semi-private room and such**

**excess Charges will not be considered Covered Services. In addition, such excess Charges will not count toward your Deductible.)**

- B. Skilled nursing care.
- C. Drugs, medications, supplies and equipment used in and furnished by the SNF.
- D. Physical, occupational and speech therapy services.
- E. Other services provided by the SNF that would be covered if you were an inpatient in a Hospital.

## **SECTION EIGHT – SPECIAL COVERED SERVICES**

1. Home Health Agency Services. We will only provide Benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible and Coinsurance.
  - A. What is a Home Health Agency? A Home Health Agency is an organization licensed or certified by Medicare to operate as a home health agency. The home health agency must be a Participating Provider.
  - B. Conditions for Home Health Agency Services. We will provide Benefits for Home Health Agency services if:
    - i. The services are supervised by a Participating Physician under a written treatment plan.
    - ii. The services are provided by a Participating Home Health Agency.
    - iii. Without these services you would need to be admitted to a Hospital or Skilled Nursing Facility.
  - C. Home Health Agency Services. We will provide Benefits for the services listed below.
    - i. Part time or intermittent skilled nursing care by or under the supervision of a registered nurse.
    - ii. Part time intermittent home health aide services, provided that such services consist primarily of caring for the patient and do not include Custodial Care.
    - iii. Physical, occupational and speech therapy services if provided by Participating Home Health Agency personnel.
    - iv. Medical supplies and drugs prescribed by a Participating Physician and laboratory services, to the same extent that laboratory services would have been covered if you were an inpatient at a Hospital or Skilled Nursing Facility.
2. Hospice Services. We will only provide Benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible and Coinsurance. **Subject to Annual Benefit Maximum. If you incur Charges for these services in excess of this**

**Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**

A. What is a Hospice? Hospice is an organization engaged in providing services to terminally ill persons. It must be federally certified to provide hospice services or accredited as a hospice by the Joint Committee of Accreditation of Health Care Organizations. The hospice must be a Participating Provider.

B. Conditions for Hospice Services.

We will provide benefits for Hospice Services under the following conditions.

- i. A Participating Physician certifies and MVP agrees that your terminal illness has a prognosis of 6 month life expectancy or less; and
- ii. The Hospice Services are supervised by a Participating Physician under a written Hospice Care Plan.

C. Hospice Services. We will only provide Benefits for the Hospice Services listed below:

- i. Up to 210 days of inpatient Hospice Services in a Participating Hospice or a Participating Hospital.
- ii. Skilled nursing visits - up to 2 visits per day.
- iii. Home health aide visits - up to 100 hours per month for personal care services only.
- iv. Continuous care - up to 5 days or 120 hours for the Member's continuous care in his home.
- v. Social service visits - up to 6 visits before the Member's death and up to 2 visits following the Member's death. Social service visits include counseling and emotional support, assessment of social and emotional factors related to the Member's condition, assistance in resolving problems, assessment of financial resources and use of available community resources.
- vi. Respite Care - up to 72 hours per month. Respite care relieves the Member's family or care givers by providing temporary relief from the duties of caring for the Member's illness.

E. Hospice Services are available only once per each Member's lifetime.

3. Non-Emergency Ambulance Transport Services. We will provide Benefits for Non-Emergency ambulance services provided by a Participating ambulance Provider, when Medically Necessary to take you to and from a Participating Hospital, between Participating Hospitals, or between a Participating Hospital and a Participating Skilled Nursing Facility. You must pay any applicable Deductible and Coinsurance.

4. Transplant Services/Donor Costs. We will provide Benefits for human organ and bone marrow transplant services only when you get such services through a Participating Specialty Network Transplant Provider. The donor and the recipient must pay any applicable Deductible and Coinsurance. **Specialty Network Only.** You may ask if a Provider is a Participating Specialty Network Transplant Provider by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

MVP will also provide Benefits for live donors for otherwise Covered Services provided in connection with a covered transplant procedure ("Donor Benefits"). These Donor Benefits are available only when the recipient of the transplant is an MVP Member who is receiving a covered transplant procedure and when the donor has met all criteria established by the Participating Specialty Network Transplant Provider.

Subject to the limitations set forth below, MVP will also provide Benefits for donor expenses for complications arising from a covered transplant procedure; provided that such complications arose within ninety (90) days from the date of the transplant ("Complications Benefits"). If a donor's complications arise after more than ninety (90) days from the date of the transplant, MVP will not provide any Complications Benefits.

Donor Benefits and Complications Benefits will be provided only up to the recipient Member's coverage limitations and after payment of the recipient Member's expenses; provided that for a non-MVP Member donor who has other HMO or insurance coverage, MVP will provide Complications Benefits only as follows: (1) MVP will provide Complications Benefits as the primary carrier for up to one hundred eighty (180) days from the date of the transplant; (2) MVP will provide Complications Benefits only as the secondary carrier after one hundred eighty (180) days from the date of the transplant. If the non-MVP Member donor does not have other HMO or insurance coverage, MVP will continue to provide Complications Benefits as the primary carrier beyond one hundred eighty (180) days, but only up to the recipient Member's coverage limitations and after payment of the recipient Member's expenses. Donor Benefits and Complications Benefits are not available if the donor is an MVP Member, but the recipient is not.

5. Bariatric Surgery. We will provide Benefits for Bariatric Surgery only when such Bariatric Surgery is performed at a Specialty Network Bariatric Surgery Hospital by a Specialty Network Bariatric Surgery Provider. You must pay any applicable Deductible and Coinsurance. You may ask if a Hospital or a Provider is a Specialty Network Provider by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). **Specialty Network Only.**

## SECTION NINE – PHARMACY BENEFITS

1. Prescription Drugs and Prescription Contraceptives. We will provide Benefits for Medically Necessary prescription drugs as described below. Prescriptions that require the mixing of two or more ingredients must contain at least one ingredient that requires a prescription. However, we will not provide Benefits for a compounded product that exists in a comparable commercially available form or that is compounded for the convenience or ease of administration of the Member. Additionally, if your prescribed

dosage is not commercially available, you may be required to make more than one Coinsurance payment. For example, if your prescription drug is available only in 20 milligram and 30 milligram doses and your Provider prescribes 50 milligrams, you may be required to make one payment for the 20 milligram dosage and a second payment for the 30 milligram dosage. We will also provide Benefits for prescription contraceptives and prescription contraceptive devices approved by the Federal Food and Drug Administration.

2. Pharmacy and Therapeutics Committee and MVP's Formulary. MVP's Pharmacy and Therapeutics Committee, which includes physicians, pharmacists and other health care professionals, evaluates prescription drugs and determines which drugs MVP will approve for coverage. The list of approved drugs is called the Formulary. Drugs that MVP has not approved for coverage are called Non-Formulary Drugs. At least two drugs in each therapeutic class will be included on the Formulary, unless there are clinically equivalent over-the-counter products readily available. MVP's Pharmacy and Therapeutics Committee reviews and must approve new drugs prior to such new drugs being included on the Formulary.
  - A. Getting Formulary Information. At any time, you may get a copy of the Formulary or ask if a drug is listed on the Formulary by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). You may also check MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com) and enter the name of a drug to see if it is listed on MVP's Formulary or to ask for a copy of the Formulary via email.
  - B. Changes to the Formulary. MVP gives at least 30 days prior written notice to affected Members when we delete previously approved drugs from the Formulary. MVP also provides written notice to all Members when new drugs are added to the Formulary.
  - C. If MVP does not give the thirty (30) day prior written notice described in paragraph B above and you try to have your prescription filled in accordance with this Certificate, MVP will provide coverage for a three (3) day supply. You must then call the Provider who wrote the prescription to change your prescription. You may also file a claim for benefits by following the instructions in Section Four.
  - D. Drugs identified on the Formulary as requiring Prior Approval (Pre-Service Review) must be prior approved by MVP. Your Participating Provider will submit a Pre-Service Claim to MVP in order to get prior approval by following instructions provided by MVP. If you use an approved Non-Participating Provider, you, or the approved Non-Participating Provider who wrote the prescription, must submit a Pre-Service Request to MVP by following the instructions set forth in Section Four, Paragraph 1. You must get MVP's prior approval before you fill the prescription. MVP will respond to the claim as described in Section Four.

3. Retail Pharmacy. We will provide Benefits for up to a thirty (30) day supply per dispensing when prescribed by a Participating Provider and filled at a Participating Retail Pharmacy. You must present your MVP ID card and pay any applicable Deductible and Coinsurance. You may request a copy of MVP's directory of Participating Pharmacies or inquire whether a particular pharmacy is a Participating Retail Pharmacy by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277) or by visiting MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com).
  - A. 90-Day Supply Benefits from Participating Retail Pharmacy. You may be able to get a ninety (90) day supply per dispensing as described in this paragraph from a Participating Retail Pharmacy. You may inquire whether a particular Participating Retail Pharmacy is eligible to provide 90-Day Supply Benefits by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). **This paragraph will apply as of October 1, 2004 only if your Group has executed a Group Contract that becomes effective on or after October 1, 2004. If your Group has executed a Group contract that is effective prior to October 1, 2004, this paragraph will apply only on or after your Group's contract renewal date, but not later than September 30, 2005. For information about the effective or renewal date of your Group's contract, please call your Group.**
4. Mail Order Pharmacy. We will provide Benefits for a ninety (90) day supply per dispensing for certain prescription drugs when prescribed by a Participating Provider and filled through MVP's Participating Mail Order Pharmacy.
  - A. Getting a Mail Order Pharmacy Drug List. At any time, you may get a copy of the list of drugs that you may get through MVP's Mail Order Pharmacy Vendor or ask if you may get a certain drug through MVP's Mail Order Pharmacy Vendor by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). You may also visit MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com) and enter the name of a drug to find out if you may get it through MVP's Mail Order Pharmacy Vendor or to request a copy of the list of drugs that you may get through MVP's Mail Order Pharmacy Vendor.
  - B. Changes to the Mail Order Pharmacy Drug List. MVP notifies Participating Providers when we add new drugs to the list of drugs that may be obtained through MVP's Mail Order Pharmacy Vendor or delete drugs from the list. MVP provides at least 30 days prior written notice to affected Members when we delete drugs from the list. MVP also provides notice of new drugs added to the list in MVP's member newsletter or similar communication. If MVP does not provide the 30 day prior written notice specified above, and you try to have your prescription filled in accordance with this Certificate, MVP will provide full coverage for a three (3) day supply. You must then call the Provider who wrote the prescription to change your prescription.

C. You must pay any applicable Coinsurance and Deductible for each fill and refill to MVP's Mail Order Pharmacy Vendor.

D. How to Use the Mail Order Program.

1. New Prescriptions. Each mail order for prescription drugs must be for up to a ninety (90) day supply. You must complete a Mail Order Pharmacy Form. You may request a copy of the Form by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). You may also visit MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com) to download the form or request a copy. Complete and sign the Form and attach the 90-day prescription with your check or credit card number for your Deductible and Coinsurance payment. Then, mail everything to the address listed on the Form.

2. Refills. When you need to refill a prescription, you may:

(a) Refill By Phone. Call the number listed on your order form. Have your prescription number, name, address and credit card information available to make your Deductible and Coinsurance payment.

(b) Refill By Mail. Complete the order form enclosed with your most recent delivery form and, if your health has changed, update your health profile. Complete the refill section, enclose your check or credit card number for your Deductible and Coinsurance payment and mail it to the address listed on the delivery form.

