# MVP VERMONT

# CERTIFICATE OF COVERAGE

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

THIS IS YOUR CERTIFICATE OF COVERAGE
Issued by
MVP Health Plan, Inc.
625 State Street, Schenectady, New York 12305
800/777-4793

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

This Certificate of Coverage ("Certificate") describes the benefits available to you under a Group 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 CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE 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

Name:
I.D. No.:
Primary Care Physician:
Phone:

MVP Health Plan is a not-for-profit health maintenance organization certified in Vermont.

VTGRCERT(10/01)

**TABLE OF CONTENTS**

## SECTION ONE – INTRODUCTION

MVP is a New York State not-for-profit corporation. MVP is certified as a health maintenance organization in New York State and the State of Vermont. MVP provides benefits for members for comprehensive health services on a prepaid basis. These services are provided by:

(1) physician and physician-hospital organizations;
(2) independent physicians and other health care professionals; and
(3) independent hospitals and other facilities through agreements with MVP.

MVP's service area includes the state of Vermont and the New York State counties of Albany, Broome, Chenango, Columbia, Delaware, Dutchess, Fulton, Greene, Hamilton, Herkimer, Lewis, Madison, Montgomery, Oneida, Onondaga, Orange, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren and Washington. Additional counties may be added in the future.

When you enroll as an MVP member, you and your covered dependents must each choose a Primary Care Physician ("PCP") from MVP's Participating Provider Directory. 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. All services must be provided by your PCP or provided by MVP participating providers after getting a referral from your PCP to be eligible for benefits under this Certificate. The following exceptions apply.

(1) emergency services.
(2) certain gynecological services.
(3) members with certain serious conditions.
(4) members in their second or third trimester of pregnancy.
(5) services not available through a MVP provider.

These exceptions are described in detail in later sections in this Certificate. You should refer to those sections to ensure that you meet all requirements. To be eligible for benefits under this Certificate services must also be:

A. Covered Services as defined in this Certificate;

B. Medically Necessary as defined in this Certificate;

C. for certain services as specified later in this Certificate, subject to precertification, prior approval, and/or concurrent review; and

D. not subject to the exclusions and limitations described in this Certificate.

If you receive services which are not Covered Services, MVP will not pay for those services. You will be responsible for paying 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. You have the right to file grievances with MVP or with the State of Vermont if you are dissatisfied with our processes, procedures, or benefit decisions. You also have certain rights to request independent external review of our decisions.

## SECTION TWO – DEFINITIONS

1. The following terms have special meanings in this Certificate.

   A. Acute Services means services which, according to generally accepted professional standards, are expected to provide significant, measurable clinical improvement within a reasonable and medically predictable period of time, not to exceed two (2) months.

   B. Calendar Year 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.

   C. Charge means the total amount billed by a provider for a service. A charge is incurred on the date the service was provided to you.

   D. Coinsurance means a dollar amount, expressed as a stated percentage of the charge. It is the amount that you must pay, in addition to the premium, for Covered Services. You must pay any coinsurance directly to the provider.

   E. Complications of Pregnancy means conditions requiring hospital admission whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy including, but not limited to:

   (1) acute nephritis
   (2) nephrosis
   (3) cardiac decompensation
   (4) missed abortion
   (5) similar medical and surgical conditions of comparable severity

   It does not include:

   (1) false labor
   (2) occasional spotting
   (3) physician prescribed rest during pregnancy
   (4) morning sickness
   (5) hyperemesis gravidarium
   (6) pre-eclampsia
   (7) similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy

   This term also includes non-elective cesarean section, ectopic pregnancy, and miscarriage.

F. Copayment means a fixed dollar amount, which you must pay, in addition to the premium, for Covered Services. You must pay any Copayment directly to the provider.

G. Covered Services 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. you may request a copy of such protocols by contacting MVP's Member Services Department at 1-888-MVP-MBRS.

H. Custodial Services means services primarily 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
(2) dressing
(3) feeding
(4) preparation of special diets
(5) administration of oral medications
(6) routine changing of dressings
(7) child care
(8) adult day care
(9) residential care
(10) care not requiring skilled professionals

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

I. Deductible means a dollar amount which you must pay, in addition to the premium, before we provide benefits under this Certificate. You pay any deductible directly to the provider.

J. Dependent 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 by MVP.

K. Diagnostic Services means radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scans, electroencephalograms, electrocardiograms, organ scans, and other medical and surgical diagnostic services.

L. Durable Medical Equipment means equipment which 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.

M. Effective Date means the date your coverage under this Certificate begins. Coverage begins at 12:01 a.m., eastern time, on that date.

N. Eligible Individual, as defined by federal law, means a person on the effective date of 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 available COBRA or state continuation coverage.

O. Experimental or Investigational Services 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.

P. External Prosthetic Devices are devices that replace all or some of the functions of a permanently inoperative and/or malfunctioning external body part. Examples of such devices are artificial limbs and breast prostheses.

Q. Member means the Subscriber or his or her Dependents.

R. Mental Health Condition means a condition or disorder involving mental illness or alcohol or substance abuse that falls under a diagnostic category listed in the mental disorders section of the international classification of disease, as periodically revised.

S. Non-participating Provider means a Provider who does not have an agreement with MVP to provide Covered Services to Members.

T. Participating Provider means a Provider who has an agreement with MVP to provide Covered Services to Members.

U. Primary Care Physician means a Participating Provider who has an agreement with MVP to provide covered primary health care services to Members.

V. Provider means a properly licensed and/or certified:

(1) physician
(2) hospital
(3) approved facility for the treatment of mental health conditions
(4) approved institution for the treatment of alcohol or substance dependency
(5) skilled nursing facility
(6) free standing ambulatory surgery center, free standing radiology/imaging center, free standing dialysis center, and free standing laboratory facility
(7) home care agency
(8) health care professional

The provider must provide health care services within the scope of his or her practice, and must charge and bill patients for such services.

W. Resident means a person who is domiciled in Vermont. It means the person intends to maintain a principal dwelling place in Vermont indefinitely. It also means that the person intends to return to Vermont if temporarily absent. One must act consistent with that intent.

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

Y. Subscriber 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.

Z. Surgery 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.

AA. Therapeutic Services means:

a. Radiation Therapy means the use of x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes for treatment of disease;

b. Chemotherapy 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 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.

d. Infusion Therapy means treatment of disease by continuous injection of curative agents; and

e. Inhalation Therapy means inhalation of medicine, water vapor and/or gases to treat impaired breathing.

BB. Therapy Services means Acute Services, limited to physical therapy, occupational therapy, and speech therapy.

CC. Totally Disabled or Total Disability means incapable of engaging in any employment or occupation for which the person is or becomes qualified by reason of education, training or experience. Such person must not, in fact, engage in any employment or occupation for wage or profit.

## SECTION THREE – ENROLLMENT AND COVERAGE

1. Initial Enrollment. Each person must choose a PCP. Refer to your Member Handbook for instructions on choosing a PCP. You must follow your group's instructions for enrollment. 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.

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

   A. The Subscriber and his or her dependents must meet the Group's eligibility requirements.

   B. If the Subscriber chooses individual coverage, then only he or she is covered.

   C. If Subscriber plus Spouse only coverage is offered and the Subscriber chooses such coverage, then only the Subscriber and his or her Spouse, as described below, may be covered under this Certificate.

   D. If Subscriber plus child or children only coverage is offered and the Subscriber chooses such coverage, then only the Subscriber and his or her child(ren), as described below, may be covered under this Certificate.

   E. If family coverage is offered and the Subscriber chooses such coverage, then the Subscriber, his or her Spouse and his or her child(ren), as described below, may also be covered:

i. The Subscriber's Spouse;

ii. 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

iii. 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.

3. Children Covered Under This Certificate. To be covered, the Subscriber's children must meet the requirements of (E)(ii) or (E)(iii) 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;

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.

4. 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 return the

completed form, requested documentation, and required premium 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 you have Subscriber plus child or children coverage or family coverage, your newborn natural child or a newborn child placed with you for adoption, will automatically be covered from the moment of birth for 31 days. 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 to continue the child's coverage beyond 31 days, you must comply with paragraph (iii) below. If you do not follow this procedure, we will not provide coverage beyond the 31 days.

ii. If you have individual coverage, or Subscriber plus Spouse coverage, your newborn natural child or a child placed with you for adoption will not automatically be covered from the moment of birth. You must comply with paragraph (iii) below in order for the child to be covered from the moment of birth. If you do not follow this procedure, we will not provide coverage for your child.

iii. 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 your step child, your 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 your step child. If you do not do so within 31 days of the events described, your child 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. If you do not notify us, we will not provide coverage for the child.

a. We will not provide benefits for a newborn child placed with you for adoption if a natural parent of the child has insurance coverage available 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 be entitled to recover the amount of benefits provided by us.

iv. To add a child for whom a court has ordered you 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. You must pay us any required premium for coverage to be effective.

