This is Your

HEALTH MAINTENANCE ORGANIZATION
CERTIFICATE OF COVERAGE

Issued by

MVP Health Plan, Inc.

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between MVP Health Plan, Inc., ("MVP") hereinafter referred to as "We", "Us" or "Our") and the Group listed in the Group Contract. This Certificate of Coverage is not a contract between You and MVP. A Summary of Benefits and Coverage (SBC), Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

In-Network Benefits. This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our HMO network and Participating Pharmacies in Our network that are located within Our Service Area or Our affiliate's Cigna network. Except for care for an Emergency or urgent Condition described in the Emergency Services and Urgent Care section of this Certificate, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

MVP Health Plan, Inc. is a not-for-profit health maintenance organization certified in Vermont and this Certificate is governed by the laws of Vermont.

MVP Health Plan, Inc.
Schenectady, NY

Christopher Del Vecchio
Chief Executive Officer

If You need foreign language assistance to understand this Certificate, You may call Us at the MVP Customer Care Center phone number listed on the back of Your MVP Member ID card.

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SECTION I – Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Acute Services: The 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.

Adverse Benefit Determination: A denial, reduction, modification or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including but not limited to:

1. a denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a health benefit plan;
2. a denial, reduction, modification or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; and
3. a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by MVP Health Plan, Inc., including the Summary of Benefits and Coverage (SBC) and any attached riders.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, children placed for adoption, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: A person other than the Subscriber, listed on the enrollment application, including family members of a civil union as defined by Vermont law, who meets all eligibility requirements, and for whom MVP has received the required premium.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Effective Date. The date Your coverage under this Certificate begins. Coverage begins at 12:01 a.m., Eastern Time, on that date.

Emergency Department Care: Emergency Services You receive from a Hospital emergency department.

Exclusions: Health care services that We do not pay for or Cover.

Experimental or Investigational Services: Health care items or services that are either not generally 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

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination. Grievance means a complaint submitted by or on behalf of a member regarding:

1. Adverse benefit determination;
2. Availability, delivery or quality of health care services;
3. Claims payment, handling or reimbursement for health care services; or
4. Matters relating to the contractual relationship between a member and a managed care organization or the health insurer offering the health benefit plan.

Group: The employer or party that has entered into an agreement with Us as a contract holder.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional that Vermont law requires to be recognized, who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Vermont Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. The services of Non-Participating Providers are Covered only for Emergency Services, Urgent Care or when authorized by Us.

Out-of-Pocket Maximum: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us or our Affiliate's Cigna network to provide services to You. A list of Participating Providers and their locations is available on Our website at **mvphealthcare.com** or upon Your request to Us. The list will be revised by Us from time to time.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine, or Naturopathic Physician) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect.

Pre Authorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. Please visit Our website at **mvphealthecare.com** or call the phone number on Your MVP Member ID card to see the list of services that require Pre Authorization.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self -administration or administration by a non-skilled caregiver.

Primary Care Provider ("PCP"): A health care provider who is contracted and enrolled with the health plan as a PCP. PCP further means a Participating Provider who has an agreement with MVP to provide covered primary health care services to Members and who, within that Provider's scope of practice as defined under the relevant state licensing law, provides primary care services, and who is designated as a Primary Care Provider by a managed care organization. A PCP is a participating nurse practitioner, Physician or naturopathic physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Blueprint Primary Care Provider: Any Vermont provider with an individual NPI on the Vermont Blueprint for Health roster.

Provider: A Physician, Health Care Professional, or facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, hearing aids, or any other equipment or supplies that are Covered under this Certificate that is licensed, registered, certified or accredited as required by state law. Provider also includes coverage for licensed athletic trainers who are MVP Participating Providers.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Summary of Benefits and Coverage: The document that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Maximums, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of Vermont, in which We provide coverage. The MVP service area includes the state of Vermont and the New York State counties of Albany, Broome, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, St. Lawrence, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates

Skilled Nursing Facility: An institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care facility, or nursing care facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The Subscriber's spouse under a legal marriage or civil union as defined by Vermont law.

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a participating Physician's office or Urgent Care Center.

Urgent Care Center: A licensed facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: MVP Health Plan, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II - How Your Coverage Works

A. Your Coverage Under this Certificate.

Your employer (referred to as the "Group") has purchased a Group health insurance; Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Summary of Benefits and Coverage; and
- Received while Your Certificate is in force.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition and Urgent Care.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request;
- Call the number on Your MVP Member ID card; or
- Visit Our website at **mvphealthcare.com**.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Language spoken; and
- Whether the Participating Provider is accepting new patients.

You are only responsible for any Cost-Sharing that would apply to the Covered Services, if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in Our online Provider directory;
- Our paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;

- We give You written notice that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- We do not provide You with a written notice within one (1) business day of Your telephone request for network status information.

In these situations, if a Provider bills You for more than Your Cost-Sharing and You pay the bill, You are entitled to a refund from the Provider, plus interest.

D. The Role of Primary Care Providers.

This Certificate does not have a gatekeeper, usually known as a Primary Care Provider ("PCP"). Although You are encouraged to receive care from Your PCP, You do not need a Referral from Your PCP before receiving certain Specialist care.

You may select any participating PCP who is available from the list of PCPs in the HMO MVP Health Plan, Inc. Network. Each Member may select a different PCP. Children covered under this Certificate may designate a participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist. To select a PCP, visit Our website at **mvphealthcare.com**.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the SBC when the services provided are related to specialty care.

E. Access to Providers and Changing Providers.

Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call their office and tell the Provider that You are an MVP Health Plan, Inc. Member, and explain the reason for Your visit. Have Your MVP Member ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your Provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

You may change Your PCP by visiting Our website at **mvphealthcare.com** and selecting sign In/Register. Once signed in, click on Select or Change a Doctor from the menu on the left-hand

side of the Manage Your account page. Then follow the online steps to change Your PCP. If You have questions or need additional assistance with changing Your PCP, You can contact the Customer Care Center at the phone number on the back of Your Member ID card.