(c) Changes to the Mail Order Drug List. MVP notifies Participating Providers, in writing, when we add new drugs to the list of drugs approved for mail order or delete previously approved drugs from the list of drugs approved for mail order. MVP provides at least 30 days prior written notice to affected Members when we delete previously approved drugs from the list. MVP also provides notice of new drugs added to the list in MVP's member newsletter or similar communication. If MVP does not provide the 30 day prior written notice specified above and you attempt to have your prescription filled in accordance with this Rider, MVP will provide full coverage for a three (3) day supply. You must then call the Provider who wrote the prescription to change your prescription or to get any necessary Prior Approval. You may also file a claim for benefits by following the instructions in Section Four.

5. Specialty Pharmacy Benefits.

1. Generally. We will provide Specialty Pharmacy Benefits for Medically Necessary Covered Drugs that are approved by the Federal Food and Drug Administration and required to be ordered through MVP's Specialty Pharmacy

Vendor. **Specialty Network Pharmacy Vendor Only.** Benefits are available for up to a thirty (30) day supply, per fill or refill, unless otherwise indicated on your Schedule or on MVP's Formulary.

- A. Getting a Specialty Pharmacy Drug List. At any time, you may get a copy of the list of drugs that you must get through MVP's Specialty Pharmacy Vendor or ask if you must get a certain drug through MVP's Specialty Pharmacy Vendor by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). You may also visit MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com) and enter the name of a drug to find out if you must get it through MVP's Specialty Pharmacy Vendor or to ask for a copy of the list of drugs that you must get through MVP's Specialty Pharmacy Vendor.
  
- B. Changes to the Specialty Pharmacy Drug List. MVP notifies Participating Providers when we add new drugs to the list of drugs that you must get through MVP's Specialty Pharmacy Vendor or when we delete drugs from the list. MVP provides at least 30 days prior written notice to affected Members when we delete drugs from the list. MVP also provides notice of new drugs added to the list in MVP's member newsletter or similar communication. If MVP does not provide the 30 day prior written notice specified above, and you try to have your prescription filled in accordance with this Certificate, MVP will provide full coverage for a three (3) day supply. You must then call the Provider who wrote the prescription to change your prescription.
  
- C. You must pay any applicable Coinsurance and Deductible for each fill and refill to MVP's Specialty Pharmacy Vendor.
  
- D. How to Use the Specialty Pharmacy Vendor Program.
  - (a) New Prescriptions. You must complete a Specialty Pharmacy Vendor Form. You may ask for a copy of the Form by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). Complete and sign the Form and attach the prescription with your check or credit card number for your Coinsurance and Deductible payment. Then, mail everything to the address listed on the Form.
  
  - (b) Refills. When you need to refill a prescription, you may
    - i. Refill By Phone. Call the number listed on your order form. Have your prescription number, name, address and credit card information available to make your Coinsurance and Deductible payment.

- ii. Refill By Mail. Complete the order form enclosed with your most recent delivery form and, if your health has changed, update your health profile. Complete the refill section, enclose your check or credit card number for your Coinsurance and Deductible payment and mail it to the address listed on the delivery form.
  
- 6. In addition to the Exclusions Section of this Certificate, the following items are excluded from coverage.
  - A. Any over-the-counter drugs, unless such drugs are listed on MVP's formulary, including vitamins and prenatal vitamins that, by federal law, do not require a prescription, even if one is written. However, insulin shall be covered as described in Section Twelve.
  - B. Any prescriptions filled at a Non-Participating Pharmacy.
  - C. Any prescription written by a Non-Participating Provider unless prior approved by MVP.
  - D. Drugs used in connection with Non-Covered Services.
  - E. Refills needed because the Member lost or misused his supply, even if ordered by a Provider.
  - F. Drugs for cosmetic reasons, including those meant to improve your appearance, such as products to:
    - 1. grow or regain hair.
    - 2. prevent skin wrinkling.
    - 3. affect the color, tone or texture of the skin.
  - G. Vaccines and immunizations.
  - H. Any refill in excess of the amount specified by the prescription.
  - I. Any refill dispensed more than one year from the date the prescription was written.
  - J. Drugs prescribed for uses and conditions other than those approved by the U.S. food and Drug Administration.
  - K. Smoking cessation drugs.
  - L. Experimental or Investigational Drugs.

- M. Drugs used in connection with assisted reproductive technologies.
- N. If MVP, in accordance with its protocols, determines that you have received contraindicated, excessive or duplicative services, MVP may restrict the manner in which you access such services, including restricting you to one or more Participating Pharmacies, one or more Participating Providers with authority to prescribe for you, and/or requiring Prior Approval of PCP changes. If MVP intends to proceed with such restrictions, we will provide you with at least thirty (30) days prior written notice. The notice will specify the effective date and scope of the restrictions, explain the reason for the restrictions, your right to file a grievance and the procedures for filing a grievance. You may request a copy of MVP's protocols regarding contraindicated, excessive or duplicative services by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

**SECTION TEN -  
COVERED EMERGENCY SERVICES AND URGENTLY NEEDED CARE**

- 1. Emergency Services.
  - A. **Pre-Service Review is NOT required for Emergency Services. A referral from your PCP is NOT required for Emergency Services. If your condition is not an Emergency Medical Condition, you must pay all Charges.**
  - B. Emergency Services. We will provide Benefits for Emergency Services only if your condition is an Emergency Medical Condition. We will only provide Benefits if a Covered Service is Medically Necessary. You must pay any applicable Coinsurance and Deductible. You will not have to pay this Deductible and Coinsurance if you are admitted to a Hospital right away. However, you will have to pay the applicable Deductible and Coinsurance for Hospital Inpatient Services.
  - C. **Concurrent Notice is required.** You, your Provider, a family member, or other representative must call MVP at 1-888-MVP-MBRS (1-888-687-6277) within 48 hours, or as soon as reasonably possible, after receiving Emergency Services or an Emergency inpatient admission to a Hospital or other facility.
- 2. Urgently-Needed Care. We will provide Benefits for Urgently Needed Care provided by a Participating or a Non-Participating Provider only if your condition requires Urgently-Needed Care. However, you must first call your PCP and follow his instructions as to what you should do. You must pay any applicable Deductible and Coinsurance.
  - A. Urgently-Needed Care provided by a Participating Provider means Medically Necessary Covered Services to treat an illness or condition that if not treated within 24 hours presents a serious risk of harm.

- B. Urgently-Needed Care provided by a Non-Participating Provider means Medically Necessary Covered Services to screen and stabilize a condition that if not treated within 24 hours presents a serious risk of harm, so that you can be safely transported to a Participating Provider; provided that such services were received because you were unable to receive services from a Participating Provider.
  - C. Your PCP must coordinate your care after you receive Urgently-Needed Care.
3. Emergency Ambulance Services. **Pre-Service Review is NOT required for Emergency Ambulance Services. A referral from your PCP is NOT required for Emergency Ambulance Services. If your condition is not an Emergency Medical Condition, you must pay all Charges.** We will provide Benefits for Emergency Ambulance Services, when used for an Emergency Medical Condition. We will only provide Benefits for local transportation to the nearest appropriate facility. We will only provide benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible and Coinsurance.
4. Emergency Air Ambulance Services. Emergency Air Ambulance Services means the air borne transportation of the Member to a Hospital that is Medically Necessary as a result of the Member Emergency Medical Condition. Benefits will only be provided for services that are provided by an Air Ambulance Services Provider that has been certified to provide air transport, and, where the Member's medical condition makes ground transport medically inappropriate.

#### **SECTION ELEVEN – COVERED PREVENTIVE CARE**

1. Covered Services. We will provide Benefits for the following Preventive Care. The services must be provided by a Participating Provider. These services are not subject to the Deductible.
- A. Well Child Care. We will provide benefits for Well Child Care for covered Dependent children from the date of birth through attainment of age 19, when provided by the child's PCP. Well Child Care means an initial newborn check-up in the hospital and well child visits. Well child visits include a medical history, a complete physical examination, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit. Such laboratory tests must be performed in the office or in a Participating clinical laboratory. All well child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics. Call MVP's Member Services Department at 1-888-MVP-MBRS/1-888-687-6277 if you would like a copy of the standards and frequency schedule. Well Child Care also includes immunizations against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type B, and hepatitis B, and other necessary immunizations. Services not described above and services which exceed the frequency levels described above are not covered under Well Child Care. You must pay the applicable Coinsurance. **Subject to Annual Benefit Maximum. If**

**you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward the Deductible or toward the Annual Out of Pocket Maximum.**

- B. Annual Adult Health Evaluations. We will provide Benefits for one visit per Member per Calendar Year for periodic routine physical examinations and immunizations for Members age 19 and older when provided by such Member's PCP. You must pay the applicable Coinsurance. **Subject to Annual Benefit Maximum. If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward the Deductible or toward the Annual Out of Pocket Maximum.**
- C. Gynecological Health Care Services. We will provide Benefits for 2 visits per female Member per Calendar Year for gynecological health care services provided by a Participating Provider. Gynecological health care services means preventive reproductive health and gynecological care, including an annual screening. You must pay the applicable Coinsurance. We will also provide Benefits for follow up services required as a result of problems identified during such visits. These Benefits will be provided without requiring a referral from your PCP. **Subject to Annual Benefit Maximum. If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward the Deductible or toward the Annual Out of Pocket Maximum.**
- D. Mammography Screenings. We will provide the following Benefits for this service:
1. for Members under age 50, we will provide Benefits for mammography screening when recommended by a Participating physician; and
  2. for Members age 50 and older, we will provide Benefits for an annual mammography screening.

You must pay the applicable Coinsurance. **Subject to Annual Benefit Maximum. If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward the Deductible or toward the Annual Out of Pocket Maximum.**

MVP will also provide Benefits for Medically Necessary Mammography, pursuant to Section VI, Paragraph 1(D) or Section XII, Paragraph 2(O).

E. Diagnostic Screening for Prostate Cancer. We will provide Benefits for this service subject to the following limits:

1. Standard diagnostic testing, including a digital rectal examination and a prostate specific antigen test, at any age for men having a prior history of prostate cancer; and
2. An annual standard diagnostic examination including a digital rectal examination and a prostate specific antigen test for men age fifty (50) and over who are not symptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.

You must pay the applicable Coinsurance. **Subject to Annual Benefit Maximum. If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward the Deductible or toward the Annual Out of Pocket Maximum.**

MVP will also provide Benefits for Medically Necessary Prostate Cancer Diagnostic Services, pursuant to Section VI, Paragraph 1(D) or Section XII, Paragraph 2(O).

## SECTION TWELVE – COVERED PROFESSIONAL CARE AND SERVICES

1. After Hours PCP Services. PCPs must provide or arrange for on-call coverage 24 hours per day, seven 7 days per week. If you become sick or injured outside of the PCP's regular office hours, you should call his office, identify yourself as an MVP member, and follow the PCP or covering physician's instructions. If you require Emergency Services or Urgently-Needed Care, you must follow the procedures set forth in Section Ten.
2. Covered Services. We will provide Benefits for the following professional care and services when rendered at the office of a Participating Provider. We will only provide Benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible and Coinsurance for each visit/service.
  - A. Participating Physician Office Visits. We will provide Benefits for the examination, diagnosis, and treatment of an injury, illness or condition, and for laboratory services provided at the time of such visit. Coverage includes shots and drugs given during a covered office visit, including shots for allergies. Coverage also includes contraceptive services, and counseling and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. You must pay any applicable Deductible and Coinsurance.
  - B. Maternity Care. We will provide Benefits for prenatal and postpartum care rendered by Participating Providers. No PCP referral is required for prenatal care and post partum visits. You must file a Post Service claim as described in Section

Four and include a certificate of completion with your claim. You must pay any applicable Deductible and Coinsurance.