5. When you Reject Initial Enrollment, But Do Not Need to Wait Until the Group's Open Enrollment Period to Enroll for Coverage. This Section 5 shall apply only to Large Groups and to Members of those Small Groups who have elected one or more open enrollment periods. If you reject initial enrollment under this Certificate, you may enroll for coverage if all of the following conditions are met:

A. You 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 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 apply for coverage under this Certificate within 30 days after termination for one of the reasons set forth in Paragraph B above.

If you enroll for coverage pursuant to this paragraph, your coverage will begin at 12:01 a.m. on the first of the month following the next premium due date after loss of coverage.

6. 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.

7. When you, your Spouse or your child is no longer eligible for coverage. You must immediately notify us 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.

8. If, because of the event, 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 or if your Group does not provide the information to MVP in a timely manner, so that the change in premium will be effective as of the date of the event. If you do not, 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.

9. Persons *Not* Eligible For Coverage Under This Certificate.

   A. Any person who is not a Vermont Resident or who does not work in Vermont. 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;
   B. Subject to paragraph 4(B), any child born to a Subscriber's dependent child, after 31 days from the date of birth.

## SECTION FOUR – MEDICAL NECESSITY

1. We will only provide benefits if a Covered Service is medically necessary. Medically Necessary or Medical Necessity means that a Covered Service is:

   A. Appropriate, in terms of type, amount, frequency, level, setting and duration, for the diagnosis or treatment of your condition;

   B. 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;

   C. One which:

      i. Helps restore or maintain your health;

      ii. Prevents deterioration of or palliate your condition; or

      iv. Prevents the reasonably likely onset of a health problem or detect an incipient problem.

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.

2. MVP maintains protocols to assist in determining whether a service is Medically Necessary. You may request a copy of such protocols by contacting MVP's Member Services Department at 1-888-MVP-MBRS.

## SECTION FIVE
## UTILIZATION MANAGEMENT

This Certificate requires precertification, concurrent review, and prior approval by MVP before you receive certain Covered Services. All other services are subject to retrospective review. MVP's approval of services through precertification, concurrent review, or prior approval are 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. Urgent Matters. Requests and claims for Retrospective Review are excluded from this paragraph 1.

   (a) In cases involving Urgently Needed Care, we will notify you and your Provider, by telephone, of our decision within 24 hours of the time that the request for precertification, concurrent review, and prior authorization is requested. You and your Provider will be notified, in writing, within 24 hours of the telephone notice.

   (b) In cases where:

      (i) application of the time periods described in paragraphs 2 or 3 below:

         (A) could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or

         (B) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or

      (ii) a physician with knowledge of your medical condition determines that a precertification, concurrent review or prior approval request is urgent,

   if all necessary information is received at the time of the request, we will notify you and your Provider, by telephone and in writing, of our decision within 48 hours after our receipt of the request. If all necessary information is not received at the time of the request, we will notify you and your Provider within 24 hours after our receipt of the request of any missing information that is needed to decide the request. You and your Provider will have 48 hours from the receipt of our notice to provide us with the missing information. In such cases, we will notify you and your Provider, by telephone and in writing, of our decision within 48 hours after: (a) our receipt of the missing information;

or (b) the expiration of your time to provide the missing information, whichever is sooner.

2. Pre-Service Determinations

(a) Precertification. Precertification means the required approval that your Provider must get from MVP before you receive inpatient or skilled nursing facility services. MVP reviews information about your medical condition and the proposed services in order to determine whether such services are Medically Necessary Covered Services.

(b) Prior Approval. Prior approval means the approval that your Provider must get from MVP before you receive certain outpatient, home care, and professional services, and certain prescription drugs. MVP reviews information about your medical condition and the services in order to determine whether such services are Medically Necessary Covered Services. It is also the approval that your PCP must get from MVP before you receive any services from a Non-Participating Provider.

If all necessary information is received at the time of the precertification or prior approval request, we will notify you, by telephone, of our decision within two working days. In the event of an adverse determination, we will also notify your Provider, by telephone of our decision. We will notify you and your Provider, in writing, within 24 hours of the telephone notice. If all necessary information is not received at the time of the prior approval or precertification request, we will notify you and your Provider within 5 days after our receipt of the request of any missing information that is needed to decide the request. You and your Provider will have 45 days from the receipt of our notice to provide us with the missing information. In such cases, we will notify you and your Provider, in writing, of our decision within two working days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner.

3. Concurrent Review. Concurrent review means MVP's review of a request to extend a course of treatment beyond the period of time or number of treatments approved under Section 2, to determine whether such services continue to be Medically Necessary Covered Services. The services reviewed include inpatient services, skilled nursing facility services, home care services, and ongoing professional care services. Your Provider must give us the information needed to conduct this review before the end of each period for which your benefits were approved. If all necessary information is received at the time of the concurrent review, we will notify you and your Provider, in writing and your provider by telephone, of our decision within 24 hours after the review. If all necessary information is not received at the time of the concurrent review request, we will contact your Provider or Facility for any missing information that is needed to conduct the review. If we deny benefits as a result of our review, we will not provide any benefits after the date that you receive notice of our decision.

4. Retrospective Review. Retrospective review means our review, after services have been provided to you, to determine whether such services are Medically Necessary Covered Services. We will review information about your medical condition and the services provided to you. If all necessary information is received at the time of the request for retrospective review, we will notify you of any adverse determination, in writing, within 30 days after our receipt of the request. If all necessary information is not received at the time of the request for retrospective review, we will notify you and your Provider within 5 days after our receipt of the request of any missing information that is needed to decide the request. You and your Provider will have 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 30 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. Except in cases of missing information, MVP's time to conduct retrospective review shall not exceed a total of thirty (30) days.

5. Emergency or Urgent Care Services. You, your Provider, or a family member or other representative must contact us at 1-888-MVP-MBRS within 48 hours, or as soon as reasonably possible, after receiving Emergency Services or Urgent Care Services or an Emergency inpatient admission so that MVP can coordinate your follow up care.

6. Right to File a Grievance. If you disagree with our decisions under this section, you may file a grievance as described in Section 18.

## SECTION SIX – COVERED HOSPITAL INPATIENT SERVICES

1. Precertification and Concurrent Review is required for all Hospital inpatient services.

2. What is a hospital? As used in this Certificate, the term "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. Such facility has organized departments of medicine and major surgery, and provides twenty-four (24) hour nursing service by or under the supervision of registered nurses. The following are not within the definition of Hospital:

- Convalescent homes.
- Convalescent, rest or nursing facilities.
- Facilities primarily affording custodial or educational care.
- Health resorts, spas or sanitariums
- Infirmaries 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.

3. Inpatient Services. We will provide benefits for the following when provided to you in a participating Hospital:

   A. Semi-private room.

   B. Board and general 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. Diagnostic and therapeutic items used in and provided by the Hospital, such as prescribed drugs, medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items.

   F. Dressings and casts.

   G. Diagnostic Services.

   H. Therapeutic Services.

   I. Professional services, equipment, and supplies in connection with oxygen, anesthesia.

   J. Laboratory services.

   K. Pathology services.

   L. Medical and surgical supplies.

   M. Therapy Services.

4. Maternity Care. We provide benefits for the inpatient services listed in paragraph 3 to a covered mother for childbirth for at least 48 hours after a non-cesarean delivery. The same benefits are provided for at least 96 hours after a cesarean delivery. The attending physician, with the mother or mother's designated representative, may determine to discharge the mother sooner. We will also provide benefits for these inpatient services for pregnancy and Complications of Pregnancy.

5. Newborn Care. We will provide benefits for the inpatient services listed in paragraph 3, and routine inpatient nursery care and examinations, for a covered newborn child for at least 48 hours after a non-caesarian delivery. The same benefits are provided for at least 96 hours after a caesarian delivery. The attending physician, with the newborn's mother

or the newborn's designated representative, may determine to discharge the newborn sooner. Subject to the requirements set forth in Section 3, paragraph 4(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.

6. Breast Cancer Care. We will provide benefits for the inpatient services listed in paragraph 3 in connection with an inpatient hospital stay following a mastectomy, lymph node dissection or lumpectomy for the treatment of breast cancer, and for physical complications of mastectomy, including lymphedemas. We will also provide benefits for these inpatient services in connection with an inpatient hospital stay 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.

7. Mental Health Care

   A. Mental Health Conditions. We will provide benefits for the inpatient services listed in paragraph 3 for treatment of mental health conditions only when provided in a mental health facility qualified pursuant to rules adopted by the secretary of human services or in an institution approved by the secretary of human services, that provides a mental health treatment program pursuant to a written plan. The facility must also be a Participating Provider.

   B. Alcohol or Substance Dependency. We will provide benefits for the inpatient services listed in paragraph 3 only when 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. The institution must also be a Participating Provider.

8. Physical Rehabilitation Care. We will provide benefits for up to 2 months per condition for the services listed in paragraph 3 only when such services are Acute Services provided by a participating free standing facility licensed to provide inpatient physical rehabilitation services or by a unit of a participating Hospital designated as providing such services.

9. 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 your Skilled Nursing Facility benefits.