You may change Your Specialist by visiting Our website at **mvphealthcare.com** and selecting sign In/Register. Once signed in, click on Select or Change a Doctor from the menu on the left-hand side of the Manage Your account page. Then follow the online steps to change Your Specialist. If You have questions or need additional assistance with changing Your Specialist, You can contact the Customer Care Center at the phone number on the back of Your Member ID card.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing

F. Services Subject to Pre Authorization.
Our Pre Authorization is required before You receive certain Covered Services, except for any admission, item, service, treatment, or procedure ordered by a Blueprint Primary Care Provider. Prescription Drugs and Out-of-Network services require Prior Approval regardless of ordering provider. For instance, if appropriate services are not available with a Network Provider, you must get Pre-Authorization. This does not include Emergency Medical Services. Your Participating Provider is responsible for requesting Pre Authorization for in-network services.

G. Pre Authorization / Notification Procedure.
If You seek coverage for services that require Pre Authorization or notification, Your Provider must call Us at the number on Your ID card.

Your Provider must contact Us to request Pre Authorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.

- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.

- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.

- Before air ambulance services are rendered for a non-Emergency Condition.

- Mental Health/Substance Use Services. For treatment and/or services that require Pre Authorization, Your Provider must contact MVP by phone at 1-800-684-9286, email at **BHServices@mvphealthcare.com**, or mail to 625 State Street, Schenectady, NY 12305. Your Provider must provide Your name, MVP Member ID number, Your Provider's name and address, the date(s) that services are requested, Your diagnosis and a copy of Your Provider's completed Pre Authorization Request Form (VT) which can be found at **https://www.mvphealthcare.com/wp-content/uploads/download-manager-files/mvp-form-prior-authorization-request-form-vt.pdf.**

- Non-Emergency Out-of-Network Specialist Services. MVP will give Pre Authorization only when we do not have a qualified Participating Specialist available to treat Your condition. To request Pre Authorization of Non-Emergency Out-of-Network Specialist Services, You must contact MVP either by phone at 1-800-568-0458 or in writing at 625 State Street, Schenectady, New York 12305. You or Your Provider must provide Your name, MVP ID number, the Non-Participating Provider's name and address, the type of service requested, the date that services are requested, Your diagnosis and the reason why services must be provided out of network. A family member or Provider may call for You. For out-of-network services, it is up to You to get Pre Authorization.

You must contact Us to provide notification as follows:
- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

H. Medical Management.
The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

i. "Concurrent Review" means utilization review conducted during a member's stay in a hospital or other facility, or other ongoing course of treatment.

ii. "Pre-service Review" means review of any claim for a benefit with respect to which the terms of coverage condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care.

iii. "Retrospective Review" means review of any claim for a benefit after services have been provided to You, to determine whether such services are Medically Necessary Covered Services .

I. Medical Necessity.

We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services, including diagnostic testing, preventive services and aftercare will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are informed by generally accepted medical or scientific evidence and provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;

- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting;
- Must be informed by the unique needs of each individual patient and each presenting situation.

See the Utilization Review and the Grievances and Independent External Review sections of this Certificate for Your right to an internal Appeal and external Appeal of Our determination that a service is not Medically Necessary.

J. Protection from Surprise Bills.

1. Surprise Bills. A surprise bill is a bill You receive for Covered Services in the following circumstances:

- For services performed by a non-participating Provider at a participating Hospital or Ambulatory Surgical Center, when:
  - A participating Provider is unavailable at the time the health care services are performed;
  - A non-participating Provider performs services without Your knowledge; or
  - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Provider is available and You elected to receive services from a non-participating Provider.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
  - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
  - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
  - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Cost-Sharing. The Non-Participating Provider may only bill You for Your Cost-

Sharing. You can sign a form to notify Us and the Non-Participating Provider that You received a surprise bill.

The form for surprise bills is available at www.cms.gov/nosurprises. You need to mail a copy of the form to Us at the address on Your Member ID card and to Your Provider.

K. Independent Dispute Resolution Process.
Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

L. Delivery of Covered Services Using Telehealth.
If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth.

"Telehealth" means the use of electronic information and audio and video telecommunication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location. "Telehealth" also includes coverage for all medically necessary, clinically appropriate health care services delivered remotely by audio-only telephone to the same extent covered if they were provided through in-person consultation. This includes services that are covered when provided in the home by home health agencies. For a service to be considered eligible for Telehealth coverage, the interactive audio and video or audio-only telecommunications must be either real-time communication with electronic transmission of Your health information, or pre-recorded videos known as "store and forward" technology.

M. Case Management. means a coordinated set of activities conducted to support the Member and the Member's health care provider in managing serious, complicated, protracted or other health conditions.

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and teamwork with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing

community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Certificate. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

As part of our hospital discharge program you will be offered meals following an inpatient hospital discharge. MVP will contact you and offer you the option to receive 14 nutritious meals during a 7 day period to help you meet your nutritional needs and recover. If you choose to receive the meals, they will be delivered to your home by our partner Mom's Meals

N. Important Telephone Numbers and Addresses.

- CLAIMS
  claims@mvphealthcare.com
  (Submit electronic claim forms to this e-mail address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  1-800-348-8515

- SURPRISE BILL CERTIFICATION FORM
  Refer to the address on Your Member ID card
  Submit surprise bill certification forms to this address.)

- CUSTOMER CARE CENTER
  1-800-348-8515
  (Customer Care Representatives are available Monday - Friday, 8:00 a.m. – 6:00 p.m.)

- PRE AUTHORIZATION
  1-800-348-7575

- OUR WEBSITE
  mvphealthcare.com

- VERMONT DEPARTMENT OF FINANCIAL REGULATION (800) 964-1784.

  The Department of Financial Regulations' Health Insurance Consumer Services unit can provide free help to You if You need general information about health insurance, have concerns about Our activities, or are not satisfied with how We resolved a complaint.

- VERMONT OFFICE OF HEALTH CARE ADVOCATE
  The Vermont Office of Health Care Advocate's telephone hotline service can provide You with free help if You have problems or questions about health care or health insurance. Call the Vermont Office of Health Care Advocate's telephone number at (800) 917-7787 or (802) 863-2316.

Other Resources:

For questions about Your rights, this Certificate, or for assistance, You can contact:
Employee Benefits Security Administration (866) 444-EBSA (3272)
State of Vermont's Health Care Advocate (800) 917-7787 or (802) 863-2316 Vermont Department of Financial Regulation (800) 964-1784.