- C. Health Education and Nutrition Counseling. We will provide Benefits for health education and nutritional counseling when provided by a Participating Provider as part of a medical treatment program in accordance with MVP protocols. You must pay any applicable Deductible and Coinsurance.
- D. Second Surgical Opinions. We will provide Benefits for a second surgical opinion when your Participating Provider has made a recommendation on the need for covered elective Surgery. Except as provided in Paragraph 2(S) below. You are not required to have a second surgical opinion. If you do, the second opinion must be given by a Participating board-certified specialist who examines you and who, by reason of his specialty, is competent to consider the proposed Surgery. You must pay any applicable Deductible and Coinsurance.
- E. Consultations. We will provide Benefits for inpatient or office consultations by Participating Providers when requested by your attending Participating Physician for the evaluation of your condition. A written report must be given to your PCP. You must pay any applicable Deductible and Coinsurance.
- F. Mental Health Services. **Pre-Service Review is required.** We will provide Benefits for Mental Health Services only when such services are provided by a licensed or certified mental health professional that is a Participating Provider. You must pay any applicable Deductible and Coinsurance.
- G. Substance Abuse Services. **Pre-Service Review is required.** We will provide Benefits for Substance Abuse Services only when such services are provided by a substance abuse counselor or other person approved by the secretary of human services that is a Participating Provider. You must pay any applicable Deductible and Coinsurance.
- H. Chiropractic Treatment. We will provide Benefits for clinically necessary chiropractic services. The services must be provided by a Participating licensed chiropractic physician. The services must be for treatment of conditions related to subluxations, joint dysfunctions, and neuromuscular and skeletal disorders. You must pay any applicable Deductible and Coinsurance. We will not provide Benefits for:
  - (i) adjunctive therapies, except physiotherapy modalities and rehabilitative exercises when used in conjunction with other, covered, chiropractic treatment; and
  - (ii) treatment of any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs.

- I. Diabetes Treatment. We will provide Benefits for equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if such equipment, supplies and training are prescribed by a licensed, Participating health care professional legally authorized to prescribe such items. We will provide Benefits for the self-management training and education, including medical nutrition therapy, described above only if provided by a Participating certified, registered, or licensed health care professional with specialized training in the education and management of diabetes. You must pay any applicable Deductible and Coinsurance.
- J. Inpatient Medical Care. We will provide Benefits for medical services rendered when you are receiving Covered Services in: (1) a Participating Hospital or Participating Skilled Nursing Facility; (2) a Participating mental health care facility or Participating institution for the treatment of alcohol or substance dependency; or (3) a Participating physical rehabilitation facility. We will not provide Benefits for Inpatient Medical Care in connection with Surgery or Maternity Care because such services are covered by a global fee. We will not provide these Benefits if services are performed in connection with Non-Covered Inpatient Services. We will only provide Benefits for one visit per day per Participating Provider. You must pay any applicable Deductible and Coinsurance.
- K. Office-Based Surgery. We will provide Benefits for Surgery and surgical care rendered by a Participating Provider in the Provider's office. You must pay any applicable Deductible and Coinsurance.
- L. Breast Cancer Care. We will provide Benefits for mastectomy and treatment of physical complications of mastectomy such as lymphedema, lymph node dissection, or lumpectomy for the treatment of breast cancer. If you are receiving Benefits under this Certificate in connection with a mastectomy, we will also provide Benefits for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined appropriate by your provider, in consultation with you. We will also provide Benefits for breast prostheses required as a result of covered breast cancer care. These services must be rendered by a Participating Provider. You must pay any applicable Deductible and Coinsurance.
- M. Anesthesia Services. We will provide Benefits for anesthesia services provided by a Participating Provider in connection with Covered Services. You must pay any applicable Deductible and Coinsurance.
- N. Laboratory Services. These services must be provided by a Participating Provider. You must pay any applicable Deductible and Coinsurance.

- O. Diagnostic Services. These services must be provided by a Participating Provider. You must pay any applicable Deductible and Coinsurance.
- P. Therapeutic Services. These services must be provided by a Participating Provider. You must pay any applicable Deductible and Coinsurance.
- Q. Casts and Dressings. These services must be provided by a Participating Provider. You must pay any applicable Deductible and Coinsurance.
- R. Medical Foods. We will provide Benefits for low protein modified food products and medical foods prescribed by a Participating Provider and obtained from a Participating Provider for use under the direction of a Participating Physician for the Medically Necessary dietary treatment of an inherited metabolic disease. A low protein modified food product must be specifically formulated to have less than one gram of protein per serving. A medical food means an amino acid modified preparation. Benefits are limited to \$2,500 per Calendar Year. You must pay any applicable Deductible and Coinsurance. **Subject to Annual Benefit Maximum. If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward the Deductible or toward the Annual Out of Pocket Maximum.**
- S. Craniofacial Disorders. We will provide Benefits for Participating Provider services for diagnosis and treatment. This includes surgical and non-surgical procedures for a musculoskeletal disorder that affects any bone or joint in the face, neck or head. Such disorder must be the result of accident, trauma, congenital defect, developmental defect, or pathology. Surgical procedures require a second opinion as set forth in paragraph 2(D) above. You must pay any applicable Deductible and Coinsurance. We will not provide Benefits for the diagnosis and treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.
- T. Physical, Occupational and Speech Therapy. We will provide Benefits for up to a combined 30 visits per Member per Calendar Year for physical therapy, occupational therapy, and speech therapy when such services Acute Services and are provided under the direction of a Participating physician by a Participating Hospital or a Participating facility or in a Participating Provider's office as described in Section Six. You must pay any applicable Deductible and Coinsurance. **Subject to Annual Benefit Maximum. If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward the Deductible or the Annual Out of Pocket Maximum.**

- U. Durable Medical Equipment. We will provide Benefits for the purchase or rental of standard Durable Medical Equipment when authorized by a Participating Physician and obtained from a Participating Provider. Durable Medical Equipment means equipment that is primarily and customarily used only for a medical purpose. Such equipment is appropriate for use in the home, and is designed for prolonged and repeated use. It is generally not useful to a person in the absence of an illness, injury or condition. Durable medical equipment includes, but is not limited to wheelchairs, hospital beds, walkers, traction equipment, and respirators. The option of whether to rent or purchase Durable Medical Equipment is at the sole discretion of MVP. Additionally, Benefits are available for Medically Necessary replacements, repairs and maintenance, when not provided for under a manufacturer's warranty or purchase agreement. You must pay any applicable Deductible and Coinsurance. **If you receive non-standard Durable Medical Equipment, you will be responsible for any Charges in excess of the Allowable Charge for standard Durable Medical Equipment and such excess Charges will not be considered as Covered Services. In addition, such excess Charges will not count toward the Deductible or the Annual Out of Pocket Maximum.**
- V. External Prosthetic Devices and Ostomy Supplies. We will provide Benefits for the purchase of standard Prosthetic Devices when authorized by a Participating Physician and obtained from a Participating Provider. Prosthetic Devices mean devices that aid the body in functioning or replace a limb or body part in order to correct a defect of body form or function. Prosthetic Devices include, but are not limited to, artificial limbs, artificial eyes, external breast prostheses following a covered mastectomy, and ostomy supplies. Prosthetic Devices also include speech generating devices for Members who have lost the ability to speak. Additionally, Benefits are available for Medically Necessary replacements, repairs and maintenance, when not provided for under a manufacturer's warranty or purchase agreement. You must pay any applicable Deductible and Coinsurance. **If you receive non-standard artificial limbs or artificial eyes, you will be responsible for any Charges in excess of the Allowable Charge for standard items and such excess Charges will not be considered as Covered Services. In addition, such excess Charges will not count toward the Deductible or the Annual Out of Pocket Maximum.**

### SECTION THIRTEEN – EXCLUSIONS

These exclusions are in addition to those described in other sections of this Certificate.

1. We will not provide Benefits for the following Hospital and Skilled Nursing Facility services:
  - A. A private room, unless it is Medically Necessary. If you stay in a private room when it is not Medically Necessary, you will be responsible for any charges in excess of the Allowable Charges. Such excess charges will not be considered Covered Services and will not count toward your Deductible.

- B. Any inpatient day that is mostly for Custodial Services or social programs.
  - C. Any inpatient day that is mostly for diagnostic purposes, such as x-rays, laboratory tests, or physical checkups, unless Medically Necessary.
  - D. Except as specifically provided in Section 11, paragraph 1(F)(4), any inpatient services for dental services.
  - E. Any charges because you did not leave your room at the discharge time.
  - F. Any services provided by a private duty nurse.
  - G. Any non-medical or items including, but not limited to, telephone, television, beauty and barber services, guest trays, guest services and accommodations.
  - H. Any items that you take home from the Hospital.
2. Services Not Covered. We also will not provide Benefits for the following:
- A. Services Starting Before Coverage Begins. We will not provide Benefits for any services you get:
    - i. prior to your Effective Date; or
    - ii. on or after your Effective Date if the service is covered or required to be covered under any other health benefits certificate, program or plan.
  - B. Non-Covered Services. We will not provide Benefits for any services not listed in this Certificate as a Covered Service. We will not provide Benefits for any service that is related to services not covered under this Certificate. We will not provide Benefits for any services in excess of any limitations or maximums described in this Certificate.
  - C. Non-Medically Necessary Services. We will not provide Benefits for any services that are not Medically Necessary.
  - D. Non-Participating Provider Services. Except as specifically provided, we will not provide Benefits for any services from a Non-Participating Provider.
  - E. Services Not Provided By, or Received Pursuant to a Referral From Your PCP. Except as specifically provided, we will not provide Benefits for any services not provided by your PCP or FOR ANY SERVICES received without a referral from your PCP.
  - F. Non-Provider Services. We will not provide Benefits for any services provided by a person or entity that we do not approve for the given service or who is not defined as a Provider. We will not provide Benefits for services provided by a person who provides services as part of his education or training program.