10. Copayment. You must pay the Copayment listed on your Copayment Schedule for Hospital inpatient services. Newborn Care is covered in full.

## SECTION SEVEN – COVERED OUTPATIENT SERVICES

1. Outpatient Services. We will provide benefits for the following outpatient services. Such services must be provided to you in the outpatient department of a participating Hospital or a participating free standing facility:

   A. Pre-surgical testing. We will provide benefits for tests given to you before your admission to a Hospital if:

      i. Your physician has ordered the tests; and
      ii. An operating room at the hospital has been reserved for surgery.

      Pre-surgical testing is covered in full.

   B. Outpatient Surgery. We will provide benefits for Surgery, including sterilizations. These services are subject to prior approval. You must pay the Copayment listed on your Copayment Schedule for each surgery.

   C. Therapeutic Services. We will provide benefits for outpatient Therapeutic Services. You must pay the Copayment listed on your Copayment Schedule for each visit.

   D. Contraceptive Services. We will provide benefits for outpatient contraceptive services. Contraceptive services are covered in full.

   E. Treatment of Mental Health Conditions. We will provide benefits for outpatient treatment of Mental Health Conditions only when provided by a participating licensed or certified mental health provider. You must pay the Copayment listed on your Copayment Schedule for each visit. These services are subject to prior approval.

   F. Treatment of Alcohol Abuse or Substance Dependency. We will provide benefits for outpatient treatment of alcohol or substance dependency only when provided by a participating licensed or certified substance abuse provider. You must pay the Copayment listed on your Copayment Schedule for each visit. These services are subject to prior approval.

   G. Mammography Screenings. We will provide the following benefits for outpatient mammography screening for breast cancer:

      (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.

Mammography screenings are covered in full.

H. Diagnostic Services. We will provide benefits for outpatient Diagnostic Services. Diagnostic Services are covered in full.

I. Laboratory Services. We will provide benefits for outpatient laboratory services. Laboratory services are covered in full.

J. Diagnostic and Therapeutic Items. This section includes benefits for items used in and furnished by the outpatient department or free-standing center. This includes: drugs, medications, sera, biologicals, vaccines, intravenous preparations and visualizing dyes administered during the course of receiving Covered Services, and the administration of such items.

## SECTION EIGHT – COVERED SKILLED NURSING FACILITY SERVICES

1. Precertification and Concurrent Review are required for all Skilled Nursing Facility services.

2. What is a Skilled Nursing Facility (SNF)? – A skilled nursing facility is a licensed facility that provides 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 SNF Services. We will provide benefits for SNF services only if the following conditions are met:

   a. you are admitted to the SNF within 28 days of your discharge from a Hospital;
   b. your admission is for ongoing treatment of the condition for which you were hospitalized;
   c. you would otherwise require skilled care as a hospital inpatient if you were not admitted to the SNF; and
   d. you require inpatient skilled nursing or Therapy Services on a daily basis.

4. Skilled Nursing Facility Services. We will provide benefits for the inpatient skilled nursing facility services listed below for up to 45 days 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.

   B. Skilled nursing care.

C. Therapy Services.

D. Drugs, medications, supplies and equipment used in and furnished by the SNF.

E. Other services provided by the SNF that would be covered if you were an inpatient in a hospital.

5. Skilled Nursing Facility Services are covered in full.

## SECTION NINE – SPECIAL COVERED SERVICES

1. Home Care.

A. Prior Approval and Concurrent Review are required for all Home Care Services.

B. What is a home care agency? A home care agency is a hospital or agency licensed or certified to operate as a home care agency.

C. Conditions for Home Care Services. We will provide benefits for home care services under the following conditions.

i. The services are supervised by a participating physician under a written treatment plan.
ii. The services are provided by a participating home care agency.
iii. Without these services you would need to be admitted to a Hospital or Skilled Nursing Facility.

D. Home Care 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. Therapy Services if provided by home health agency personnel.

iv. Medical supplies, drugs, the purchase or rental of durable medical equipment, and laboratory services, to the same extent that such laboratory services would have been covered if you were an inpatient in a Hospital or Skilled Nursing Facility.

E. Copayment. You must pay the Copayment listed on your Copayment Schedule for each home care visit. You must pay the Coinsurance listed on your Copayment Schedule for Durable Medical Equipment.

2. Ambulance Services. We will provide benefits for Hospital, municipal, professional, or licensed voluntary ambulance services to and from a Hospital, between Hospitals, and between a Hospital and a Skilled Nursing Facility. These services are subject to prior approval. Ambulance services are covered in full.

3. Hospice Services.

A. Prior approval and concurrent review are required for all Hospice Services.

B. 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 and must be a Participating Provider.

C. Conditions for Hospice Services.

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

i. A physician certifies and MVP agrees that your terminal illness has a prognosis of 6 month life expectancy or less; and
ii. You and your physician consent to a written Hospice care plan.

D. Hospice Services. We will only provide benefits for the Hospice Services listed below:

i. Up to 210 days of inpatient hospice care in a Hospice or 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 or her 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 gives by providing temporary relief from the duties of caring for the Member's illness.
vii. Durable Medical Equipment
viii. Prescription drugs.

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

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

1. Emergency Services. We will provide benefits for emergency services provided by a Participating or Non-Participating Provider only if your condition is an Emergency Medical Condition.

   A. Emergency services provided by a Participating Provider mean Medically Necessary Covered Services to evaluate and treat an Emergency Medical Condition.

   B. Emergency services provided by a Non-Participating Provider mean Medically Necessary Covered Services to screen and stabilize an Emergency Medical Condition so that you can be safely transported to a Participating Provider. Such services must have been received by you because you were unable to receive services from a Participating Provider.

   C. Emergency Medical Condition 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.

   D. If your condition is an Emergency Medical Condition, you are not required to get a referral from your PCP, or approval from MVP, before receiving emergency services. However, if your condition is not an Emergency Medical Condition, you must pay all charges.

   E. You, your Provider, or a member of your family must call MVP at 1-888-MVP-MBRS within 48 hours, or as soon as reasonably possible, after receiving Emergency services.

   F. Your PCP must coordinate your care after you receive Emergency services.

   G. You must pay the Copayment listed on your Copayment Schedule for Emergency services. You will not have to pay this Copayment if you are admitted to a Hospital right away. However, you must pay the Copayment for Hospital inpatient services.

2. Urgently-Needed Care. We will provide benefits for Urgently Needed Care provided by a Participating or a Non-Participating Provider. However, you must first call your PCP and follow his or her instructions as to what you should do.

   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. You, your Provider, or a member of your family must call MVP at 1-888-MVP-MBRS within 48 hours, or as soon as reasonably possible, after receiving Urgently-Needed Care.

   D. Your PCP must coordinate your care after you receive Urgently-Needed Care.

   E. You must pay the applicable Copayment listed on your Copayment Schedule. You will not have to pay this Copayment if you are admitted to a Hospital right away. However, you must pay the Copayment for Hospital inpatient services.

3. Ambulance Services. We will provide benefits for ambulance services, when used for an Emergency Medical Condition. Ambulance services are covered in full.

## SECTION ELEVEN – 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 or her 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 10.

2. Covered Services. We will provide benefits for the following professional care and services at the office of a participating provider. Except as otherwise provided, you must pay the Copayment listed on your Copayment Schedule for each visit.

   A. Preventive Care Services. These services must be provided by a Participating Provider, but need not be Medically Necessary.

      i. Well Child Care. We will provide benefits for Well Child Care for covered children from the date of birth through attainment of age 19, when provided by your 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 clinical laboratory. All well child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics. 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.

ii. Periodic Health Evaluations. We will provide benefits for periodic routine physical examinations and immunizations for covered persons age 19 and older as determined appropriate by age and sex, when provided by your PCP.

iii. Gynecological Health Care Services. We will provide benefits for 2 visits per Calendar Year for gynecological health care services provided by a Participating Provider. Gynecological health care services means preventive and routine reproductive health and gynecological care, including contraceptive services. Such services include annual screening, counseling and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. 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. However, the Provider must discuss the services and treatment plan with your PCP. The Provider must provide your PCP with all relevant and necessary medical information relating to your treatment.

iv. Mammography Screenings. We will provide the following benefits for mammography screening for breast cancer:

(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.

B. Participating Provider Office or Home Visits. We will provide benefits for the examination, diagnosis, and treatment of an injury, illness or condition, and for prenatal and postpartum care, and laboratory services provided at the time of such visit. Coverage includes injections given during a covered office visit. No PCP referral is required for prenatal care and post partum visits.

C. Health Education and Nutrition Counseling. We will provide benefits for health education and nutritional counseling when provided by Participating Providers as part of a medical treatment program.

D. Consultations. We will provide benefits for inpatient or office consultations by Participating Providers when requested by your attending physician for the evaluation of your condition. A report must be given to your PCP.

E. Second Surgical Opinions. We will provide benefits for a second surgical opinion when your provider has made a recommendation on the need for covered elective surgery. You are not required to have a second surgical opinion. The second opinion must be given by a participating board-certified specialist who examines you and who, by reason of his or her specialty, is competent to consider the proposed surgery. The specialist who gives the second opinion must not perform the surgery.