SECTION III - Access to Care and Transitional Care

A. Authorization to a Non-Participating Provider.

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve an Authorization to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will not be Covered.

B. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Pre Authorization, Referrals, and a treatment plan approved by Us. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

C. New Members In a Course of Treatment.

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Pre Authorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

D. Travel Times.

You should not usually have to travel more than 30 minutes from home or work for:

- PCP services
- Routine office-based mental health and substance use treatment

You should not usually have to travel more than 60 minutes for:

- Prescription drugs
- Labs
- X-rays
- MRIs
- Eye Exams
- Intensive outpatient, partial hospital, residential or inpatient mental health and substance use services
- Inpatient medical rehabilitation
- outpatient physician specialty care

You should not usually have to travel more than 90 minutes for:

- Kidney transplants
- Major trauma treatment
- Open-heart surgery
- Cardiac catheterization laboratory services
- Neonatal intensive care

Some Members may get services at "centers of excellence" outside Vermont.

E. Waiting Times for Appointments

You shall have instant access to Emergency care.

Appointment: You should not usually have to wait longer than:

- 24 hours for Urgently Needed Care.
- Two weeks for routine initial treatment. Prompt follow-up visits and visits to specialists, if needed.
- Thirty days for routine lab, x-ray, general optometry and all other routine services.
- Ninety days for preventive care. This includes routine physical exams.

SECTION IV - Cost-Sharing Expenses and Allowed Amount

Your Payments.

Deductibles. Please see Your Summary of Benefits and Coverage (SBC) to see if You have an embedded or aggregate Deductible. These Deductibles are explained below.

Embedded Deductible.
Except where stated otherwise, You must pay the Deductible amount in the SBC attached to this Certificate for Covered Services during each Plan Year before We provide coverage. If your Plan has an Embedded Deductible and You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the SBC in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

Aggregate Deductible.
Except where stated otherwise, You must pay the Deductible amount in the SBC during each Plan Year before We provide coverage. If your Plan has an Aggregate Deductible and You have other than individual coverage, You must pay the family Deductible in the SBC for Covered Services under this Certificate during each Plan Year before We provide coverage for any person covered under this Certificate. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the SBC in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

No Deductible Services. You do not have to pay any Deductible for certain Covered Services. These services are identified on Your SBC.

The following payment does not count toward Your Individual or Family Deductible:

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

Coinsurance. Any required Coinsurance payments are listed on Your SBC. Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network benefit as shown on the SBC. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.

Copayments. Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the SBC for Covered in-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

Participating Providers. When You get Medically Necessary Covered Services from a Participating Provider, You must, in most cases, pay the Copayment, Deductible and/or Coinsurance that applies to the Participating Provider before MVP provides benefits. The Copayment, Deductible and/or Coinsurance for each Covered Service is listed on Your SBC.
Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.

Preventive Care by Participating Providers. When You get designated Preventive Care Covered Services from Participating Providers, You do not pay any Copayment, Deductible or Coinsurance to the Participating Provider. These Preventive Care Covered Services are covered in full. They are described in this Certificate and listed on Your SBC.

Annual Out of Pocket Maximums. Please see Your SBC to see if You have an embedded or aggregate Out of Pocket Maximum. These Out of Pocket Maximums are explained below.

Embedded Out of Pocket Maximum.
When You have met Your Out-of-Pocket Maximum in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the SBC, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If your Plan has an Embedded Out of Pocket Maximum and You have other than individual coverage, once a person within a family meets the per person in a family Out-of-Pocket Maximum in the SBC, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Pocket Maximums in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the SBC, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family.

Aggregate Out-of-Pocket Maximum.
When You have met Your Out-of-Pocket Limit in payment of Deductibles, Copayments, and Coinsurance for a Plan Year in the SBC, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of the Plan Year. If your Plan has an Aggregate Out of Pocket Maximum and You have other than individual coverage, You must pay the family Out-of-Pocket Maximum in the SBC for in-network Services under this Certificate during each Plan Year. However, after the family Out-of-Pocket Maximum for any and all persons covered

under this Certificate collectively total the family Out-of-Pocket Maximum, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year.

Cost-sharing for out-of-network services, except for Emergency Services does not apply toward Your Out-of-Pocket Maximum.

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible or Out-of-Pocket Maximums.

Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

Out-of-Network Providers at Network Facilities.
If you receive Medically Necessary, Covered Services from an Out of Network Provider at a Network facility without your informed consent, we will cover your care as if you had been treated by a Network Provider. You must pay any Cost-Sharing amounts required under your Contract, which will in no event be more than as if you received those services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. Under federal law, unless you give your informed consent, providers are prohibited from billing you for these services beyond your Cost-Sharing amounts. If the Out of Network Provider requests any payment from you other than your Cost-Sharing amounts, please contact us at the number on the back of your ID card so that we can work directly with the Provider to resolve the request.

SECTION V - Who is Covered

A. Who is Covered Under this Certificate.

You, the Subscriber to whom this Certificate is issued, is covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.

If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental or physical disability and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate, and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered

Members in relation to eligibility for coverage under this Certificate periodically, but no more frequently than once every year.

D. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed 90 days.

2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.

3. If You, the Subscriber, marry while covered, and We receive notice of such marriage within 30 days thereafter, coverage for Your Spouse and Child starts on the first day of the month following such marriage. If We do not receive notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.

4. If You, the Subscriber, have a newborn Child Your newborn child will be covered without notice or additional premium for the first 60 days from the moment of birth. Your adopted newborn Child will be covered for 60 days from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth. Your newborn or adopted newborn will be subject to their own Cost-Sharing for Covered services beginning on their date of birth, whether or not you add them to your coverage permanently. 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. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 60 days of the birth or adoption in order for coverage continue beyond 60 days. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

5. To continue the child's coverage beyond 60 days, You must complete and return an enrollment form, any requested documentation, and the required premium. If You do so within 60 days of the date of birth, adoption, placement for adoption, legal guardianship, legal custody, or within 60 days of the date the child became Your stepchild, Your child will be added to Your coverage and will be covered effective as of the date of birth, adoption, placement for adoption, or legal guardianship, legal custody, or as of the date

the child became Your stepchild. If You do not do so within 60 days of the events described, You will not be able to add Your child to Your coverage until the first day of the month following the next premium due date after the next open enrollment period when We get the completed form, requested documents, and premium. Remember, a newborn child is always covered for the first 60 days.