- G. Specialty Network Provider Only Services. We will not provide Benefits for Specialty Network Provider Only Services if such services are provided by a non-Specialty Network Provider.
- H. Non-Standard Allergy Services. We will not provide Benefits for non-standard allergy services. This includes, but is not limited to, skin titration, cytotoxicity testing, treatment of non-specific candida sensitivity and urine autoinjections.
- I. Alternative Services. We will not provide Benefits for alternative or complementary health services, products, remedies, treatments and therapies. This includes, but is not limited to, acupuncture, biofeedback (except for treatment or urinary incontinence), massage therapy, hypnosis and hypnotherapy, naturopathy, homeopathy, primal therapy, carbon dioxide therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, aroma therapy, hair analysis, thermograms and thermography, yoga, meditation, and recreational therapy and any related diagnostic testing.
- J. Aviation. We will not provide Benefits for any illness, injury, or condition directly resulting from air travel, except when you are a fare paying passenger on a commercial airline scheduled flight.
- K. Blood Products. We will not provide Benefits for charges for whole blood, blood plasma, packed blood cells, or other blood products or derivatives if a volunteer blood replacement program is available. If a program is not available, we will provide Benefits if billed by a Participating Provider. We will provide Benefits for autologous blood donations when they are medically necessary. We will also provide Benefits for administration and processing charges.
- L. Certification Examinations. Except as specifically provided, we will not provide Benefits for any services related to routine physical examination and/or testing to certify health status. This includes, but is not limited to, examinations required for school, employment, insurance, marriage, divorce, adoption, custody, medical research, licensing, travel, camp or sports.
- M. Chiropractic Treatment. We will not provide Benefits for chiropractic treatment performed by a provider other than a licensed chiropractic physician. This includes, but is not limited to, doctors of osteopathy.
- N. Communication Devices. Except as otherwise provided, we will not provide Benefits for the purchase, rental, repair, replacement or maintenance of devices for speaking, listening, or otherwise communicating. This includes, but is not limited to, telecommunication devices for the deaf (TDDs) and teletype machines (TTYs), and services for evaluation, fitting, or modification of such devices.
- O. Cosmetic Services and Surgery. We will not provide Benefits for any services or surgery that are mostly meant to improve your appearance. This includes but is

not limited to, plastic surgery and scar repair or revision. We will provide Benefits for services for reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part. This includes breast reconstruction and symmetry surgery as described in Section Six, paragraph 6 and Section Twelve, paragraph 2(L) (Breast Cancer Care). We will also provide Benefits for reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect. Please see Section Three paragraphs 2(F) and 5(B) for more information about covered newborn children.

- P. Court-Ordered Services. We will not provide Benefits for court-ordered services, services required as a condition or probation or parole, or for administratively ordered services, such as by the Department of Motor Vehicles, unless such services are Covered Services, are Medically Necessary, and are provided by your PCP or by a Participating Provider pursuant to a referral from your PCP. Such services include, but are not limited to, custody evaluations and special medical reports not directly related to treatment and reports prepared for legal actions.
- Q. Criminal Behavior and War. We will not provide Benefits for any services related to an illness, injury or condition arising out of your participation in a felony, riot or insurrection. The felony, riot, or insurrection will be determined by the law of the state where the criminal behavior occurred. We also will not provide Benefits for any services related to an illness, injury, or condition that results from an act of disclosed or undisclosed war.
- R. Custodial Services. We will not provide Benefits for Custodial Services or for bed rest or convenience reasons.
- S. Dental Services. Except as provided in Section Twelve, Paragraph 2(S) and for accidental injury to sound, natural teeth provided within 12 months of the accident or when a claim is made within 12 months of the date of the accident establishing that it is Medically Necessary for the dental services to be provided more than 12 months of the date of the accident and provided further that the Member must be covered under this Certificate when services are provided, and except for dental services necessary due to congenital disease or anomaly, we will not provide Benefits for dental services. **Services provided pursuant to this exception are subject to Pre-Service Review.** Call [MVP] at [1-800-568-0458]. This includes, but is not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, bony impacted teeth, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, dental implants, and prosthetic restoration of dental implants.
- T. Dietician Services. We will not provide Benefits for dietician services, homemaker services, home delivered meals, or other food or food-related

services, except for nutritional counseling as described in Section Twelve and nutritional counseling for persons with diabetes.

- U. Disposable Medical Supplies. Except as specifically provided, we will not provide Benefits for disposable medical supplies. This includes, but is not limited to, diapers, chux, sponges, syringes, needles, incontinence pads, reagent strips, catheters, elastic support stockings, compressive garments, dressings, and bandages.
- V. Educational Services. We will not provide Benefits for services required to determine appropriate educational placements or services or for other educational testing. We will not provide Benefits for special education and related services, and assistive technology devices and assistive technology services determined to be needed as a result of such educational evaluations. This includes, but is not limited to, therapy services, cognitive retraining and rehabilitation, behavioral modification, evaluation and treatment of learning disabilities, interpreter services and lessons in sign language.
- W. Employer Services. We will not provide Benefits for any services furnished by a medical department or clinic provided by your employer.
- X. Experimental or Investigational Services. Except as specifically provided in this paragraph, we will not provide Benefits for services which we determine are Experimental or Investigational Services. We will provide Benefits for Experimental or Investigational Services if we determine: (a) that the proposed service has demonstrated promise in treating the underlying condition through a Phase III or Phase IV clinical trial sanctioned by the United States Food and Drug Administration; and (b) that an expert panel with quality assurance and technology assessment expertise has reviewed the proposed service and deemed it appropriate. Except as required by applicable law, Phase I and II clinical trials, whether or not sanctioned by the United States Food and Drug Administration, are excluded. MVP will also provide Benefits for routine patient care costs, but only to the extent required by applicable law.
- Y. Exploratory Counseling. We will not provide Benefits for exploratory counseling for personal growth and development or other similar reasons.
- Z. Family Services. We will not provide Benefits for services provided by any member of your immediate family. This applies even if charges are billed.
- AA. Foot Care. We will not provide Benefits for routine or palliative foot care. This includes, but is not limited to, any services in connection with corns, callouses, flat feet, fallen arches, weak feet, toenails, chronic foot strain, or symptomatic complaints of the feet. We will provide Benefits for Medically Necessary diabetic foot care.

- BB. Free Services. We will not provide Benefits for any services provided to you without charge or services that would normally be provided without charge. This applies even if charges are billed.
- CC. Government Benefits. We will not provide Benefits for any services for which benefits are available to you under any federal, state, or local government program, except Medicaid, but including Medicare to the extent it is your primary payor. This exclusion applies even if you fail to enroll, do not make a proper or timely claim, fail to pay the charges for the program, fail to appear at any hearing, or otherwise do not claim the benefits available to you.
- DD. Government Hospital. We will not provide Benefits for services you receive in any hospital or other facility or institution which is owned, operated or maintained by the Veteran's Administration, the federal government, or any state or local government, or the United States Armed Forces. However, we will provide Benefits for otherwise Covered Services in such hospital, facility or institution if the conditions of coverage described in Section Ten (Covered Emergency Services and Urgently Needed Care) are satisfied or for otherwise Covered Services provided for non-military service related conditions.
- EE. Home Modifications and Fixtures. We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of home modifications and fixtures. This includes, but is not limited to, installation of electrical power, water supply or sanitary waste disposal, elevators, escalators, ramps, seat lift chairs, stair glides, handrails, swimming pools, whirlpool baths, home tracking systems, exercise or physical fitness equipment, air or water purifiers, central or unit air conditioners, humidifiers, dehumidifiers, and emergency alert systems and equipment, and business or vehicle modifications, or for services for evaluation, fitting or modification of such modifications and fixtures.
- FF. Late Submitted Charges. We will not provide Benefits for charges for services rendered by Participating Providers which are submitted to MVP more than 180 days after the date of service, except when Coordination of Benefits applies and MVP is the secondary payor.
- GG. Military Service-Connected Illnesses, Injuries and Conditions. We will not provide Benefits for any services in connection with any military service-connected illness, injury, or condition if such services are covered by the Veteran's Administration.
- HH. No-Fault Automobile Insurance and MedPay. We will not provide Benefits for any service that is covered by mandatory automobile no-fault benefits or applied to any no-fault deductible, for any service that is covered by MedPay or for any service that is covered by similar policies or programs. This exclusion applies even if you do not make a proper or timely claim for benefits available to you under such policy or program or if you fail to appear at any hearing. We will also

not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you get money from that lawsuit and have repaid the medical expenses you received payment for under such policy or program.

- II. Ophthalmic Services. We will not provide Benefits for vision correction or accommodations or for the expense of purchasing corrective lenses.
  
- JJ. Orthotic Devices for Feet. We will not provide Benefits for orthotic devices for the feet. However, we will provide Benefits for foot orthotics for persons with diabetes. This includes, but is not limited to, custom made shoes, orthopedic shoes, arch supports, and shoe inserts, or for services for evaluation, fitting, or modification of such devices.
  
- KK. Outside the United States. Except for Emergency Services, we will not provide Benefits for services accessed outside the United States and its possessions. To the extent provided below, we will provide Benefits for prescription drugs purchased in Canada and used in Canada or prescription drugs reimported legally, subject to all of the terms and conditions of this Certificate. This means that, among other things, the pharmacy must be a Participating Provider. The foregoing will apply as of October 1, 2004 only if your Group has executed a Group contract for MVP that becomes effective on or after October 1, 2004. If your Group has executed a Group contract for MVP that is effective prior to October 1, 2004, this paragraph will apply only on or after your Group's contract renewal date, but not later than September 30, 2005. For information about the effective or renewal date of your Group's contract with MVP, please call your Group.
  
- LL. Personal Hygiene and Comfort and Convenience Items and Services. We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of personal hygiene or comfort and convenience items or provider services including, but not limited to, massage services, spa services, and other provider services, central or unit air conditioners, air or water purifiers, waterbeds, massage equipment, radio, telephone, television, beauty and barber services, commodes, hypoallergenic bedding, mattresses, waterbeds, dehumidifiers, humidifiers, hygiene equipment, saunas, whirlpool baths, exercise or physical fitness equipment, emergency alert systems and equipment, handrails, heat appliances, and business or vehicle modifications, or for services for evaluation, fitting or modification of such items.
  
- MM. Reproductive Procedures. We will not provide Benefits for any services for or related to artificial means to induce pregnancy. This includes, but is not limited to, artificial insemination, in vitro fertilization and embryo transplantation, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and drugs used in connection with such procedures, cryopreservation and storage of sperm, eggs, or embryos, intracytoplasmic sperm injection (ICSI), sperm storage, sperm

banking, gender selection, donor costs, surrogate parenting, acrobeads sperm assay, hamster egg penetration test, hypo-osmotic swelling test, retrieval of sperm through electrostimulation, preimplantation genetic diagnosis and gender selection and drugs used in connection with such services.

- NN. Reversal of Elective Sterilization. We will not provide Benefits for this service.
- OO. Self-Help Education and Training. Except as specifically provided, we will not provide Benefits for biofeedback, self-diagnosis, self-treatment or self-help training or materials related to such self-help education and training.
- PP. Smoking and Caffeine Cessation Services. We will not provide Benefits for programs to help you stop smoking or to alleviate caffeine dependence, including drugs used in connection with such services.
- QQ. Special Charges. We will not provide Benefits for stand-by services, missed appointments, new patient processing, interest, copies of provider records or completion of claim forms, Provider's time to write reports, or for postage, shipping, handling or tax.
- RR. Support Therapies. Except as provided in Section Eight, paragraph 2 (Hospice Services), we will not provide Benefits for support therapies. This includes, but is not limited to, marriage counseling, pastoral or religious counseling, sex counseling, or other social counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, and play therapy.
- SS. Terminated Coverage. Except as provided in Section Fifteen, we will not provide Benefits for any services provided after the termination date of your coverage under this Certificate.
- TT. Transsexual Surgery and Related Services. We will not provide Benefits for any services related to or leading up to transsexual surgery. This includes, but not limited to, hospital services, hormone therapies, procedures, treatments or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender.
- UU. Travel and Transportation Costs. Except as specifically provided, we will not provide Benefits for travel and transportation expenses and related expenses such as meals and lodging.
- VV. Unlicensed Provider. We will not provide Benefits for services provided by an unlicensed Provider or for services that are outside of a Provider's scope of practice.
- WW. Vision and Hearing Examinations, Therapies and Supplies. We will not provide Benefits for any services related to eye or hearing examinations for prescribing,

fitting, or determining the need for eyeglasses, lenses, frames, contact lenses, or hearing aids, or for eyeglasses, lenses, frames, contact lenses or hearing aids. We will not provide Benefits for vision or hearing therapy or training, vision perception training or orthoptics. We will not provide Benefits for the correction of refractive errors by means of any surgical or other procedures, including radial keratotomy. We will not provide Benefits for services for disorder of vision correction or accommodations.