F. Treatment of Mental Health Conditions. We will provide benefits for treatment of mental health conditions only when provided by a licensed or certified mental health professional who is a Participating Provider.

G. Treatment of Alcohol or Substance Dependency. We will provide benefits for treatment of alcohol or substance dependency only when provided by a substance abuse counselor or other person approved by the secretary of human services who is a Participating Provider.

H. Chiropractic Treatment. We will provide benefits for clinically necessary chiropractic services, provided by a participating licensed chiropractic physician, for treatment of conditions related to subluxations, joint dysfunctions, and neuromuscular and skeletal disorders. 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 the lesser of the Copayment listed on

your Copayment Schedule or the Coinsurance listed on your Copayment Schedule.

J. Allergy Tests and Treatment. We will provide benefits for diagnosis and treatment of allergies by Participating Providers, including test and treatment materials.

K. Inpatient Medical Care. We will provide benefits for medical services rendered when you are receiving covered inpatient services in: (1) a participating Hospital or Skilled Nursing Facility; (2) a participating mental health care facility or institution for the treatment of alcohol or substance dependency; or (3) a participating physical rehabilitation facility. We will only provide benefits for one visit per day per Participating Provider. These services are covered in full.

L. Surgery. We will provide benefits for surgery and surgical care rendered by a Participating Provider. These services, when provided in the outpatient department of a hospital or in a free standing ambulatory surgery center, are subject to prior approval.

M. 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. Following a covered mastectomy, we will 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, but you must pay the Coinsurance listed on your Copayment Schedule for external prosthetic devices. These services must be rendered by a Participating Provider.

N. Anesthesia Services. We will provide benefits for anesthesia services provided by a Participating Provider in connection with Covered Services. These services are covered in full.

O. Laboratory Services. These services must be provided by a Participating Provider and are covered in full.

P. Diagnostic Services. These services must be provided by a Participating Provider.

Q. Therapeutic Services. These services must be provided by a Participating Provider.

R. Casts and Dressings. These services must be provided by a Participating Provider.

S. Medical Foods. We will provide benefits for low protein modified food products and medical foods prescribed by 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 the Coinsurance listed on your Copayment Schedule.

T. Craniofacial Disorders. We will provide benefits for Participating Provider services for diagnosis and treatment, including surgical and non-surgical procedures, of a musculoskeletal disorder that affects any bone or joint in the face, neck or head provided that such disorder is the result of accident, trauma, congenital defect, developmental defect, or pathology. Surgical procedures require a second opinion as set forth in paragraph 2(E) above, and are subject to prior approval requirements. We will not provide benefits for the diagnosis and treatment of dental conditions or disorders or for dental pathology primarily affecting the gums, teeth, or alveolar ridge. We will also not provide benefits for prescription or non-prescription drugs prescribed or recommended by a dentist. You must pay the Copayment and Coinsurance amounts applicable to the particular services you receive.

U. Therapy Services. These services must be provided by a Participating Provider.

V. Durable Medical Equipment. We will provide benefits for the purchase, rental, procurement, repair or replacement of Durable Medical Equipment authorized by a Participating Physician and obtained from a Participating Provider. The option of whether to rent or purchase authorized Durable Medical Equipment is at the sole discretion of MVP. You must pay the Coinsurance listed on your Copayment Schedule.

W. Transplant Services/Donor Costs. We will provide benefits for organ and bone marrow Transplant Services, including transplant surgeries only when such services are obtained through MVP's Transplant Network. You may obtain a description of this Network by calling the MVP Member Services Department at 1-888-MVP-MBRS. Transplant Services are subject to prior approval. MVP will also provide benefits for live donor medical expenses up to your coverage limitations and after payment of your expenses. You must pay the Copayment and Coinsurance amounts applicable to the particular services you receive. The cost of outpatient drugs associated with these services will not be covered.

X. External Prosthetic Devices. We will provide benefits for the purchase, repair and replacement of External Prosthetic Devices, and for medical appliances, including breast prostheses and ostomy supplies, when authorized by a Participating Physician and obtained from a Participating Provider. Custom prosthetics will not

be covered if a standard device exists, unless a custom device is Medically Necessary; you must pay the Coinsurance listed on your Copayment Schedule.

Y. Preventive Dental Care for Children. We will provide benefits for the following Dental Services for MVP Members to age 19 when such services have been recommended, approved and certified as necessary and reasonable by a licensed dentist and rendered by a licensed dentist:

1. Dental Services. One initial oral examination per child; periodic oral examinations once every six months; bitewing x-rays, once every six months; full mouth x-rays and panoramic x-rays, once every 36 months; routine cleaning, scaling and polishing of teeth, once every six months; fluoride treatments, once every six months; pulp vitality testing, as needed; diagnostics casts as needed; sealants, once per tooth per child up to age 16; space maintainers and recementation thereof, as needed; intra-oral and periepical x-rays, as needed.

2. You must pay the Copayment listed on your Copayment Schedule.

3. You may see the licensed dentist of your choice to receive the benefits described in this paragraph X. These benefits will be provided without requiring a referral from your PCP. However, the provider must provide your PCP with all relevant and necessary medical information about your treatment. Your provider may require you to pay for the services at the time rendered in which case you should submit the claim to the address below and you will be reimbursed in full, less your applicable Copayment. You may obtain a claim form by calling the MVP Member Services Department at 1-888-MVP-MBRS. Claim forms must be mailed to: Dental Benefit Providers 7200 Wisconsin Avenue, Suite 800, Bethesda, Maryland 20814. Claims for Dental Services must be filed as soon as reasonably possible, but not later than one year after the service is performed. Claims filed later than one year from the date of service will not be covered.

4. In addition to Section 12, the following Dental Services are also excluded from coverage: Services which are not approved by the Council of Dental Therapeutics of the American Dental Association; Coverage of hospitalization for any dental procedures; Implantation or pharmacological regimens; and Drugs obtainable with or without a prescription, when prescribed or recommended by a dentist.

Z. Vision Exams. We will provide benefits for a Vision Exam once every two Calendar Years. A Vision Exam means an eye care exam for prescribing, fitting or determining your need for eye glasses or contact lenses. You must pay the Copayment listed on your Copayment Schedule. You may see the participating optometrist or ophthalmologist of your choice to receive the benefits described in

this paragraph AA. These benefits will be provided without requiring a referral from your PCP. However, the provider must provide your PCP with all relevant and necessary medical information about your treatment.

## SECTION TWELVE – EXCLUSIONS

In addition to any exclusions and limitations 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 must pay the difference between the charge for the private room and the charge for a semi-private room.

   B. Any inpatient days that are mostly for Custodial Services or social programs.

   C. Any inpatient days that are mostly for diagnostic purposes, such as x-rays, laboratory tests, or physical checkups, unless Medically Necessary.

   D. An inpatient stay while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available to you.

   E. Except as specifically provided in Section 11, paragraphs 2(T) and 2(Z), we will not provide benefits for inpatient services for dental services.

   F. We will not provide benefits for charges because you did not leave your room at the discharge time.

   G. We will not provide benefits for services provided by a private duty nurse, unless they are Medically Necessary and prior approved by MVP.

   H. We will not provide benefits for non-medical or items including, but not limited to, telephone, television, beauty and barber services, guest trays, guest services and accommodations.

   I. We will not provide benefits for items that you take home from the Hospital.

2. Services Not Covered. We will also not provide benefits for the following:

   A. Services Starting Before Coverage Begins. If you are receiving services on the day your coverage under this Certificate begins, we will not provide benefits for any services you receive:

      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.

If the service is not covered and are not required to be covered under any other health benefits certificate, program or plan, MVP will provide benefits provided that you comply with the terms of this Certificate.

B. Non-Covered Services. We will not provide benefits for any services not listed in this Certificate as a Covered Service or any service that is related to services not covered under 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 received without a referral from your PCP.

F. Non-Standard Allergy Services. We will not provide benefits for non-standard allergy services, including, but not limited to skin titration, cytotoxicity testing, treatment of non-specific candida sensitivity and urine autoinjections.

G. Alternative Services. We will not provide benefits for alternative or complementary health services, products, remedies, treatments and therapies including, but not limited to acupuncture, biofeedback, massage therapy, hypnosis and hypnotherapy, naturopathy, homeopathy, primal therapy, chelation 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.

H. 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.

I. 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.

J. Certification Examinations. Except as specifically provided in Section 11, paragraph 2(A)(ii), we will not provide benefits for any services related to routine physical examination and/or testing to certify health status, including, but not

limited to, examinations required for school, employment, insurance, marriage, licensing, travel, camp, sports, or adoption.

K. Chiropractic Services. We will not provide benefits for chiropractic services, as set forth in Section 11, paragraph 2(H), when such services are performed by a provider other than a licensed chiropractic physician, including but not limited to doctors of osteopathy.