E. Special Enrollment Periods.

You, Your Spouse or Child can also enroll for coverage within 30 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within 30 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first (1st) and fifteenth (15th) day of the month, Your coverage will begin on the first (1st) day of the following month. If Your application is received between the sixteenth (16th) day and the last day of the month, Your coverage will begin on the first (1st) day of the second month.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan; or
2. You or Your Spouse or Child becomes eligible for Medicaid or a state child health plan.

We must receive notice and Premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth (15th) day of the month, Your coverage will begin on the first (1st) day of the following month. If Your application is received between the sixteenth (16th) day and the last day of the month, Your coverage will begin on the first (1st) day of the second month.

SECTION VI - Preventive Care

Please refer to the Summary of Benefits and Coverage (SBC) for Cost-Sharing requirements and visit Our website at **mvphealthcare.com** for services that may require Pre Authorization.

Preventive Care.
We Cover the following services for the purpose of promoting good health and early detection of disease. Unless otherwise noted, Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your MVP Member ID card or visit Our website at **mvphealthcare.com** for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. **Well-Baby and Well-Child Care.** We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Cost-Sharing when provided by a Participating Provider.

B. **Adult Annual Physical Examinations.** We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website at mvphealthcare.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Plan year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

C. Adult Immunizations. We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Cost-Sharing when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at mvphealthcare.com, or will be mailed to You upon request. This benefit is not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

E. Family Planning and Reproductive Health Services. We Cover family planning services which consist of: FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered under the Prescription Drug Coverage section of this Certificate; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; pregnancy tests; ultrasounds; STD and STI testing; and sterilization procedures for females and males. Such services are not subject to Co-payments, Deductibles or Co-insurance when provided by a Participating Provider..

F. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We provide coverage for screening mammography and for other medically necessary breast imaging services upon recommendation of a health care provider as needed to detect the presence of breast cancer and other abnormalities of the breast or breast tissue. In addition, We provide coverage for screening by ultrasound or another

appropriate imaging service for a patient for whom the results of a screening mammogram were inconclusive or who has dense breast tissue, or both.

Benefits provided for mammography, ultrasound, and other breast imaging services are covered in full and shall not be subject to any copayment, deductible, coinsurance, or other cost-sharing requirement or additional charge, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account.

"Mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and digital detector. The term includes breast tomosynthesis.

"Screening" includes the mammography, magnetic resonance imaging (MRI) or ultrasound imaging procedures and a qualified physician's interpretation of the results of the procedure, including additional views and interpretation as needed.

G. **Screening for Prostate Cancer**. This is an Adult Preventive Care Service. You will not be required to make a payment for this service. We will provide coverage for screening for prostate cancer consistent with the recommendations by the Centers for Disease Control and Prevention or upon recommendation of a health care provider. Benefits are subject to the following limits:

An annual standard diagnostic examination, including a prostate specific antigen test for men, in accordance with the standards set forth by the Centers for Disease Control and Prevention.

H. **Screening Colonoscopies and Sigmoidoscopies**. This is an Adult Preventive Care Service. MVP will cover this in-network only as follows:

(1) For Members age forty-five (45) years and older we will provide benefits for an annual fecal occult blood test plus one flexible sigmoidoscopy every five (5) years; or, one colonoscopy every ten (10) years or more often as Medically Necessary.

(2) Colonoscopy means a procedure that enables a physician to examine visually the inside of a patient's entire colon and includes the removal of polyps, biopsy or both.

(3) Sigmoidoscopy means a procedure that enables a physician to examine visually the inside of the distal portion of a patient's colon.

For Members at high risk for colorectal cancer, we will provide benefits for cancer screening examinations and laboratory tests as recommended by the treating physician. You are considered to be at high risk if You have:

(1) a family medical history of colorectal cancer or a genetic syndrome predisposing the individual to colorectal cancer;

(2) a prior occurrence of colorectal cancer or precursor polyps;

(3) a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or Ulcerative Colitis; or

(4) other predisposing factors as determined by the individual's treating physician.

In addition, You shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include one or more of the following:

(1) removal of tissue or other matter;
(2) laboratory services;
(3) physician services;
(4) facility use; and
(5) anesthesia.

I. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Cost-Sharing when provided by a Participating Provider and in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

J. **Tobacco Cessation Services**. We will cover the cost of at least two (2) tobacco cessation attempts per Member per Benefit Year. We will also cover at least two three-month supplies per year of tobacco cessation medication, including over-the-counter medication, when prescribed by a Participating Provider. You must pay the applicable prescription drug co-payment for the tobacco cessation medication.

"Tobacco cessation medication" means all therapies approved by the federal Food and Drug Administration for use in tobacco cessation.

K. **Weight Loss Services**. We will provide Benefits for any Medically Necessary Covered Services or care set forth in your COC when rendered in connection with weight reduction or dietary control, including, laboratory services, and gastric stapling, gastric bypass, gastric bubble or other surgery for treatment of obesity.

We will provide Benefits for bariatric surgery only when such surgery is performed at a participating bariatric center of excellence. You can get a list of participating centers of excellence by calling the MVP Customer Care Center at 1-888-687-6277.

We will not provide coverage for medications used for weight loss, dietary supplements, exercise classes, or gym memberships.

SECTION VII - Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Summary of Benefits and Coverage (SBC) for Cost-Sharing requirements and visit Our website at **mvphealthcare.com** for any Pre-Authorization requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Pre-Authorization.

A. Emergency Ambulance Transportation.

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under Vermont law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance.

Coverage for Emergency Medical Services outside of the service area is the same as coverage within the service area. If a Non-Network Provider bills you for the balance between the charges and what we pay, please notify us by calling our customer service team at the number on the back of your ID card. We will defend against and resolve any request or claim by a Non Network Provider of Emergency Medical Services.

We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed.