- XX. Weight Loss Services. We will not provide Benefits for any services or programs in connection with weight reduction, dietary control, dietary supplements, and exercise classes. We will not provide Benefits for surgical weight loss procedures including, but not limited to gastric stapling, gastric by-pass, and gastric bubble unless such services have been **subject to Pre-Service Review** and are provided by a Specialty Network Participating Provider.
- YY. Wigs. We will not provide Benefits for wigs. This includes toupees, hairpieces, hair transplants, hair extensions or similar hair items. We will not provide Benefits for any products or services to promote hair growth.
- ZZ. Workers' Compensation. Except for sole proprietors and partners who are not voluntarily covered under a workers' compensation insurance policy, and except for, executive officers of a corporation with no employees who are not voluntarily covered under a workers' compensation policy, we will not provide Benefits for any service for which you have received or are eligible to receive benefits under a workers' compensation act or similar law or for services which are the subject of a controverted workers' compensation claim or case. This exclusion applies even if you do not receive such benefits because you did not submit a proper or timely claim for benefits or because you fail to appear at a hearing. We will also not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the workers' compensation act or similar law.

## **SECTION FOURTEEN - TERMINATION AND SUSPENSION OF YOUR COVERAGE**

This section describes how your coverage may terminate or be suspended. When your coverage terminates or is suspended, benefits stop at 12:00 midnight on the termination or suspension date, unless you are eligible for benefits after termination or suspension as described below and in the next section.

1. Automatic Termination. Your coverage will automatically terminate in the event of any of the following:
  - A. Discontinuance of Your Group Membership. If you are covered under this Certificate as a member of a group (or as the Dependent of a member of a group), your coverage will automatically terminate on the date of discontinuance of the

Subscriber's group membership, or the date to which your premium is paid, whichever is sooner. See Section Fifteen as to how you may get continuation and conversion coverage.

- B. Termination of Group Contract. If the group contract under which this Certificate was issued is terminated, your coverage will automatically terminate as of the date the group contract terminates. Your group must give you prior written notice if the group contract is terminated. See Section Fifteen as to how you may get conversion coverage.
- C. On Your Death. If you have individual coverage, your coverage will automatically terminate on the date of your death. If you have family coverage, coverage will automatically terminate as of the date to which the last premium before your death was paid. However, your Spouse and/or Dependents may request substantially similar replacement coverage. Your Spouse or Dependents must notify us right away (or as soon as reasonably possible) of your death. See Section Fifteen as to how your Spouse and/or Dependents may get continuation and conversion coverage.
- D. Dissolution of Marriage or Civil Union. If you become divorced, or your marriage or civil union is annulled or otherwise legally dissolved, your Spouse's coverage will automatically terminate on the date of dissolution, or the date to which your premium is paid, whichever is sooner. You must notify us right away (or as soon as reasonably possible) of any such dissolution. See Section Fifteen as to how your Spouse may get continuation and conversion coverage.
- E. Termination of Coverage of a Child. Your child's coverage under this Certificate will automatically terminate at the end of the month in which: (a) the child reaches age 19; (b) marries; or (c) is no longer chiefly dependent upon you for support and maintenance, or the date to which your premium is paid, whichever is sooner. If your child is covered pursuant to Section Three, paragraph 1(C)(ii), the child's coverage will automatically terminate on the date the child is no longer incapable of self-sustaining employment, is no longer disabled or is no longer chiefly dependent upon you for support and maintenance, or the date to which your premium is paid, whichever is sooner. You must notify us right away (or as soon as reasonably possible) when your child is no longer eligible for coverage. See Section Fifteen as to how your child may get continuation and conversion coverage.
  - i. Special Rule for Children Covered Pursuant to Qualified Medical Support Orders. We will not terminate the coverage of a child required to be covered pursuant to a qualified medical support order until we are provided satisfactory written proof that:
    - (a) The order is no longer in effect, or

- (b) The child is or will be enrolled in comparable coverage through another insurer which will take effect not later than the date coverage under this Certificate would terminate.
- (c) Your employer has eliminated dependent health coverage for all of its employees, if allowed by law.

You must notify us right away (or as soon as reasonably possible) of these circumstances. In such instances, the child's coverage will terminate on the last day of the month following the date of the event described in subparagraph (a) or (b), or the date to which your premium is paid, whichever is sooner.

2. MVP's Termination of Your Coverage. MVP may terminate your coverage for the following reasons. Except as otherwise described, we will give you 30 days prior written notice:
  - A. Fraud or Misrepresentation. MVP will immediately terminate your coverage for any fraud made by you when you enrolled, provided any initial or continuing eligibility information, or any fraud or material misrepresentation when you filed any claim under this Certificate. The termination will be effective as of the date of the fraud or intentional misrepresentation and MVP shall be entitled to all remedies provided for in law and equity, including but not limited to recovery from you for the charges for benefits provided, attorneys fees, costs of suit, and interest. MVP will provide you with written notice of such termination.
  - B. Discontinuance of Class of Certificate. We discontinue the entire class of Certificates to which this Certificate belongs. We will give you 90 days prior written notice.
  - C. Withdrawal from the Applicable Market. We withdraw from the applicable market as permitted by Vermont law and regulation. We will give you 180 days prior written notice.
  - D. Residency. You are no longer a Resident of Vermont and no longer work in Vermont for your Group. Your Coverage will terminate as of the date you are no longer a resident of Vermont and are no longer working in Vermont for your Group. This does not apply to children for whom the Subscriber has been ordered to provide dependent health insurance coverage pursuant to a qualified medical support order.
  - E. Regulatory. Any reason found to be acceptable to BISHCA and as authorized by the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations thereunder.
3. Your Option to Terminate Coverage. You may terminate your coverage at any time by giving us 30 days prior written notice.

4. Obligations on Termination. Except as specifically provided in paragraph 5 below, once your coverage ends, MVP will not provide any more Benefits except for Covered Services received before termination.
5. Benefits After Termination. If you are Totally Disabled or pregnant on the date your coverage terminates, and such Total Disability or pregnancy occurred before your coverage terminated, we will continue to provide benefits for otherwise covered services which are directly related to the illness, injury or condition causing the Total Disability or the pregnancy. This extension of benefits will continue until the earliest of: (1) the date you are no longer Totally Disabled; or (2) the date that your pregnancy is complete; or (3) twelve months from the date your coverage would otherwise have terminated. However, we will not provide more benefits than would otherwise have been provided if your coverage under this Certificate had not been terminated.
  - A. Other than Individual Coverage. If you have coverage other than individual coverage under this Certificate, this extension of benefits covers only the member with the Total Disability. MVP will terminate the coverage of other family members who were covered under this Certificate as of the termination date.
  - B. Other Exceptions. If your coverage was terminated for the reasons set forth in paragraph 2(A), we will not provide this extension of Benefits.
6. MVP's Right to Recover. If we incorrectly provide benefits after your coverage or this Certificate has been terminated, MVP may recover from you the charges for benefits provided, and any attorneys' fees, costs, and interest.

#### **SECTION FIFTEEN - POST TERMINATION CONTINUATION OF COVERAGE; CONVERSION TO A DIRECT CONTRACT**

If your coverage under this Certificate terminates for the reasons described below, you may be able to continue coverage or purchase a new contract that is available to non-group Subscribers.

1. Continuation Coverage:
  - A. Under Federal Law. Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act 1985 (COBRA), most employer sponsored group health plans must offer: (1) employees and (2) their spouses and dependents, as those terms are defined by federal law (these person are called "qualified beneficiaries"), the opportunity for continuation of health insurance coverage when their coverage would otherwise end as the result of a "qualifying event". This means that: (1) civil union spouses and dependents and (2) domestic partners and their dependents are not eligible for COBRA coverage unless such spouses/partners and dependents meet the federal law definition of spouse or dependent and therefore are "qualified beneficiaries" or unless your Group has elected, by purchasing a Rider to this Certificate, to extend COBRA coverage beyond that required by law. Members should call or write your Group or us to

find out if your employer offers COBRA and, if so, whether you are eligible for COBRA coverage. For purposes of references to COBRA in this section, the term “spouse” and “dependent” shall be defined as set forth in federal law.

1. Eligibility. The following are considered “qualifying events”:
  - a. If you are covered as an employee of your Group, you will become a qualified beneficiary if you lose coverage under this Certificate because:
    - (1) Your hours of employment are reduced; or
    - (2) Your employment ends for any reason other than your gross misconduct.
  - b. If you are covered as the spouse of an employee of your Group, you will become a qualified beneficiary if you lose your coverage under this Certificate because:
    - (1) Your spouse dies;
    - (2) Your spouse’s hours of employment are reduced;
    - (3) Your spouse’s employment ends for any reason other than his gross misconduct;
    - (4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
    - (5) You become divorced or legally separated from your spouse.
  - c. If you are covered as the Dependent child of an employee of your Group, you will become a qualified beneficiary if you lose your coverage under this Certificate because:
    - (1) The parent-employee dies;
    - (2) The parent-employee’s hours of employment are reduced;
    - (3) The parent-employee’s employment ends for any reason other than his gross misconduct;
    - (4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
    - (5) The parents become divorced or legally separated; or
    - (6) The Dependent child stops being eligible for coverage under this Certificate as a Dependent child.
  - d. If your Group provides retiree health coverage under this Certificate, sometimes the filing of a bankruptcy under title 11 of the United States Code can be a qualifying event. If a bankruptcy proceeding is filed against your employer Group and that bankruptcy results in the loss of coverage of any retired employee

covered under this Certificate, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if the bankruptcy results in their loss of coverage under this Certificate.

B. Under Vermont Law. If your employer is not required to offer COBRA coverage as set forth above, you, your Spouse and your Dependents may be eligible for continuation of coverage under state law. If your Group is an employer group and your coverage would terminate because of the termination of employment of the Subscriber, the death of the Subscriber, or the divorce or legal separation of the Subscriber from the Subscriber's spouse, or a dependent child ceasing to be a covered dependent child under this Certificate, you may be entitled to continue your coverage under this Certificate, subject to the terms of your Group's contract. Members should call or write your Group or us to find out if your employer offers state continuation coverage and, if so, whether you are eligible for such coverage. Such coverage will not be available if:

1. The deceased or terminated Subscriber was not covered under this Certificate during the entire 3-month period preceding the death or termination;
2. The Member seeking continuation coverage is or could be covered by Medicare;
3. The Member is or could be covered as an employee, member or dependent by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group under which the member was not covered immediately prior to termination; or
4. The Subscriber's termination of employment was due to misconduct as defined by Vermont law.