L. Communication Devices. We will not provide benefits for the purchase, rental, repair, replacement or maintenance of devices for speaking, listening, or otherwise communicating, including, but not limited to telecommunication devices for the deaf (TDDs) and teletype machines (TTYs), or for services for evaluation, fitting, or modification of such devices.

M. Cosmetic Services and Surgery. We will not provide benefits for any services or surgery which are primarily intended to improve your appearance. We will provide benefits for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, including breast reconstruction and symmetry surgery as described in Section 6, paragraph 6 and Section 11, paragraph 2(M). We will also provide benefits for reconstructive surgery because of congenital disease or anomaly of a covered newborn child.

N. Court-Ordered Services. We will not provide benefits for court-ordered services or services required as a condition or probation or parole. Such services include, but are not limited to special medical reports not directly related to treatment and reports prepared in connection with legal actions unless they are Medically Necessary Covered Services.

O. Criminal Behavior. 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.

P. Custodial Services. We will not provide benefits for Custodial Services or for bed rest or convenience reasons.

Q. Dental Services. Except as specifically provided in Section 11, paragraphs 2(T) and 2(Z), we will not provide benefits for dental services, including, but 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. We will also not provide benefits for temporomandibular joint disease or dysfunction where such disease or

dysfunction is dental in nature. We will also not provide benefits for inpatient or outpatient hospital services in connection with dental services unless such services are Medically Necessary and precertified by MVP.

R. Dietician Services. Except as specifically provided, we will not provide benefits for dietician services, homemaker services, home delivered meals, or other food or food-related services.

S. Disposable Medical Supplies. Except as specifically provided, we will not provide benefits for disposable medical supplies including, but not limited to diapers, chux, sponges, syringes, needles, incontinence pads, reagent strips, catheters, elastic support stockings, compressive garments, dressings, and bandages.

T. Educational Services. We will not provide benefits for services required to determine appropriate educational placements or services or for other educational testing. We will also 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, including, but not limited to therapy services, cognitive retraining and rehabilitation, treatment of behavioral disorders and behavioral training, services for remedial education, evaluation and treatment of learning disabilities, interpreter services and lessons in sign language.

U. Employer Services. We will not provide benefits for any services furnished by a medical department or clinic provided by your employer.

V. 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. However, 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. Phase I and II clinical trials, whether or not sanctioned by the United States Food and Drug Administration, are excluded.

W. Exploratory Counseling. We will not provide benefits for exploratory counseling for personal growth and development or other similar reasons.

X. Family Services. We will not provide benefits for services provided by your immediate family.

Y. Foot Care. We will not provide benefits for routine or palliative foot care, including but 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. However, we will provide benefits for Medically Necessary foot care.

Z. Free Services. We will not provide benefits for any services provided to you without charge or services that would normally be provided without charge.

AA. 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.

BB. 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 10 are satisfied or for otherwise covered services provided for non-military service related conditions.

CC. Home Modifications and Fixtures. We will not provide benefits for the purchase, rental, repair, replacement or maintenance of home modifications and fixtures including but 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.

DD. Late Submitted Charges. We will not provide benefits for charges for services rendered by Participating Providers which are submitted to MVP more than one hundred eighty (180) days after the date of service, except when coordination of benefits applies and MVP is the secondary payor. We will not provide benefits for charges for services rendered by Non-Participating Providers which are submitted to MVP more than twenty-four (24) months after the date of service, or twelve (12) months after the date of service for Preventive Dental Services obtained under Section 12, paragraph 2(Z), except when coordination of benefits applies and MVP is the secondary payor.

EE. Prescription Drugs. We will not provide benefits for prescription drugs except for: (i) those that are administered to you in the course of covered outpatient or Inpatient treatment in a Hospital, through Covered Home Care or Hospice Services, or for immunizations; (ii) medical foods prescribed for the Medically

Necessary treatment for an inherited metabolic disease in accordance with Section 11, paragraph 2(S); and (iii) drugs prescribed for the Medically Necessary treatment of diabetes in accordance with Section 11, paragraph 2(I).

FF. 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 the Veteran's Administration is responsible for providing such services.

GG. No-Fault Automobile Insurance. We will not provide benefits for any service which is covered by mandatory automobile no-fault benefits or applied to the no-fault deductible. This exclusion applies even if you do not make a proper or timely claim for benefits available to you under any available no-fault policy 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 receive money from that lawsuit and have repaid the medical expenses you received payment for under the no-fault policy.

HH. Orthotic Devices. We will not provide benefits for orthotic devices, including but not limited to custom made shoes, orthopedic shoes, arch supports, elastic support stockings and shoe inserts, or for services for evaluation, fitting, or modification of such devices.

II. 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.

JJ. Reproductive Procedures. We will not provide benefits for any services for or related to artificial means to induce pregnancy, including but 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.

KK. Reversal of Elective Sterilization. We will not provide benefits for reversals of elective sterilization.

LL. Self-Help Education and Training. Except as specifically provided, we will not provide benefits for self-diagnosis, self-treatment or self-help training.

MM. Smoking Cessation Services. We will not provide benefits for programs to help you stop smoking.

NN. 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.

OO. Support Therapies. Except as provided in Section 9, paragraph 3, we will not provide benefits for support therapies including, but not limited to, family counseling, marriage counseling, pastoral or religious counseling, sex counseling, or other social counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, and stress management.

PP. Transsexual Surgery and Related Services. We will not provide benefits for any services related to or leading up to transsexual surgery, including 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.

QQ. 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.

RR. Unlicensed Provider. We will not provide benefits for services provided by an unlicensed provider or are outside of a provider's scope of practice.

SS. Vision and Hearing Examinations, Therapies and Supplies. Except as provided in Section 11, paragraph 2(AA), 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, for eyeglasses, lenses, frames, contact lenses or hearing aids, for vision or hearing therapy or training, vision perception training or orthoptics, or for the correction of refractive errors by means of any surgical or other procedures, including radial keratotomy, or for services for disorder of vision correction or accommodations. However, we will provide for Medically Necessary eye and ear care.

TT. 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, or for surgical weight loss procedures including, but not limited

to gastric stapling, gastric by-pass, and gastric bubble. We will provide benefits for Medically Necessary Covered Services for the treatment of morbid obesity. Morbid obesity is defined as weighing more than twice the ideal amount specified for your frame, age, height and sex in the most recent generally accepted life insurance tables.

UU. Workers' Compensation. Except for sole proprietors and partners who are not voluntarily covered under a workers' compensation insurance 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. 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 THIRTEEN - TERMINATION OF YOUR COVERAGE

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

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, your coverage will automatically terminate on the date of discontinuance of your group membership, or the date to which your premium is paid, whichever is sooner. See Section 14 as to how you may obtain 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 is required to give you prior written notice if the group contract is terminated.

   C. On Your Death. If you have individual coverage, your coverage will automatically terminate on the date of your death. If you have two person or family coverage, coverage will automatically terminate on the date of your death, or the date to which your premium is paid, whichever is sooner. Your Spouse or Dependents must immediately notify us of your death. However, your Spouse and/or Dependents may request substantially similar replacement coverage. See Section 14 as to how your Spouse and/or Dependents may obtain 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 immediately notify us of any such dissolution. See Section 14 as to how your Spouse may obtain continuation and conversion coverage.

E. Termination of Coverage of a Child. Your child's coverage under this Certificate will automatically terminate on the last day of the month following the earliest of the following dates, or the date to which your premium is paid, whichever is sooner: (a) the child reaches age 19; (b) marries; or (c) is no longer chiefly dependent upon you for support and maintenance. If your child is covered pursuant to Section 3, paragraph 2(D)(iii), the child's coverage will automatically terminate on the earliest of 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. You must immediately notify us when your child is no longer eligible for coverage. See Section 14 as to how your child may obtain 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 evidence 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.

You must immediately notify us 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. We will give you 30 days prior written notice:

A. Fraud or Misrepresentation. MVP will immediately terminate your coverage for any fraud or material misrepresentation made by you when you enrolled or 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.

B. Discontinuance of Class of Certificate. We discontinue the entire class of Certificates to which this Certificate belongs. We will offer you coverage under a replacement plan. 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 or no longer work in Vermont. MVP will also refuse to renew your coverage if you will not be a resident of Vermont or will not be working in Vermont on or after your group's renewal date. 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 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 on the date your coverage terminates, and such Total Disability 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. This extension of benefits will continue until the earliest of: (1) the date you are no longer Totally Disabled; or (2) 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 and we will not provide benefits for any services covered or required to be covered under any other insurance plan or Contract.

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.

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 FOURTEEN - POST TERMINATION CONTINUATION OF COVERAGE; CONVERSION TO A DIRECT CONTRACT

If your coverage under this Certificate terminates under the circumstances described below, you may be able to continue coverage in some circumstances or to purchase a new contract available to nongroup Subscribers:

1. Continuation Coverage:

   A. Under Federal COBRA 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, the opportunity for continuation of health insurance coverage when their coverage would otherwise end. 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 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.