We cover Ambulance services as long as your condition meets our definition of an Emergency Medical Condition:

- to the nearest facility from the scene of an accident or medical emergency; or from one acute facility to the nearest acute facility capable of providing the necessary care related to the member's condition (e.g., burn unit, cardiac care unit, trauma units, neonatal units); or
- between Facilities or between a facility and home (but not solely according to the patient's or the Provider's preference)

Limitations

- You must get Prior Approval for non-emergency transport including air or water transport.
- We cover transportation only to the closest facility that can provide services appropriate for the treatment of your condition.
- We do not cover Ambulance services when the patient can be safely transported by any other means. This applies whether or not transportation is available by any other means.
- We do not cover Ambulance transportation when it is solely for the convenience of the Provider, family or member.

We Cover Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-Participating Hospital to a Participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care facility; or
- From an Acute care facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
  - The point of pick-up is inaccessible by land vehicle; or
  - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

D. Payments for Air Ambulance Services. We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the air ambulance service.

We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the air ambulance service or an amount We have determined is reasonable for the air ambulance service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity (IDRE), We will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any Cost-Sharing for air ambulance services. The Non-Participating Provider may only bill You for Your Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your Cost-Sharing, You should contact Us.

SECTION VIII - Emergency Services and Urgent Care

Please refer to the Summary of Benefits and Coverage (SBC) for Cost-Sharing requirements and visit Our website at **mvphealthcare.com** for any Pre Authorization requirements that apply to these benefits.

A. Emergency Services.

We cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

Emergency Condition. A sudden and, at the time, unexpected onset of an illness, medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities

available at the Hospital or the independent freestanding emergency department, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility, or to deliver a newborn child (including the placenta). Emergency Services are not subject to Pre Authorization requirements. Emergency Services also include items and services for which benefits are provided or covered that are furnished (regardless of the department of the hospital in which such items or services are furnished) after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay which respect to the visit in which the pre-stabilization Emergency Services are furnished.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. If you are experiencing a mental health crisis, You may also call 988 for assistance. Emergency Department Care does not require Pre Authorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**.

   We do not Cover follow-up care or routine care provided in a Hospital emergency department.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Certificate and on Your MVP Member ID card within 48 hours of Your admission, or as soon as is reasonably possible.

3. **Payments Relating to Emergency Services.** We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the Emergency Services.

   We will pay a Non-Participating Provider the amount we have negotiated with the Non-Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

   If a dispute involving a payment for Emergency Services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for the services.

You are responsible for any Cost-Sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your Cost-Sharing. The Non-Participating Provider may only bill You for Your Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your Cost-Sharing, You should contact Us.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. **Urgent Care is Covered in or out of Our Service Area**.

1. **In-Network.** We Cover Urgent Care from a Participating Physician or a Participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.

2. **Out-of-Network.** We Cover Urgent Care from a non-Participating Urgent Care Center or Physician outside Our Service Area.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

SECTION IX - Outpatient and Professional Services

Please refer to the Summary of Benefits and Coverage (SBC) section for Cost-Sharing requirements and visit Our website at **mvphealthcare.com** for any Pre-Authorization requirements that apply to these benefits.

A. Advanced Imaging Services.

We Cover PET scans, MRI, nuclear medicine, and CAT scans.

B. Allergy Testing and Treatment.

We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

C. Ambulatory Surgical Center Services.

We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

D. Chemotherapy and Immunotherapy.

We Cover chemotherapy and immunotherapy in an outpatient facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Certificate.

E. Chiropractic Services.

We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation, and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Certificate. Pre Authorization is not required if using an MVP participating provider.

F. Clinical Trials.

We Cover the routine patient costs for Your participation in all four types (phases I-IV) of approved clinical trials that are conducted under the auspices of cancer care providers and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and the Grievances and Independent External Review sections of this Certificate.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

If you participate in a clinical trial administered by a cancer care provider that is not in our network, your routine follow-up care must be provided within our network, unless the cancer care provider determines this would not be in your best interest.

G. Dialysis.

We Cover dialysis treatments of an Acute or chronic kidney ailment. This means removal of waste materials when a Member has acute kidney failure or chronic, irreversible kidney deficiency, and the use of equipment and disposable medical supplies. Alternatively, Dialysis may be provided at home. If provided at home, MVP will provide Benefits for the reasonable rental cost of equipment, as determined by us, plus Medically Necessary supplies for home dialysis treatment when ordered by Your physician. MVP will not provide benefits for any furniture, electrical or other fixtures or plumbing to perform the dialysis treatments at home. For outpatient or home-based Dialysis to be covered, the treatments must be provided, supervised or arranged by Your physician, and You must be a registered patient of an MVP approved kidney diseases treatment center. Benefits for Dialysis will continue until You are covered by Medicare or until Your MVP coverage is terminated.

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 Contract'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 Contract (this means that Medicare is the Primary Plan after this waiting period).

H. Home Health Care.
We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent skilled nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide which consist primarily of caring for the patient;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, equipment, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility. The medical necessity of equipment may be reviewed by reference to the Medicare guidelines for durable medical equipment.

Home Health Care is limited to 60 visits per Plan Year. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation Services benefits.

I. Infertility Treatment.
We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Infertility is determined by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older; or the inability of an individual to establish a clinical pregnancy due to sexual orientation or gender identity. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine.

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;

- Postcoital test;
- Endometrial biopsy;
- Pelvic ultra sound;
- Hysterosalpingogram;
- Sono-hystogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be Covered if the tests are determined to be Medically Necessary.

2. **Additional Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover Additional Infertility Services.

   Additional Infertility Services include:
   - Ovulation induction and monitoring;
   - Pelvic ultrasound;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Exclusions and Limitations.** We do not Cover:
   - In vitro fertilization, gamete intrafallopian tube transfers (GIFT) or zygote intrafallopian tube transfers (ZIFT) and drugs used in connection with such procedures;
   - Costs for an ovum donor or donor sperm;
   - Sperm storage costs;
   - Sperm banking;
   - Artificial insemination (AI) or Intrauterine insemination (IUI)
   - Cryopreservation and storage of eggs or embryos;
   - Ovulation predictor kits;
   - Gender selection;
   - Acrobeads sperm assay, hamster egg penetration test, hypo-osmotic swelling test
   - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

   All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. We will not discriminate based on Your expected length of life,

present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

J. Infusion Therapy.
We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional And provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

K. Abortion Services. We Cover abortion services. Coverage for abortion services includes any Prescription Drug prescribed for an abortion, inducing both Generic Drugs and Brand-Name Drugs, even if those Prescription Drugs have not been approved by the FDA for abortions, if the Prescription Drug is a recognized medication for abortions in one of these reference compendia:

- The WHO Model Lists of Essential Medicines;
- The WHO Abortion Care Guidelines; or
- The National Academies of Science, Engineering and Medicine Consensus Study Report.