2. Requesting Continuation Coverage:

A. COBRA

- (1) Notifying the Plan Administrator of a Qualifying Event. If your Group is subject to COBRA requirements, it will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event, as described above, has occurred. When the qualifying event is the end of employment or a reduction of hours of employment, the death of the employee, the employee's becoming eligible for Medicare benefits (under Part A, Part B, or both), or, if your Group provides retiree health coverage under this Certificate, commencement of a bankruptcy proceeding with respect to your employer

Group, your employer must notify the plan administrator. For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the plan administrator within sixty (60) days (or a longer time period if allowed by your Group's rules) after the qualifying event occurs. You must provide this notice in the manner directed by your Group.

- (2) Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA Continuation Coverage even if the employee does not. Similarly, COBRA Continuation Coverage may be elected for only one, several, or for all Dependent children who are qualified beneficiaries. Covered employees may elect COBRA continuation coverage on behalf of the spouses and parents may elect COBRA continuation coverage on behalf of their Dependent children. Your Group will provide you with an election notice and an election form that describes who is eligible to elect COBRA continuation coverage, the maximum amount of time that such persons could be covered under such COBRA continuation coverage, and the monthly cost of such COBRA continuation coverage for each such eligible person. You must complete and submit the election form as described on the form. Under federal law, you have sixty (60) days after the date of the election notice to submit the election form. If you do not submit the election form within this time frame, you will lose your right to elect COBRA continuation coverage.
- (3) Each qualified beneficiary may be required by your Group to pay the entire cost of his COBRA Continuation Coverage. The amount you may be required to pay may not exceed 102% (or in the case of an extension of COBRA Continuation Coverage due to disability, 150%) of the cost to your Group (including both employer and employee contributions) for coverage of similarly situated Members who are not receiving COBRA Continuation Coverage. Each qualified beneficiary's required payment will be described in a notice provided by your Group. You do not have to send any payment with your election form. However, you must make your first payment not later than forty-five (45) days after the date of your election. This is the date the election notice is post-marked, if mailed. If you do not make your first payment in full not later than forty-five (45) days after the date of your election, you will lose all COBRA Continuation rights under this Certificate. You are responsible for making sure that the amount of your first payment is correct. You may call your Group for information about how to confirm that your first payment is correct. After you make your first payment, you will be required to make monthly or other periodic payments for each subsequent coverage period. Your

Group will provide you with notice of these amounts and information about when each of these periodic payments is due. If you make a periodic payment on before the first day of the coverage period to which it applies, your COBRA Continuation coverage will continue for that coverage period without any break in coverage. Your Group will inform you whether or not it sends notices of payments due for each coverage period. Your Group will also inform you where to send your initial and periodic payments.

- (4) Grace Periods. You will be give a grace period of thirty (30) days (or longer if permitted by your Group's rules) after the first day of the coverage period to make each periodic payment. Your COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for that coverage period, your COBRA Continuation Coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under this Certificate.

- B. Vermont Continuation Coverage. If you wish to elect Vermont continuation coverage, you must request the coverage, in writing, to your Group, within sixty (60) days if the Subscriber is deceased, or within thirty (30) days if the Subscriber has been terminated or becomes divorced or legally separated, or if a dependent child ceases to be a covered dependent child under this Certificate, from the earlier of: (i) the date that coverage under this Certificate would otherwise terminate; or (ii) the date you are given notice of the right to continuation. Your applicable premium payment must be included with this election.

- C. Maximum Period of COBRA Continuation Coverage. Except as provided in paragraphs D and E below, COBRA Continuation Coverage will last as described below:

1. If you were covered as the Subscriber, the date eighteen (18) months after your coverage would have terminated because of termination of employment or a reduction in hours of employment.
2. If you were covered as an eligible Dependent, the date thirty-six (36) months after coverage would have terminated due to: the death of the Subscriber; divorce or legal separation from the Subscriber; the

Subscriber's becoming eligible for Medicare; or a Dependent child ceasing to be a Dependent under the terms of this Certificate.

3. If the qualifying event is the Subscriber's termination of employment or reduction in hours of employment, and the Subscriber became eligible for Medicare less than eighteen (18) months before the qualifying event, the date thirty-six (36) months after the date of Medicare entitlement.

D. **Termination of COBRA Continuation Coverage.** COBRA Continuation Coverage will be terminated before the end of the maximum period described in paragraph C above if:

1. Any required premium is not paid in full on time;
2. A qualified beneficiary becomes covered, after electing COBRA Continuation Coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
3. A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA Continuation Coverage; or
4. Your employer Group ceases to provide any group health plan for its employees.
5. COBRA Continuation Coverage may also be terminated for any reason under this Certificate that coverage would be terminated for a Member not receiving continuation coverage (such as fraud).

E. Extending the Maximum Period of COBRA Continuation Coverage. If you elect COBRA Continuation Coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your COBRA administrator of a disability or a second qualifying event in order to extend the period of coverage. Failure to provide this notice may affect your right to extend the period of coverage. Further, this extended maximum period of coverage may be terminated for the reasons described in paragraph C above.

1. Disability Extension. An eleven (11) month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the sixtieth (60<sup>th</sup>) day of COBRA Continuation Coverage and must last at least until the end of the eighteen (18) month period of initial COBRA Continuation Coverage. You must call your Group for instructions about providing notice of a disability determination, including the time frame and procedures for giving such notice to your

COBRA administrator. Each qualified beneficiary who has elected continuation coverage will be entitled to the eleven (11) month disability extension if any one of them qualifies. If, during this extension period, the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA administrator of that fact within thirty (30) days after SSA's determination. In such cases, the extended COBRA Continuation Coverage will terminate thirty-one (31) days after SSA's determination that you are no longer disabled.

2. Second Qualifying Event. An eighteen (18) month maximum extension of coverage is available to spouses and Dependent children who elect COBRA Continuation Coverage if a second qualifying event occurs during the first eighteen (18) months of COBRA Continuation Coverage. The maximum amount of COBRA Continuation Coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events may include the death of the covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage under this Certificate as a Dependent child. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under this Certificate if the first qualifying event had not occurred. You must notify your Group within sixty (60) days after a second qualifying event occurs if you want to extend your continuation coverage.

F. Termination of Vermont Continuation Coverage. Continuation Coverage shall terminate upon the occurrence of any of the following:

1. Six (6) months after the date the Member's benefits under this Certificate would otherwise have terminated because of the death of the Subscriber or the Subscriber's termination of employment or group membership, or the Subscriber's divorce or legal separation, or a dependent child ceasing to be a covered dependent child under this Certificate.
2. The end of the period for which premium payments were made, if the Group or the Member fails to make timely payment of a required premium payment.
3. The member is or could be covered by Medicare.
4. The date on which the group's contract with MVP is terminated. However, in such event, if coverage is replaced by similar coverage under another Group Contract:

- a. The Member shall have the right to become covered under the replacement Group Contract for the balance of the period that he would have remained covered under the prior Group Contract;
  - b. The minimum level of benefits provided by the replacement Group Contract shall be the applicable level of benefits of the prior Group Contract, reduced by any benefits payable under that prior Group Contract; and
  - c. The prior Group Contract shall continue to provide benefits to the extent of its accrued liabilities and extension of benefits as if the replacement had not occurred.
  
- 3. Conversion to a Direct Contract: When continuation coverage under this Certificate terminates because of the death of the Subscriber or the Subscriber's termination of employment or group membership, the Subscriber and/or the Subscriber's Dependents may purchase a direct contract with MVP in accordance with the following rules:
  - A. The following Members may obtain an individual, direct payment conversion contract from MVP under which no Pre-Existing Condition exclusion period will be applied to him or her.
    - 1. An Eligible Individual.
    - 2. Any person who produces proof of continuous health benefit coverage during the 9 months prior to his effective date under the individual direct payment contract (a break in coverage of up to 63 days is allowed).
    - 3. A child placed with the Subscriber of the direct payment contract for adoption, or an adopted child. When such child is adopted or placed after the effective date of the direct payment contract.
    - 4. A Subscriber's newborn natural child or a newborn child placed with the Subscriber for adoption, provided that the child is enrolled within 94 days of the date of birth.
    - 5. If a Member does not qualify under one of the above categories, the Member may still be eligible to purchase a direct payment contract from MVP. However, a pre-existing condition exclusion period may be imposed.
  
  - B. Creditable Coverage. If a Pre-Existing Condition exclusion applies to you, the exclusion period can be reduced. The time you were covered under Creditable Coverage before you become covered under a direct payment contract will be counted to reduce the excluded period. This only applies if there was not a break

in coverage greater than 63 days between termination of the previous Creditable Coverage and your Effective Date under this Certificate.

- C. Notice and Application Requirements. You must apply for conversion coverage not later than 30 days prior to the date of termination of your continuation coverage. To apply, you must submit a written application and the first premium payment to MVP within this timeframe.
- D. Circumstances Under Which Conversion is Not Available. MVP does not have to provide Conversion Coverage if:
1. the Member was not entitled to or did not properly elect Continuation Coverage;
  2. the person is or could be covered by Medicare;
  3. the person is covered for similar benefits by another individual contract or policy;
  4. the person is or could be covered for similar benefits under any insured or self insured group arrangement, or by reason of any state or federal law, and together with this Conversion Coverage, would result in overinsurance according to MVP's standards; or
  5. your Group cancels coverage with us and gets coverage with another health insurer or you are otherwise eligible for group coverage, we cannot continue your Group or direct-pay coverage.
4. Suspension of Coverage – If you are a member of the Armed Forces of the United States or a member of a reserve component of the Armed Forces of the United States, including the National Guard, you may, upon written request, have your coverage suspended during a period of active duty as described below. MVP will refund any unused premium during the period of suspension. You will be entitled to resume coverage upon written application and payment of the required premium within sixty (60) days after the date of termination of the period of active duty, with no limits or conditions imposed as a result of such period of active duty, except as described in this subsection. Coverage will be retroactive to the date of termination of the period of active duty. There will be no exclusion period in connection with the resumption of coverage, unless:
- A. The condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty; or
  - B. Any exclusion described in this Contract was not completed prior to the suspension. In no event shall the sum of the exclusion period imposed prior to and subsequent to the period of suspension exceed the length of the exclusion originally imposed.

This Section applies only if you are: (1) a member of the Armed Forces of the United States; or (2) a member of a reserve component of the Armed Forces of the United States, including the National Guard, you serve no more than five (5) years of active duty, and you either

voluntarily or involuntarily enter upon active duty (other than for purposes of determining your physical fitness and other than for training); or have your active duty voluntarily or involuntarily extended during the period when the President in Office authorized to order units of the ready reserve or members of the reserve component to active duty; provided that such additional duty is at the request and for the convenience of the federal government.

## **SECTION SIXTEEN – EFFECT OF MEDICARE**

1. When you become eligible for Medicare, you must notify MVP in writing and, except as described below, Medicare then becomes your Primary Plan. If you are eligible for Medicare, you must enroll under both Part A and Part B. If you are eligible, but do not enroll, the amount of benefits that Medicare would have provided will be subtracted from any Benefits that MVP will provide. This subtraction will be made if: you fail to enroll in Medicare; you do not pay the premiums or other charges for Medicare; or you receive services at a hospital or from a provider that cannot bill Medicare. If you are covered under Medicare, we will coordinate benefits with Medicare.
2. If you are covered under Medicare, Medicare will be your Primary Plan, except under the following circumstances:

A. Eligibility for Medicare by Reason of Age. You are entitled to benefits under Medicare by reasons of your age, and the following conditions are met:

1. the Subscriber is in "current employment status" (working actively and not retired) with the Group Contract Holder; and
2. the Subscriber's employer maintains or participates in an employer group health plan that is required by law to have this Certificate pay benefits before Medicare.