   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 or the death of the Subscriber, 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:

      (i) the deceased or terminated Subscriber was not covered under this Certificate during the entire 3 month period preceding the death or termination;
      (ii) the Member seeking continuation coverage is or could be covered by Medicare;
      (iii) 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
      (iv) the Subscriber's termination of employment was due to misconduct as defined by Vermont law.

1. Written Request for Continuation:

   (i) A member who wishes to elect continuation coverage must request continuation in writing to the group within 60 days if the Subscriber is deceased, or 30 days if the Subscriber has been terminated, of the earlier of the date that coverage under this Certificate would otherwise terminate or the date the Member is given notice of the right to continuation. The Member's applicable premium contribution must be included with this election.

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

   i. 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

   ii. 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; or

   iii. the member is or could be covered by Medicare; or

   iv. 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.

2. 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 Member may purchase a direct contract with MVP in accordance with the following rules:

The following Members may purchase an individual, direct payment contract from MVP, without evidence of insurability, under which no pre-existing condition exclusion period will be applied to him or her.

A. HIPAA Eligible Individual; or

B. Any person who produces evidence of continuous health benefit coverage during the 9 months immediately prior to his or her effective date under the individual direct payment contract; or

C. 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; or

D. 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; or

E. 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, without evidence of insurability. However, a pre-existing condition exclusion period may be imposed.

Credit Towards The Twelve Month Pre-Existing Condition Exclusion Period – 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. Creditable coverage includes:

(1) Coverage provided under a group health plan such as an employer plan.

(2) A health insurance policy or Certificate.

(3) Self-insured group health benefit plans.

(4) Medicaid.

(5) Medicare.

(6) Government-sponsored health benefit programs such as CHAMPUS/TRICARE, Peace Corps, or Indian Health Service.

(7) Federal Employees Health Benefits Program.

(8) A State health benefits risk pool.

(9) Coverage under any health insurance plan sponsored by a state, county or other political subdivision.

Creditable coverage does not include:

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

Please see your Member Handbook for the method we use to count creditable coverage and for information about getting a certificate of creditable coverage.

F. 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.

G. Circumstances Under Which Conversion is Not Available. MVP is not required 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; or (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.

4. Supplementary Suspension, Continuation and Conversion Coverage. To the extent required by law, if you, the Subscriber, enter active duty but the Group does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect in writing to the Group, within 60 days of being ordered to active duty, to continue coverage under this Certificate for yourself and eligible Dependents. Such continued coverage shall not be subject to evidence of insurability. You must pay the required Premium in advance to the Group, but not more frequently than once a month.

A. This paragraph applies only to the extent required by law and only if you are 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:

i. voluntarily or involuntarily enter upon active duty (other than for the purpose of determining your physical fitness and other than for training); or

ii. 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 to the Federal Government.

B. Supplementary continuation shall not be available to any person who is, or could be, covered by Medicare or any other group coverage. Coverage available through the Federal government for active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.

C. In the event that you are reemployed or restored to participation in the group upon return to civilian status after the period of continuation coverage or suspension, you (and your covered dependents if other than individual coverage applies), shall be entitled to resume coverage under this Certificate. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty provided the applicable premium has been paid from that date. No exclusion or waiting period shall be imposed in connection with resumed coverage except regarding:

i. A condition that arose during the period of active duty and that has been determined by the U.S. Secretary of Veteran's Affairs to be a condition incurred in the line of duty; or

ii. A waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

In the event that you are not reemployed or restored to participation in the Group upon return to civilian status, you may, within 31 days of the termination of active duty, or discharge from hospitalization incident to active duty which continues for a period of not more than one year, submit a written request for Continuation Coverage to the Group, or a request for Conversion Coverage directly to MVP, as described elsewhere in this Certificate.

D. The maximum period of Supplementary Continuation Coverage for the Subscriber and his or her Dependents shall be the lesser of: (1) the 18 month period beginning on the date on which the Subscriber's absence begins; or (2) the day after the date on which the Subscriber fails to apply for or return to a position of employment, as determined by federal law.

## SECTION FIFTEEN – 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.. We will not provide benefits for any service or care for which benefits are payable under Medicare. When you are eligible for Medicare, we will reduce our benefits by the amount Medicare would have paid for the services or care. This reduction is made even 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.

2. If you are eligible for Medicare, this exclusion will not apply if:

   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 this exclusion does not apply and MVP is the Primary Plan, MVP will provide benefits under the terms of this Certificate.
   B. 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 this exclusion does not apply and MVP is the Secondary Plan, you must follow Medicare's rules, the terms of this Certificate, and pay all Deductible, Copayments, 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.

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 SIXTEEN - COORDINATION OF BENEFITS

This Section applies only if you have other group health benefits with another group health plan.

1. When You Have Other Health Benefits. You may be covered by two or more health plans which provide similar benefits. If you receive a service which 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 which were not covered by the Primary Plan.

2. The following are considered to be health plans:

   A. Any 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 and any plan whose benefits are, by

law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and

E. Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.

3. Rules to Determine Payment. In order to determine which plan is the Primary Plan, certain rules have been established:

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 2(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. In the event that MVP is considered to be the secondary payor, you are required to follow the rules and procedures of the primary plan before MVP will make payment. If MVP is to make payment on a secondary basis, the rules and procedures of MVP as otherwise stated in this Certificate must also be followed. 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. However, 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 benefits greater than we should have under this provision, we have the right to recover the overpayment from you or from any other person, insurance company, or organization which may have gained from our overpayment. When the overpayment includes services which you received under this Certificate, the amount of the overpayment will be based on prevailing rates for those services. You agree to do whatever is necessary to help us to recover our excess payment, including but 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 all applicable Copayments.

   In the event that you receive 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.

## SECTION SEVENTEEN
## THIRD PARTY LIABILITY AND RIGHTS OF REPAYMENT

1. Introduction. If MVP provides benefits to a Member 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. MVP may recover the full cost of all benefits provided by MVP without regard to any fault by the Member.

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. MVP 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 undersinsured 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.

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:

      (1) 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;
      (2) providing any relevant information;
      (3) obtaining the consent of MVP before releasing any party from liability for payment of medical expenses;

(4) taking such other actions as may be needed to assist MVP in making a full recovery of the cost of all benefits provided; and

(5) 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, a Member shall be responsible for all benefits provided by MVP in addition to costs, attorneys' fees, and interest incurred by MVP in obtaining repayment.

## SECTION EIGHTEEN – 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 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.

(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 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. 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 grievances as follows:

   A. Grievances related to Emergency Services or Urgently-Needed Care and in cases where:

      (i) application of the time periods described in subparagraph B below:

         (A) could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or

         (B) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or

      (ii) a physician with knowledge of your medical condition determines that a precertification, concurrent review or prior approval request is urgent.

      MVP will notify you of our decision within 24 hours after our receipt of the grievance. In cases involving mental health conditions, a licensed mental health review agent will make a decision within 24 hours of the date the grievance is submitted. You will be notified of our decision by telephone and in writing.

   B. All other Grievances. MVP will notify you of our decision within 15 days after our receipt of the grievance. In cases involving mental health conditions, a licensed mental health review agent will make a decision within 10 days of the date the grievance is submitted. You will be notified of our decision in writing.

6. Time Limit for Submitting a Second Level Grievance. In cases not involving Mental Health Conditions, 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. 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 also 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 Conditions, please see paragraph 8 below.

7. MVP's Response to Second Level Grievances. MVP will respond to second level grievances as follows:

   A. Grievances related to Emergency Services or Urgently Needed Care and in cases where:

      (i) application of the time periods described in subparagraph B below:

         (A) could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or

         (B) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or

      (ii) a physician with knowledge of your medical condition determines that a precertification, concurrent review or prior approval request is urgent.

      MVP will notify you of our decision within 48 hours after our receipt of the grievance. You will be notified of our decision by telephone and in writing.

   B. All other Grievances. MVP will notify you of our decision within 15 days after our receipt of the grievance. You will be notified of our decision in writing.

8. Review of First Level Grievance Decisions in Cases Involving Mental Health Conditions. In cases involving Mental Health Conditions, 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 BISHCA. You must contact BISHCA at 1-800-631-7788 for assistance in submitting this appeal.

9. Independent External Review.

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. You may request an independent external review 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 obtain 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 contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact 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 obtain 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 obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## SECTION NINETEEN - GENERAL PROVISIONS

1. Assignment. Only you are eligible for benefits under this Certificate. You cannot assign your right any benefits due under this Certificate to any person, corporation or other organization, your right to collect for those benefits, or your right to bring legal action against us. Any such assignment shall be null and void and, at our option, may result in termination of your coverage.

2. Notices. Any notice which we give you will be mailed to you at your address as it appears in our records. You must immediately notify MVP 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 become covered under this Certificate, you automatically authorize each and every provider to:

   A. disclose to MVP all facts about your care, treatment, and condition to assist us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

   B. give reports about your care, treatment and condition to assist us in reviewing a treatment of claim; and

   C. permit MVP to review and copy your records.

   Further, at any time requested by us, you will provide us with a signed authorization to obtain your records for these purposes. We have the right to deny benefits under this Certificate if you refuse to provide us with such authorization. We will maintain your medical records in accordance with state and federal confidentiality laws. However, you automatically authorize us to provide your medical records to BISHCA or other quality oversight organizations.