Abortion services are not subject to Cost-Sharing when provided by a Participating Provider.

L. Laboratory Procedures, Diagnostic Testing and Radiology Services.
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

M. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician, licensed midwife or certified nurse midwife, an advanced practice registered nurse who is certified as a nurse midwife, Hospital or birthing center. Services of a midwife are covered when provided in a hospital, birthing center, or at home. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) non-hospital breast pump per pregnancy for the duration of breast feeding from a Participating Provider or designated vendor.

Doula Support Services Reimbursement
The purpose of this maternal wellness program is to provide support and guidance from a certified doula, empowering you to take a more active role in managing your pregnancy, prenatal, and postnatal care.

2. Program Description
DONA (Doulas of North America) defines a doula as "a trained professional who provides continuous physical, emotional, and informational support to a mother before, during, and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible."

Doula support is not a substitute for medical care provided by a licensed healthcare provider.

Doula services may include:

- Physical, emotional, educational, and non-medical support before, during, and after childbirth or the end of pregnancy.
- Development of a birth plan.
- Support with provider communications.
- Patient-centered advocacy, and physical, emotional and non-medical support.
- Education, support, guidance, and health navigation,

3. Eligibility
You, the Subscriber, your Covered Spouse, and eligible Covered Dependents may participate in the Doula Support Services Reimbursement program.

- The birthing person must be covered under this Certificate to be eligible for reimbursement.

4. Participation
The preferred method for accessing information about the Doula Support Services Reimbursement program is through our website at mvphealthcare.com or by contacting our Customer Care Center at the phone number on the back of your Member ID card. We will provide information on how to participate and get reimbursed for doula services.

5. Conditions for Reimbursement
Eligible members who pay for and use the services of a certified doula may receive up to $1,500 in reimbursement for out-of-pocket costs.

- The maximum reimbursement is available to the subscriber (contract holder) only. For example, a family of four enrolled under one contract is eligible for one maximum reimbursement per plan year.
- Reimbursement applies to the calendar year in which the service or item is paid. For example, if a service was provided in December but paid for in January, it applies to the current calendar year's reimbursement.

- All reimbursement forms must be received no later than one year after the date of payment.

To qualify for reimbursement:

- Members must complete a reimbursement form and attach all required documentation, including proof of payment.
- Members must use a certified doula and pay for their services.
- The certified doula must sign the reimbursement form, attesting that services were provided.

Submission Instructions
The completed form must be an original (not photocopied) and is non-transferable.
Mail the original reimbursement form to:
MVP Health Care
PO Box 2207
Schenectady, NY 12301-2207

Participation requirements, preauthorization requirements, and detailed descriptions of available activities can also be accessed by calling our Customer Care Center at the phone number on the back of your Member ID card.

N. Medical Foods.

We will provide benefits for low protein modified food products, enteral formulae, medical foods, formulas or supplements administered through a feeding tube, and 100% amino acid formula prescribed by a participating provider for use under the direction of a participating physician for the medically necessary treatment of any dietary condition including. 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. You must pay the Cost Share listed on your SBC.

O. 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. There is no limit on the number of visits for nutritional counseling. You must receive nutritional counseling from one of the following Network Providers or we will not provide Benefits:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- nutritionist licensed in Vermont;
- certified diabetic educator (C.D.E.);
- naturopathic physician (N.D.); or
- nurse practitioner.

P. Office or Home Visits.
We Cover the examination, diagnosis and treatment of 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..

Q. Outpatient Hospital Services.
We Cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. Unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests. We will provide for up to 36 visits per member per Plan Year for cardiac rehabilitation services and only when such services are Acute Services and are provided by a Participating Hospital or Participating facility.

R. Preadmission Testing.
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

S. Prescription Drugs for use in the Office and Outpatient Facilities.
We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate, if You have Prescription Drug Coverage.

T. Rehabilitation services.
We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a facility or in a Health Care Professional's office up to 30 visits per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and
- The therapy is ordered by a Physician.

In no event will the therapy continue beyond 365 days after such event.

U. Second Opinions.

1. **Second Cancer Opinion**. We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating provider on an in-network basis.

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We give Pre Authorization for a surgical procedure. There is no cost to You when We request a second opinion.

    - The second opinion must be given by a board certified Specialist who personally examines You.
    - If the first and second opinions do not agree, You may obtain a third opinion.
    - The second and third surgical opinion consultants may not perform the surgery on You.

4. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will give Pre Authorization for Covered Services supported by a majority of the Providers reviewing Your case.

V. Outpatient Surgical Services.

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

Sometimes two (2) or more surgical procedures can be performed during the same operation.

If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount We would otherwise pay for the other procedures.

We also provide benefits for abortion services, male and female sterilizations and one attempt at reversal of sterilization. These services are subject to Pre-Authorization. Voluntary sterilization procedures for females and males are covered with no Cost Share..

W. Oral Surgery.
We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

X. Anesthesia for Certain Dental Procedures. We will cover general anesthesia for certain dental procedures in a hospital or ambulatory surgical center given by a Participating Provider who is licensed to give anesthesia. You must obtain Pre Authorization from MVP before receiving benefits. You must pay the Cost Share listed on your SBC. These Benefits are covered for:

(1) a Member who, as declared by a licensed dentist, are not able to get Medically Necessary dental care in an outpatient setting. The treating Provider must certify that hospitalization and general anesthesia are a must to treat the patient; or

(2) a Member with a diagnosed phobia or a documented mental health condition, whose dental needs are sufficiently complex and urgent that delaying treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity; for whom a successful result cannot be expected from dental care provided under local anesthesia; and a better result can be expected from dental care given under general anesthesia; or

(3) a Member who has exceptional medical circumstances or a developmental disability, as determined by a licensed physician, which place the person at serious risk.

Benefits are only for general anesthesia and any related hospital or facility charges. Except as specifically provided in Section IX, MVP will not provide benefits for the dental procedure. The

anesthesia must be given by a fully accredited specialist in pediatric dentistry, a fully accredited specialist in oral and maxillofacial surgery or a dentist who has hospital rights.