In this case, Medicare is the Secondary Plan.

B. Eligibility for Medicare By Reason of Disability Other than End-State Renal Disease. You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:

1. the Subscriber is in "current employment status" (working actively and not retired) with the group contract holder; and
2. the Subscriber's employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Certificate pay its benefits before Medicare pays.

In this case, Medicare is the Secondary Plan.

C. Eligibility for Medicare By Reason of End-Stage Renal Disease. You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. We will not reduce this Certificate's benefits, and we will provide benefits before Medicare pays,

during the waiting period (this means that Medicare is the Secondary Plan during this waiting period). We will also provide benefits before Medicare pays during the coordination period with Medicare. After the waiting period, Medicare will pay its benefits before we provide benefits under this Certificate (this means that Medicare is the Primary Plan after this waiting period).

3. MVP as Primary Plan.
  - A. If the circumstances in paragraph 2 apply, then MVP is your Primary Plan.
  - B. MVP will provide benefits under the terms of this Certificate.
  - C. The benefits provided by Medicare will be reduced to provide benefits only to the extent not provided by MVP.
4. MVP as Secondary Plan. If the circumstances in paragraph 2 do not apply, then MVP is your Secondary Plan. If MVP is your Secondary Plan, you must follow Medicare's rules as well as the terms of this Certificate, and pay any applicable Deductible and Coinsurance before MVP will provide Benefits. The Benefits provided by MVP will be reduced to provide benefits only to the extent not provided by Medicare, up to MVP's Allowable Amount.
5. Recovery of Overpayment. If we provide more benefits than we should have, we have the right to recover the overpayment from you or from any other person, insurance company, agency or organization. You must cooperate with us to recover the overpayment.

## **SECTION SEVENTEEN - COORDINATION OF BENEFITS**

This Section applies only if you have other health benefits.

1. When You Have Other Health Benefits. You may be covered by two or more health plans which provide similar benefits. If you get a service that is covered at least in part by any of the plans involved, we will coordinate our Benefits with the benefits under the other plan. This prevents overpayment or duplicate payments for the same service. One plan (called the Primary Plan ) will pay benefits (up to the limits of its policy). The other plan (called the Secondary Plan) will pay benefits (up to the limits of its policy) if the benefits of the Primary Plan do not fully cover your expenses. The benefits of the Secondary Plan will be reduced to cover only those expenses that were not paid by the Primary Plan.
2. The following are considered to be health plans:
  - A. Any individual or group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g. Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;

- B. Any Blue Cross, Blue Shield, or other service type group plan;
- C. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;
- D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid, CHAPMUS/TRICARE, and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall be Secondary Plans; and
- E. If you have an accident and you are covered for accident-related expenses under any of the following types of coverage, the other plan is primary and MVP is the secondary plan:
  - i. No-Fault auto insurance;
  - ii. Group auto insurance;
  - iii. traditional fault-type auto insurance;
  - iv. uninsured or underinsured motorists insurance;
  - v. automobile-medical payment insurance;
  - vi. homeowner's insurance;
  - vii. personal injury protection insurance;
  - viii. financial responsibility insurance;
  - ix. medical reimbursement insurance coverage that you did not purchase; or
  - x. any other property and liability insurance providing medical payment benefits.

3. Rules to Determine Payment. In order to determine which plan is the Primary Plan, MVP follows these rules:

- A. If your other plan does not have a provision like this one which coordinates benefits it will always be the Primary Plan.
- B. If you are covered under one plan as a subscriber and under the other plan as a dependent, the plan which covers you as a subscriber is the Primary Plan.
- C. If you are covered as a dependent under two plans, then the rules are as follows: (i) the coverage of the parent whose birthday is first in a year will be primary and the parent whose birthday is later in the year will be secondary; (ii) if both parents have the same birthday, the benefits of the plan in effect longer will be primary; (iii) if the other plan does not have this rule, but instead has a rule based upon the parents' gender; and if as a result, the plans do not agree on the order of benefits, then the rule in the other plan will determine the order of benefits.

- D. There are special rules for a child of separated or divorced parents:
- (1) if the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary
  - (2) if no such court decree exists or if the Plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:
    - a. first, the Plan of the parent with custody of the child;
    - b. then, the Plan of the spouse of the parent with custody of the child;
    - c. finally, the Plan of the parent not having custody of the child.
- E. A plan which covers you as an active employee or that employee's dependent is primary; a plan which covers you as a laid off or retired employee (or as that employee's dependent) is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on which plan is primary, this subsection 3(E) is ignored.
- F. If none of the above rules determines the order of benefits, the benefits of a plan which covered you longer is primary.

The above rules apply whether or not you actually make a claim under both contracts or policies.

4. MVP as Secondary Plan. If MVP is considered the Secondary Plan, you must follow the rules and procedures of the Primary Plan and MVP before MVP will make payment. When MVP is the Secondary Plan, Benefits under this Certificate will be reduced so that the total benefits payable under the Primary Plan and MVP do not exceed your expenses for an item of service. We will not pay more than we would have paid if MVP was the Primary Plan. We count as actually paid by the Primary Plan any items of expense that would have been paid if you had made the proper claim.
5. Recovery of Overpayment. If we provide an overpayment of Benefits to you, we have the right to recover the overpayment from you or from any other person, insurance company, or organization that may have gained from our overpayment. We may reduce or withhold future Benefits to recover any incorrect payments. You agree to do what is necessary to help us to recover our excess payment. This includes but is not limited to: (1) agreeing to complete and file claim forms with other organizations or insurance companies and endorsing checks over to us, and (2) authorizing MVP to complete and file claim forms with other organizations or insurance companies on your behalf. Whether MVP is the primary or secondary plan, you will be responsible for payment of all applicable Copayments or Deductible and Coinsurance.

In the event that you get benefits or services under this Certificate, including but not limited to coverage for drugs (prescription or otherwise), after coverage has lapsed or has been terminated, MVP is entitled to recover payment for such services through any and all reasonable means, including but not limited to, the collections process.

6. Copayments When You are Enrolled in Two MVP Plans. If you are covered under MVP as a Subscriber and also a Dependent of a separate MVP plan, you are responsible for the Copayment under the Primary Plan only.
7. Payments to Others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid to you or a Provider.

### **SECTION EIGHTEEN THIRD PARTY LIABILITY AND RIGHTS OF REPAYMENT**

1. Introduction - If MVP provides Benefits for an injury, illness, or condition for which a third party is or may be responsible, then MVP retains the right to repayment of the full cost of all Benefits provided by MVP that are for or related to the injury, illness or condition.
2. Right to Subrogation - When MVP has provided Benefits as described above and the Member has not yet recovered such costs from the third party, MVP is subrogated to the Member's rights of recovery against any third party for the full cost of Benefits, to the extent permitted by applicable law. MVP may proceed against any third party without the consent of the Member.
3. Right to Reimbursement - When MVP has provided Benefits as described above and the Member or Member's representative has recovered such costs from the third party, MVP is entitled to reimbursement from the Member for the full cost of Benefits. As a condition of coverage under this Certificate, each Member hereby grants to MVP: (1) an assignment of the proceeds of any settlement, judgment, benefits under any automobile policy or other coverage, or any other payment received by the Member, to the extent of the full cost of all Benefits provided by MVP; and (2) a first priority lien against the proceeds of any settlement, verdict, judgment, benefits under any automobile policy or other coverage, insurance proceeds, or any other payment received by the Member, to the extent of the full cost of all Benefits provided by MVP.
4. Sources of Payment - MVP's rights apply to any payments made to or on behalf of a Member from third-party sources, including, but not limited to: (1) payments made by a tortfeasor or any insurance company on behalf of such third-party tortfeasor, (2) any payments or awards under an uninsured or underinsured motorist automobile policy, (3) any worker's compensation or disability award or settlement, (4) medical payments coverage under any automobile policy, (5) premises or homeowners medical payments coverage or premises or homeowners insurance coverage, (6) any other payments from a

source intended to compensate a Member for injuries resulting from alleged negligence of a third party. No court costs or attorneys fees may be deducted from MVP's recovery without MVP's prior written consent, unless such deduction is permitted by applicable law without such prior written consent.

5. Cumulative Rights - MVP may choose to exercise either or both rights.
6. Member's Obligations
  - A. Promptly notify MVP when notice is given to any third party to pursue a claim for injuries, illnesses or conditions that may be the legal responsibility of a third party.
  - B. Cooperate with MVP to protect MVP's rights to reimbursement and subrogation, including:
    - i. signing and delivering, within 30 days of a reasonable request to do so, any documents needed to secure MVP's subrogation claim, to protect MVP's right to reimbursement, or to effect the assignment or lien described in paragraph 3 above;
    - ii. providing any relevant information;
    - iii. getting the consent of MVP before releasing any party from liability for payment of medical expenses;
    - iv. taking such other actions as may be needed to assist MVP in making a full recovery of the cost of all benefits provided; and
    - v. not taking any action that prejudices MVP's rights to reimbursement or subrogation, including but not limited to making any settlement or recovery which specifically attempts to reduce or exclude the full cost of benefits provided by MVP.
7. Consequence of Failure to Comply – If the Member fails to comply with the requirements of paragraph 6, that Member shall be responsible for all Benefits provided by MVP in addition to costs, attorneys' fees, and interest incurred by MVP to get repayment.

### **SECTION NINETEEN – GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW**

1. Grievances. A grievance means a written or verbal complaint submitted to MVP by or on behalf of a Member expressing dissatisfaction regarding the availability, delivery or quality of health care services, claims payment, handling or reimbursement for health care services, or expressing dissatisfaction regarding matters governed by or related to this Certificate, including requests that MVP change decisions that services are not Medically Necessary or are not Covered Services. You, your designated representative (such as a family member, friend, or lawyer), or a Provider acting on your behalf, may submit a grievance. You must call MVP at 1-888-MVP-MBRS (1-888-687-6277) in

order to designate a representative. Your decision as to whether or not to submit a grievance has no effect on your rights to any other benefits under this Certificate. Upon request and free of charge, MVP will provide you with reasonable access to and copies of documents, records, and other information relevant to your grievance.

2. Grievance Reviewers. This paragraph applies to physical health grievances. For grievances involving mental health services or substance abuse services, please see Paragraph 8.
  - (a) First Level Grievances. Medical grievances are reviewed by one of MVP's medical directors. Non-medical grievances are reviewed by a member of MVP's administrative staff who has the necessary education and experience to resolve the matter. First level grievances are reviewed by persons who were not involved in making the initial decision and who are not subordinate to such persons.
  - (b) Second Level Grievances. Second level grievances are reviewed by a panel comprised of MVP senior medical and administrative staff and/or board members with the necessary education, training and experience to resolve the matter. The medical staff participating in at least one level of grievance review will have appropriate training and experience in the field of medicine involved in the particular grievance, and will be actively practicing in the same or similar specialty who typically treats the condition or provides the services that is the subject of the grievance. Alternatively, MVP may engage independent organizations to provide medical specialists practicing in the same or similar specialty as consultants for a particular grievance. Second level grievances are reviewed by persons not involved in making the initial decision or the first level grievance decision and who are not subordinate to such persons. Further information about the panel reviewing your grievance is included in MVP's written response to the grievance.
3. Information Reviewed. MVP will review all comments, documents, records and other information you provide, without regard to whether such information was submitted or considered when making the initial decision or any first level grievance decision. Grievances are reviewed without deference to the initial decision or any first level grievance decision.
4. Time Limit for Submitting a First Level Grievance. You must submit a first level grievance within 180 days of receiving our decision regarding the matter that is the subject of the grievance. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral grievance by calling MVP at 1-888-MVP-MBRS (1-888-687-6277). You may submit a written grievance to MVP Health Plan, Inc., 625 State Street, Schenectady, New York 12305.