4. Changes to this Certificate.

   A. We may change the terms of this Certificate and modify 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.

   B. This Certificate may not be modified, amended or changed, except in writing, and signed by our Chief Executive Officer.

5. Time to File Claims. Claims for services rendered by Participating Providers under this Certificate must be submitted to us for payment within 180 days after the date of service. Claims for services rendered by Non-Participating Providers must be submitted to us for payment within 24 months after the date of service.

6. Who Receives Payment Under this Certificate. Payments for Covered Services provided by a Participating Provider will be made by us directly to the provider. When services are provided by a Non-Participating Provider, you or the provider must submit a claim to MVP. Payments may be made to you or to the provider.

7. Legal Action. No legal action may be maintained against us prior to exhaustion of the grievance process specified in Section 18. You must start any lawsuit against us within 3 years from the date we made a second level grievance decision. 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.

8. 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.

9. MVP's Relationship with Providers. MVP and Participating Providers have an independent contract relationship. 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. Participating and Non-Participating 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 most 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, MVP may pay the provider's charges or a different rate negotiated with the provider or with an out of system provider network.

10. Termination of Participating Providers. A provider's participation with MVP may be terminated at any time by MVP or the provider. In such event, MVP shall provide notice to affected members within fifteen (15) days of our receipt of a notice of termination without cause or the date of a termination for cause. Covered Services rendered by the provider 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. Thereafter, we will not provide benefits for services rendered by the terminated provider. If the Member's PCP is the terminated provider, the Member must select another PCP. If a non-primary care physician is the terminated provider, the Member must be referred by

his or her PCP to another Participating Provider. It is your responsibility to ensure that a provider is a Participating Provider at the time you receive 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) sixty (60) 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 receiving services from the terminated provider until the completion of postpartum care. We will provide these benefits only if the terminated provider agrees to abide by MVP's payment rates, quality of care standards and protocols, and to provide MVP with any necessary clinical information.

11. Use of Non-Participating Providers by New Members. We will provide benefits for Covered Services for new Members with life threatening, disabling or degenerative conditions who are receiving an ongoing course of treatment from a non-participating provider until the earlier of: (1) sixty (60) days from the date of enrollment or (2) the date the Member is accepted by a participating provider. We will also provide benefits for Covered Services for new Members in their second or third trimester of pregnancy who are receiving services from a Non-Participating Provider until the completion of postpartum care. We will provide these benefits only if the Non-Participating Provider agrees to abide by MVP's payment rates, quality of care standards and protocols, and to provide MVP with any necessary clinical information.

12. Other Use of Non-Participating Providers. Except as otherwise specifically provided in this Certificate, in order for services to be eligible for benefits under this Certificate, services must be provided by your PCP or by a Participating Provider pursuant to a referral from your PCP. However, in circumstances where a qualified Participating Provider is not available to provide Covered Services to a Member, MVP may provide benefits for Covered Services provided by a Non-Participating Provider. When seeking benefits for Non-Participating Provider services in these circumstances, your PCP must comply with the precertification or prior approval requirements set forth in Section 5, and provide information regarding 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.

13. 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.

14. Construction and Interpretation of this Certificate. Except as otherwise provided by law or regulation, MVP has the authority to determine to whether and to what extent Members are entitled to coverage and benefits and to construe disputed or unclear terms under this Certificate. MVP shall be deemed to have properly exercised such authority unless it acts arbitrarily and capriciously. In the event of any dispute or question

concerning enrollment, eligibility, coverage, or other terms and conditions, this Certificate controls over the MVP Vermont Member Handbook or other sources of general information issued by MVP.

15. 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. In the event of a dispute concerning the provision or denial of benefits, MVP may require that a Member be examined, at MVP's expense, by a provider designated by MVP.

16. 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.

17. Recovery of Overpayments. If we make a payment to you in error, we will explain the problem to 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.

18. Waiver. MVP's waiver or failure to insist on strict performance of this Certificate shall not be considered a waiver or act as a bar to any decision or action for subsequent acts of non-performance.

19. Time Limit on Certain Defenses. After 3 years from the effective date of this Certificate, no misstatements, except fraudulent misstatements, made by the Subscriber or his or her Dependents 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.

20. Choice of Law. Unless federal law applies, this Certificate shall be governed by the laws of Vermont.

21. Severability. The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

# MVP HMO 15

| SERVICES RENDERED | COPAY |
|---|---|
| **Physician Services** | |
| Office Visits | |
| Well Baby and Child Care | $15 Copay/Office Visit |
| Periodic Physicals, Gynecological Exams | $15 Copay/Office Visit |
| Vision Exams Every 2 Years, Surgery | $15 Copay/Office Visit |
| Laboratory Services | No Charge |
| Second Surgical Opinions (Not Required) | $15 Copay/Office Visit |
| Pap Tests, X-Ray Services | $15 Copay/Office Visit |
| Hospital Services | |
| Surgery | No Charge |
| Anesthesiology | No Charge |
| Radiology | No Charge |
| Visits/Consultations | No Charge |
| **Hospital** | |
| Hospital Inpatient | $240 Copay/Admission** |
| Hospital Outpatient–Surgery | 20% or $100 Copay/Visit† |
| Hospital Outpatient–Lab & X-Ray | No Charge |
| Hospital Outpatient–Therapeutic Services | $15 Copay/Visit |
| **Maternity** | |
| Physician Services | No Charge |
| Hospital Services | No Charge†† |
| Nursery Care | No Charge |
| **Emergency Hospital Care** | |
| In-Area (Copay Waived when Followed by Hospitalization)†† | $50 Copay/Visit |
| Out-of-Area | No Charge†† |
| **Ambulance** | No Charge |
| **Preventive Dental Care For Kids** | |
| (Please Check with Your Employer to Find Out if Your Plan Includes This Benefit)* | |
| Periodic Exams and X-Rays to Age 19 | $10 Copay/Office Visit |
| **Chiropractic Benefit** | |
| Requires PCP Prescription | $15 Copay/Office Visit |
| **Durable Medical Equipment** | 20% Copay |
| **Mental Health/Substance Abuse Diagnosis & Treatment** | |
| Inpatient | No Charge†† |
| Outpatient | $15 Copay/Office Visit |
| **Physical Therapy** | |
| Requires PCP Prescription | |
| Short Term Only–2 Month Maximum | $15 Copay/Office Visit |
| **Home Health Care** | $15 Copay/Visit |
| **Lifetime Maximum Coverage** | No Maximums |

*This benefit is offered through MVP Health Plan, Inc. as part of the fully-insured, community-rated HMO product only and thus may not be available to employees of companies who offer other MVP options or who offer other dental plans and is not available to MVP CompCare members. Please call MVP Marketing at 1-800-TALK-MVP if you have questions.

**The $240 Copay will apply to the first admission only per member; per calendar year.

†Whichever is less.

††Subject to Hospital Inpatient Copay, excluding newborns.

Exclusions: Services by non-participating providers (unless emergency or authorized by MVP), custodial care, employment or insurance physicals, personal comfort items, experimental procedures, cosmetic surgery, family planning and infertility services, reversal of voluntary sterilization, eye glasses/contact lenses, routine foot care, dental care for adults and TMJ. Benefits are covered when delivered, arranged or authorized by a member's Primary Care Physician. Services provided by non-participating physicians are not covered unless determined to be medically necessary by, and arranged by, an MVP physician and the Medical Director. This chart is intended to provide a general outline of MVP coverage. In the event of any conflict between this document and your Group or Subscriber Contract and any pertinent rider(s), your contract and riders will be controlling. Benefits may vary by state. For details, call 1-800-TALK-MVP.



*Continued on Back*

# Here's How It Works

## You choose a Primary Care Physician

You must choose a Primary Care Physician from our extensive network for you and each covered member of your family. Your current doctor is probably on our list of thousands of participating physicians. Go to joinMVP.com to try a Doctor Search now or call **1-888-MVP-MBRS**.

## Your Primary Care Physician coordinates all your health care

For regular check-ups...ordering prescriptions...if you are sick...or when you need a referral to see a specialist, you will always first see your Primary Care Physician – the doctor who knows you and your medical history.

## You need a referral to see a participating specialist

MVP's network includes physicians from nearly every medical specialty. You must first get a referral from your Primary Care Physician to see a participating specialist.