Y. Reconstructive Breast Surgery.
We Cover breast or chest wall reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast or chest wall on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast or chest wall to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Z. Other Reconstructive and Corrective Surgery.
We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

AA. Telemedicine Program.
In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition.

The telemedicine programs are provided pursuant to contracts with Amwell, Galileo, and UCM Digital Health, and are services that provide Participants with access to a national network of Providers for medical care in connection with a wide range of conditions and cases, including some mental health disorders. A member can access these services through video and/or phone, using either desktop or mobile devices. More information can be found at **StartWithGia.com**.

BB. Transplants.
We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated as Centers of Excellence to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

CC. Out of Pocket costs for treatment of victims of sexual assault. Treatment and examinations for victims of sexual assault are covered with no Cost Share.

DD. Contraceptive Services. We will provide benefits for outpatient contraceptive services as per HRSA guidelines for all FDA approved contraceptive methods including office visits, consultations, and follow-up services. We will provide benefits for office visits associated with insertion, removal, counseling, and monitoring of contraceptive devices as medically necessary. Contraceptive services are covered in full.

EE. Gynecological Health Care Services. We will provide benefits 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. For a list of Participating Providers who specialize in obstetrics or gynecology, contact the Customer Care Center at 1-800-348-8515

SECTION X – Additional Benefits, Equipment and Devices

Please refer to the Summary of Benefits and Coverage (SBC) for Cost-Sharing requirements and visit Our website at **mvphealthcare.com** for any Pre Authorization requirements that apply to these benefits.

A. Coverage for Diagnosis and Treatment of Early Childhood Developmental Disorders.

1. **Definitions**. In this section the following terms have the following meanings:

   a. **Applied Behavior Analysis** means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. This includes direct observation, measurement and functional analysis of the relationship between environment and behavior.

   b. **Autism Spectrum Disorders** means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger's disorder.

   c. **Behavioral Health Treatment** means evidence-based counseling and treatment programs, including applied behavior analysis, that are:

      (i) necessary to develop skills and abilities for the maximum reduction of physical or mental disability and for restoration of an individual to the individual's best functional level, or to ensure that an individual achieves proper growth and development; and

      (ii) provided or supervised by a nationally board-certified behavior analyst or by a licensed provider, so long as the services performed are within the provider's scope of practice and certifications.

   d. **Diagnosis of early childhood developmental disorders** means Medically Necessary assessments, evaluations, or tests to determine whether an individual has an early childhood developmental delay, including autism spectrum disorder.

   e. **Early childhood developmental disorder** means a childhood mental or physical impairment or combination of mental and physical impairments that results in functional limitations in major life activities, accompanied by a diagnosis defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Disease (ICD). The term includes autism spectrum disorders, but does not include a learning disability.

f. **Treatment for early developmental disorders** means evidence-based care and related equipment prescribed or ordered for an individual by a licensed health care provider or a licensed psychologist who determines the care to be medically necessary, including:

- behavioral health treatment;
- pharmacy care (medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need for or effectiveness of a medication);
- psychiatric care (direct or consultative services provided by a licensed physician certified in psychiatry by the American Board of Medical Specialties;
- psychological care (direct or consultative services provided by a psychologist licensed pursuant to 26 V.S.A. chapter 55.); and
- therapeutic care (services provided by licensed or certified speech language pathologists, occupational therapists, or physical therapists).

2. **Benefits**.

- We will provide coverage for the evidence-based diagnosis and treatment of early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, as Medically Necessary.
- The amount, frequency, and duration of treatment described in this section shall be based on medical necessity and is subject to Pre Authorization.
- We will provide coverage for applied behavior analysis when the services are provided or supervised by a licensed provider who is working within the scope of the provider's license or who is a nationally board-certified behavior analyst.
- We will provide coverage for services under this section delivered in the natural environment (home or child care setting) when the services are furnished by a provider working within the scope of the provider's license or under the direct supervision of a licensed provider or, for applied behavior analysis, by or under the supervision of a nationally board-certified behavior analyst.
- Except for inpatient services, if You are receiving treatment for an early developmental delay, we may require treatment plan reviews based on Your needs, consistent with reviews for other diagnostic areas and with rules established by the department of financial regulation. We may review the treatment plan for children under the age of eight once every six months.
- Diagnosis and Treatment of Early Childhood Developmental Disorders are subject to the same Cost Share that is required for the diagnosis and treatment of other mental health conditions.
- You must pay the applicable Cost Share listed on Your SBC.

- We will not provide Benefits to an individual for services provided under an individualized family service plan, individualized education program, or individualized service program.

B. 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. We will provide benefits for Medically Necessary routine foot care. You must pay the Cost Share for prescription drugs set forth on your SBC for diabetic equipment and supplies. Diabetic treatment services are subject to your medical benefit cost share in your SBC.

1. **Equipment and Supplies.**

   We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:

   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump
   - Glucagon for injection to increase blood glucose concentration
   - Glucose acetone reagent strips
   - Glucose kit
   - Glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
   - Glucose reagent tape
   - Glucose test or reagent strips
   - Injection aides
   - Injector (Busher) Automatic
   - Insulin
   - Insulin cartridge delivery
   - Insulin infusion devices

- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, designated by regulation as appropriate for the treatment of diabetes.

Diabetic equipment and supplies are Covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with Us to provide all diabetic equipment or supplies required by law for Members through participating pharmacies. If You require a certain item not available from Our designated diabetic equipment or supply manufacturer, You or Your Provider must submit a request for a medical exception by calling the number on Your MVP Member ID card. Our medical director will make all medical exception determinations. Diabetic equipment and supplies are limited to a 30-day supply up to a maximum of a 90-day supply when purchased at a pharmacy.

2. Self-Management Education.

Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, or other licensed health care Provider authorized to prescribe under Vermont law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Vermont law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations.

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

C. Durable Medical Equipment.

We Cover the rental or purchase of durable medical equipment.