5. MVP's Response to First Level Grievances. MVP will respond to first level grievances as follows:
  - A. First Level Internal Grievances related to Emergency Services or Urgent Care. MVP will notify you of our decision in writing within 24 hours after our receipt of the grievance. In cases involving Mental Health Services or Substance Abuse Services, a licensed mental health review agent will notify you of the decision within 24 hours of the date the grievance is submitted.
  - B. First Level Internal Medical Grievances. MVP will notify you of our decision in writing within 15 days after our receipt of the grievance. In cases involving Mental Health Services or Substance Abuse Services, a licensed mental health review agent will notify you of the decision within 10 days of the date the grievance is submitted.
  - C. All other First Level Internal Grievances. MVP will notify you of our decision in writing within 30 days after our receipt of the grievance. In cases involving Mental Health Services or Substance Abuse Services, a licensed mental health review agent will notify you of the decision within 10 days of the date the grievance is submitted.
6. Time Limit for Submitting a Second Level Grievance. In cases not involving Mental Health Services or Substance Abuse Services, if you are not satisfied with MVP's decision issued in response to the first level grievance, you may submit a second level grievance. You must submit this grievance within 180 days of receiving our decision issued in response to the first level grievance. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral grievance by calling MVP at 1-888-MVP-MBRS (1-888-687-6277). You may submit a written grievance to MVP Health Plan, Inc., 625 State Street, Schenectady, New York 12305. As described in paragraph 2, second level grievances are reviewed by a panel. You have the right to appear before the panel to discuss your grievance. If you cannot appear before the panel in person, you may communicate with the panel by conference call or other appropriate technology. For cases involving Mental Health Services and Substance Abuse Services, please see paragraph 8 below.
7. MVP's Response to Second Level Grievances. MVP will respond to second level grievances as follows:
  - A. Second Level Internal Grievances related to Emergency Services or Urgent Care. MVP will notify you of our decision in writing within 48 hours after our receipt of the grievance.
  - B. All other Second Level Internal Grievances. MVP will notify you of our decision within 15 days after our receipt of the grievance.
8. Review of First Level Grievance Decisions in Cases Involving Mental Health Services or Substance Abuse Services. In cases involving Mental Health Services or Substance

Abuse Services, if you are not satisfied with the decision issued in response to the first level grievance, you, your Provider, or your authorized representative may submit an appeal to the Independent Panel of Mental Health Care Providers established by the Vermont Department of Banking, Insurance Securities, and Health Care Administration (“BISHCA”). You must call BISHCA at 1-800-631-7788 for assistance in submitting this appeal.

9. Independent External Review. This process is available with respect to issues involving physical health conditions only. For Mental Health and Substance Abuse conditions, please refer to paragraph 8 above.
  - A. You have the right to an “independent external review” of certain second level grievance decisions made by MVP. An independent external review is an independent review of our decision by a third party known as an independent review organization. Independent review organizations are selected by BISHCA and must not have any conflict of interest associated with the review. You may have the right to an expedited external review if the subject of the review concerns an emergency medical condition, emergency services, or urgently needed care. The timeframes for expedited external reviews are shorter than the timeframes for standard external reviews.
  - B. You must request this review within 90 days of receiving MVP’s second level adverse decision. To request an independent, external review, you must call BISHCA at 800-631-7788.
  - C. An independent external review will be provided only if the service that is the subject of the review is a Covered Service.
  - D. You may not request an external review unless we have issued a second level grievance decision. This means that you must exhaust our internal process before requesting an external review.
  - E. To be eligible for external review, the second level grievance decision must be based on a decision that the requested service is not Medically Necessary, is Experimental or Investigational, is an off-label use of a drug, or is a service involving a medically-based decision that a condition is preexisting, or that we have limited your selection of a provider in a manner inconsistent with the terms of this Certificate or applicable laws and regulations. You do not have the right to external review of any other decisions, even if those other decisions affect your eligibility or benefits.
10. Effect of Review Organization’s Decision; Coverage. The decision of the review organization is binding on MVP. If the organization decides in our favor, we will not change our decision or provide benefits for the service that is the subject of the review. If the organization decides in your favor, we will provide benefits subject to all other terms and conditions of this Certificate. We will not provide benefits for any service that is not

a Covered Service. In addition, this section does not change any Copayment, Coinsurance, or Deductible.

11. Statement of ERISA Rights. If your group's plan is covered by the Federal Employee Retirement Income Security Act of 1974 ("ERISA"), you are entitled to certain rights and protections under ERISA, as described below:

ERISA provides that all plan participants shall be entitled to:

- A. Receive Information About Your Plan and Benefits. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- B. Continue Group Health Plan Coverage. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
- C. Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

- D. Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
- E. Assistance with Your Questions. If you have any questions about your plan, you should call the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance getting documents from the plan administrator, you should call the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.
- F. Newborns and Mothers Health Protection Act. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider get authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
- G. Women's Health and Cancer Rights Act of 1998. Federal law requires us to notify you of our benefits for reconstructive surgery following mastectomy. The Women's Health and Cancer Rights Act of 1998 requires that we provide benefits

for reconstruction of the breast on which a mastectomy has been performed and/or the other breast (to produce a symmetrical appearance). We also cover prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as required by the Act. Benefits for the above services are subject to all terms and conditions of your Certificate. For example, they require the same Coinsurance and Deductibles as the rest of your coverage. If you have any questions about your rights under this Act, please call MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

## SECTION TWENTY - GENERAL PROVISIONS

1. Assignment. Only you are eligible for Benefits under this Certificate. You cannot assign your right to receive Benefits due under this Certificate to any person, corporation or other organization. Any such assignment shall be voidable by MVP.
2. Notices. Any notice that we give you will be mailed to you at your address as it appears in our records. You must notify MVP right away of any change of address. All notices to MVP must be mailed, postage prepaid, registered or certified mail, return receipt requested, or personally delivered to us at 625 State Street, Schenectady, New York 12305.
3. Your Medical Records. To provide Benefits, it may be necessary to get your medical records from Providers who treated you. Providing Benefits includes determining your eligibility, processing your claims, reviewing grievances involving your care, and quality assurance and quality improvement reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you complete an enrollment application and/or access services for which you seek Benefits under this Certificate, MVP and each Provider who provides such services may use your protected health information for its treatment, payment and healthcare operations purposes and for other purposes otherwise permitted by applicable state and federal law.
4. Changes to this Certificate.
  - A. We may change the terms of this Certificate and change or eliminate any of the benefits if approved by BISHCA. Members have no vested rights to any Benefits or other provisions of this Certificate. We will provide you with at least 30 days prior written notice or a change or elimination.
  - B. This Certificate may not be modified, amended or changed, except in writing, and signed by our Chief Executive Officer.
5. Choice of Law. Unless federal law applies, this Certificate shall be governed by the laws of Vermont.
6. Legal Action. You may not commence any legal action against MVP prior to the expiration of sixty (60) days after written Proof of Loss was submitted to MVP in

accordance with Section Four of this Certificate. In addition, you may not start a legal action against MVP prior to exhausting the second level appeal process outlined in Section Nineteen. Finally, you may not bring any legal action against MVP after the expiration of three (3) years from the date written Proof of Loss was required to be submitted to MVP in accordance with Section Four of this Certificate. Service or process must be made upon an officer of MVP at 625 State Street, Schenectady, New York 12305 or otherwise in accordance with state or federal law.

- A. Physical Examination and Autopsy. MVP may require you to have a physical exam as often as necessary about any injury or illness that results in a claim made under this Certificate. MVP may also have the right and opportunity to make an autopsy in the case of death, where it is not prohibited by law.
  - B. Examination Under Oath. MVP shall have the right and opportunity to examine under oath the Member for whom claim is made when and so often as we may reasonably require during the pendency of such claim made under this Certificate.
7. Venue for Legal Action. You must start any lawsuit against us in a court in Vermont. You agree not to start a lawsuit against us in a court located anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action we bring against you.
8. Time Limit on Certain Defenses. After 3 years from your Effective Date of this Certificate, no misstatements, except fraudulent misstatements, made by you in the enrollment application for this Certificate, shall be used to void this Certificate or used as a basis to deny a claim after the expiration of such 3-year period.
9. MVP's Relationship with Providers. Providers are not agents or employees of MVP and MVP is not an agent or employee of any Provider. This Certificate does not require any particular Provider to accept you as a patient and we do not guarantee such acceptance by any particular Provider. Providers are solely responsible for all services rendered or not rendered to Members. MVP does not control the treatment or other professional actions of Providers. MVP's decisions relate only to whether we will provide Benefits under this Certificate and are not a substitute for the professional judgment of your Provider. Further, the persons making these decisions for MVP do not receive incentives to limit or deny Benefits and are not paid based upon the quantity or type of such decisions.

MVP pays many Participating Providers on a fee for service basis, which means that Providers bill MVP for services rendered and MVP pays the Providers according to an agreed upon fee structure. MVP also has arrangements with some Participating Providers, which allows MVP to withhold a certain percentage of the agreed upon fee during the course of a year and to keep all or a part of this withheld amount if medical costs have exceeded a certain budgeted amount. Some Participating Providers are paid through a capitation arrangement. This means that MVP pays the provider a fixed amount on a regular basis, usually monthly, based upon the number of MVP Members

the Provider serves. This fixed amount is paid regardless of how many or how few services are provided to MVP Members during the month. If services are rendered by a Non-Participating Provider and MVP approves Benefits for these services, MVP may pay the Provider's Charges or pay a different rate negotiated with the Provider or with an out of system provider network.

10. Identification Cards. Possession of a card confers no automatic right to Benefits. To be eligible for Benefits, you must be listed on a completed enrollment form submitted to and accepted by us and your premiums must be paid in full. We may terminate your coverage if you allow another person to wrongfully use an MVP identification card.
11. Construction and Interpretation of this Certificate. Subject to your rights under the law, including the right to appeals a denial of Benefits, MVP has the authority to interpret and apply the terms of this Certificate and to determine whether and to what extent there is coverage for a requested service, even when a Provider has prescribed or recommended the service.
12. Furnishing Information. You must, within 30 days of our request, provide us with all information and records that we may need to perform our obligations under this Certificate.
13. Inability to Provide Service. In the event of circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of our offices, a significant part of our network, or entities with whom MVP has arranged for services, and our ability to provide Benefits under this Certificate is delayed or becomes impossible, we will not be liable for such delay or failure, except to refund unearned premiums. We are required only to make a good faith effort to provide or arrange for the provision of Benefits.
14. Recovery of Overpayments. If we make a payment to you in error, we will tell you and you must return the amount of the overpayment to us within 60 days. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we make to you.
15. Nonwaiver of Our Rights. We may choose not to enforce certain terms or conditions of your Certificate. This does not mean we give up the right to enforce these terms or conditions later.
16. Severability. If any provisions of your Certificate are declared invalid or illegal for any reason, the remaining terms and provisions will remain in full force and effect.