# Features and Benefits

### Basics

- *Thousands of doctors* to choose from
- *No claim forms or deductibles* – just a low, fixed copay
- A high rating for quality from the *National Committee for Quality Assurance*

### Benefits

- *Comprehensive* preventive and sick care for adults
- *Worldwide emergency coverage*
- *Covered preventive care* including routine immunizations, for children to age 19
- *Preventive Dental Care for Kids to Age 19* – Covered check-ups, X-Rays, cleanings, fluoride treatments and sealants (Please Check with Your Employer to Find Out if Your Plan Includes this Benefit)*
- *Covered eye exams* every two years for all members
- *Complete hospital coverage* – no day or dollar limits
- *Free mammograms*

### Better Service

- Calls answered – *by a real person* – in seconds
- *MVP After Hours* – reach our *Member Services Department* every day through midnight **(1-888-MVP-MBRS)**
- The region's *most advanced health plan Web site* – featuring many convenient services – mvphealthcare.com
- *Mail Order Pharmacy***saves you time and money

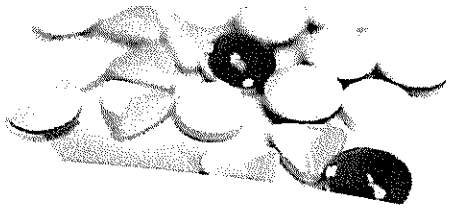
### And Beyond!

- Exclusive *member discounts* on health and safety items, health clubs and beyond
- A variety of *special education programs* for expectant mothers and families

*...and more!*

*This benefit is offered through MVP Health Plan, Inc. as part of the fully-insured, community-rated HMO product only and thus may not be available to employees of companies who offer other MVP options or who offer other dental plans and is not available to MVP CompCare members. Please call MVP Marketing at 1-800-TALK-MVP if you have questions.

**Available with MVP Prescription Rider.



# Prescription Drug Coverage
# $10/$30/$50

## Your MVP Prescription Benefits Rider

Great news! Your employer offers MVP's Prescription Benefits Rider. This valuable benefit entitles you (and your covered dependents) to coverage for thousands of medications on MVP's approved drug list. With your plan, you get formulary generic prescriptions for just $10 and formulary brand name prescriptions for $30. If you are prescribed a non-formulary drug, your copay is $50.

## Rx Made Easy

MVP makes filling your prescriptions easy. Choose from hundreds of participating pharmacies – including one near you. Just show your MVP I.D. card...pay your copay...and pick up your medication. For a complete listing of participating pharmacies, check the MVP *Provider Directory* or go to *"Rx Info"* on our Web site at **mvphealthcare.com**. You may also take advantage of the MVP Mail Order Pharmacy.

## The MVP Prescription Drug Formulary

MVP has in place a "drug formulary," which determines our approved list of covered medications – those proven safe and effective, in the best interests of our members.

MVP's approved list of medications includes thousands of drugs. Every month, new prescription drugs are reviewed for potential addition to our approved list to ensure you have access to the latest advances in medicine. For an updated listing of covered drugs, go to *"Rx Info"* at **mvphealthcare.com** or call **1-888-MVP-MBRS**.

Decisions on which drugs we cover are made exclusively by the MVP Pharmacy and Therapeutics Committee, comprised of primary care and specialty physicians, pharmacists and other health care professionals. No newly introduced drugs are added until the committee has reviewed them. If the committee determines that a new drug represents a significant advantage over existing drugs, it will be considered for addition to our approved list.

Some drugs, while covered in the formulary, may still require prior approval from MVP. Policies specific to these restricted drugs are clearly written and made available to all practitioners.

**YOUR COPAY**
**$10 Formulary Generic**
**$30 Formulary Brand Name**
**$50 Non-Formulary**

## New From MVP: Medco Health Solutions, Inc.

Beginning January 1, 2007, Medco Health Solutions will be MVP's pharmacy benefit manager (PBM) for retail and mail order prescription drug coverage.

For the past five years, Medco has been rated the number one PBM in customer satisfaction for Mail-order Pharmacy, Online Pharmacy, and for the first year, the number one PBM for Medicare Prescription Discount Card Savings, according to the 2005 WilsonRx® *Pharmacy Benefit Satisfaction Report.* Also, **medco.com®** was ranked the number one Web site in the Customer Respect Group's Pharmaceutical and Healthcare Study in 2005.

## Mail Order Pharmacy

Save money and time with Medco By Mail. This home-delivery service lets you buy MVP approved maintenance drugs (drugs taken on a daily or routine basis) in larger quantities. Receive a 90-day supply for the cost of two copayments, or 3-for-2 savings. In addition, Medco By Mail saves you trips to the pharmacy because prescriptions are delivered right to your door. Go to *"Rx Info"* at **mvphealthcare.com**, or call **1-888-MVP-MBRS** for details.

A variety of online tools are available using Medco's Web site, **medco.com**. After creating an online account, you can manage and obtain information about your prescriptions, such as:

- Ordering refills, with a valid prescription
- Transfer retail prescriptions to mail order online
- Order status with estimated delivery date of mail order prescriptions
- Accurate real-time mail and retail drug pricing
- Online mail service and retail history
- Prescription expense summary for mail and retail claims
- E-mail refill reminders
- Online "Ask the Pharmacist" with 24-hour turnaround.



*Continued on back*

# MVP Mail Order Pharmacy Q&A

***Please note: Medco will manage MVP's Mail Order and Retail Pharmacy Programs as of January 1, 2007. Benefits coverage and functionality of the features listed will not be available until January 1, 2007.***

**For questions regarding your Prescription Benefits Rider, please contact the MVP *Member Services Department* toll-free at**

**1-888-MVP-MBRS**

*7 days a week / 8:00 am to 10:00 pm (excluding holidays), Eastern Time*

## What prescriptions can be filled through Medco By Mail?

You can order most medications that are taken on a regular basis, including:

- Endocrine agents including Estrogen, contraceptives, thyroid medications and androgens
- Cardiovascular agents such as cholesterol, blood pressure and angina medications
- Respiratory agents including antihistamines and antiasthmatic agents
- and many more

Visit **mvphealthcare.com** or call **1-888-MVP-MBRS** for a complete listing.

## What are the advantages of Medco By Mail?

When you order qualified drugs through Medco By Mail, you save time (eliminating trips to the pharmacy) and money (generally giving you three months of medications for the cost of only two copayments, or 3-for-2 savings). For instance, with your copay you could save $30 every 90 days if you take a formulary brand name maintenance drug.

## If my MVP Prescription Benefits Rider includes a formulary, does the formulary apply when I order prescriptions by mail?

Yes, the formulary would apply to mail order prescriptions, too.

## How do I use Medco By Mail?

**For your initial order...**

When your doctor prescribes a drug eligible for the mail order program, ask him or her to write two prescriptions – one for up to 30 days to be filled at your local pharmacy, and one to last up to 90 days which will be filled through Medco By Mail.

For mail order prescriptions after January 1, 2007, please mail your prescription, along with a completed order form, to:

*MEDCO*
*PO Box 30493*
*Tampa, FL 33630-3493*

As of December 15, 2006, You may obtain order forms online at **mvphealthcare.com** or by calling **1-888-MVP-MBRS**.

**For mail order refills...**

When you need to refill a prescription that is already on file at MEDCO, simply choose one of the following...

- **Refill by phone:**
  Call **1-800-4REFILL (1-800-473-3455)** toll-free. Select the refill option from the menu and have your Member I.D. number and refill slip with prescription information ready.
- **Refill by mail:**
  Complete the order form enclosed with your most recent refill slip and mail to:
  *MEDCO*
  *PO Box 30493*
  *Tampa, FL 33630-3493*
- **Refill via Internet:**
  Go to **mvphealthcare.com** and click on the Medco link on the member home page and logon onto MVP's **medco.com** Web site.

## How long will it take to receive my prescription?

When you order by mail, you will receive your first prescriptions generally within 14 days. Standard shipping is free, and expedited shipping is available for an additional fee. To ensure that you do not run out of medication, MVP recommends that you allow two to three weeks for your order to be processed and shipped.

## How can I pay for my prescriptions?

Checks, money orders or major credit cards can be used to cover your copayments. Credit cards are preferred to allow for variations in the prices of drugs.

## Can I speak with a pharmacist if I use the Medco By Mail benefit?

Yes! Pharmacists are available to answer questions or concerns regarding your medication toll-free at **1-800-716-3752**. In an emergency, a pharmacist will respond to your call promptly 24 hours a day.

**MVP HEALTH PLAN, INC.**
**RIDER R142-V**
**RIDER FOR $500 INPATIENT HOSPITALIZATION COPAYMENT**

This Rider amends the terms of your MVP Health Plan, Inc. Certificate of Coverage (the "Certificate"), as follows:

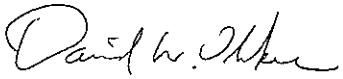
1. The Copayment for Inpatient Hospital Services shall be $500.

2. **Benefits Not Extended in Event of Point of Service (POS) Rider.** The benefits contained in this Rider do not extended to the "out-of-system" benefits provided in the event the group has purchased, and the Certificate of Coverage includes, a POS Rider.

3. **Other Provisions.** All other terms, condition and limitations of your Certificate also apply to this rider, except where specifically changed by this rider.

4. Your group has added this Rider to your Certificate. In addition to the provisions of paragraph 3, this Rider may be deleted, at your group's option, upon renewal of the group's contract with MVP.

MVP Health Plan, Inc.
Schenectady, New York

By: 
President

INHOSP-500(11/01)