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

In addition to the above items, a listing of non-covered DME items can be found on Our website at **MVP Commercial DME Non-Covered Items**. This list will be updated from time to time based solely on changes made by CMS. We recommend that you check this list prior to purchasing any DME item to ensure it is a covered item, and not on the list of Non-Covered items. Some examples of Non-Covered DME items are hot water bottles, exercise equipment, toilet rails, and tub stools. This list will be revised from time to time by Us. If you are unable to access the website or need additional information, call the number on Your MVP ID card.

D. Hearing Aid Exam and Devices.

Exam. We will provide benefits for an annual hearing exam for prescribing, fitting, or determining the need for hearing aids and for hearing therapy or training. A hearing aid exam is subject to the specialist visit cost share.

External Hearing Aids. We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered Services include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years. External hearing aids are subject to the durable medical equipment cost share.

Cochlear Implants. We cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Contract, unless more than one is Medically Necessary. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions. Cochlear implants are internal prosthetic devices. Pre-Authorization is required.

E. Hospice.

Conditions for Hospice Services.

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

Hospice Services are available only once per each Member's lifetime. We Cover up to 210 days of inpatient Hospice Services in a Hospice or Hospital and home care and outpatient services provided by the hospice, including drugs and medical supplies. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care. You must pay the Copayment, Deductible and/or Coinsurance that applies.

F. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

G. Inherited metabolic disease.

We Cover the diagnosis and medically necessary treatment of inherited metabolic disease. Pre Authorization is required.

H. Prosthetics.

1. External Prosthetic Devices.

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered, except for treatment of certain medical conditions of the eye.

We do not Cover shoe insert orthotics, lifts, arch supports, or special shoes not attached to a brace.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for the most appropriate model that is Medically Necessary to meet Your medical needs.

We shall provide coverage for prosthetic devices that is at least equivalent to that provided by the federal Medicare program. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

I. Craniofacial disorders.
We Cover the diagnosis and medically necessary treatment of services for diagnosis and treatment, including surgical and non-surgical procedures, for 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 Section IX, paragraph W, and are subject to Pre-Authorization requirements.

J. Gender Reassignment Services for Gender Dysphoria.
We will provide benefits for medically necessary Gender reassignment services.

K. Acupuncture Coverage.
We will provide benefits for acupuncture with a maximum allowance of $500. This benefit will be a reimbursement. The Member may use any licensed provider. Members are reimbursed up to a maximum of $500 for acupuncture services. Once the $500 allowance is met, the benefit is exhausted and no further acupuncture services will be covered. Dollar amounts reimbursed will not accumulate toward deductibles or out of pocket maximums.

L. Annual Eye Exam Coverage.
We will provide Benefits for one (1) routine eye examination (refraction) per Covered Member once per Plan Year. A vision exam means an eye care exam for prescribing or determining your need for eyeglasses or contact lenses, and fittings for the contact lenses. The exam must be provided by a participating optometrist or ophthalmologist. Please see your SBC for your Cost Share obligations. We do not provide Benefits for eyewear.

M. Routine Foot Care. We cover Medically Necessary routine foot care.

SECTION XI – Inpatient Services

Please refer to the Summary of Benefits and Coverage (SBC) for Cost-Sharing and visit Our website at **mvphealthcare.com** for any Pre Authorization or Referral requirements that apply to these benefits.

A. Inpatient Services.

We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis, including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the SBC apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

B. Observation Services.

We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

D. Inpatient Stay for Maternity Care.
We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the SBC that apply to home care benefits.

E. Inpatient Stay for Mastectomy Care.
We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. Autologous Blood Banking Services.
We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury and are Medically Necessary. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Rehabilitation Services.
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for 30 days per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:
1. Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and
2. The therapy is ordered by a Physician.

H. Skilled Nursing Facility.
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Certificate). An admission

to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 60 days per Plan Year for non-custodial care.

I. End of Life Care.

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in an Acute care facility that specializes in the care of terminally ill patients. Your attending Physician and the facility's medical director must agree that Your care will be appropriately provided at the facility. If We disagree with Your admission to the facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

J. Centers of Excellence.

Centers of Excellence are Hospitals that We have approved and designated for certain services. To find out if a Hospital is a Center of Excellence call the number on Your Member ID card or visit Our website at mvphealthcare.com.

We Cover the following Services only when performed at Centers of Excellence:

A. Bariatric Surgery
B. Transplants

See the Utilization Review and the Grievances and Independent External Review sections of this Certificate for Your right to an internal Appeal and external appeal if We determine that the above services must be performed at a Center of Excellence.

K. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

SECTION XII – Mental Health Care and Substance Use Services

Please refer to Your Summary of Benefits and Coverage (SBC) for Cost-Sharing requirements and visit Our website at **mvphealthcare.com** for any Pre Authorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Inpatient Mental Health Services. We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. We will provide Benefits for Inpatient Services listed in Section XI Paragraph A for treatment of Mental Health Conditions. Coverage for inpatient services for mental health care is limited to mental health facilities 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. In the absence of a similarly qualified or approved facility, the facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations, or a national accreditation organization recognized by Us. We will also provide benefits for mental health residential treatment centers. The facility must be an MVP Participating Provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

We will not provide benefits for the following services: adventure-based activities, wilderness programs residential programs that focus on education, socialization or delinquency, Custodial Care (see Section XIV – Exclusions and Limitations, paragraph 4), and we will not provide benefits for marriage counseling.

B. Inpatient Alcohol or Substance Use Disorder Services. We will provide Benefits for the Inpatient Services listed in Section XI, Paragraph A for Services relating to the diagnosis and treatment of substance use disorders only when such services are provided pursuant to a written treatment plan in a facility approved by the secretary of human services that provides a program for the treatment of alcohol or substance use disorders. In the absence of a similarly approved facility, the facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us. The facility must be a Participating Provider. This includes Coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use disorder. We also provide benefits for substance use residential treatment centers, including room and board charges. The residential treatment center must be a Participating Provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

We will not provide Benefits for the following services: adventure-based activities, wilderness programs, residential programs that focus on education, socialization, or delinquency, and Custodial Services (see Section XIV – Exclusions and Limitations, paragraph 4).

C. Outpatient Mental Health Services. We Cover outpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. We will provide Benefits for outpatient treatment of Mental Health Conditions only when provided by a participating licensed or certified mental health provider. Covered Services include outpatient individual, group, and family therapies, medication management, psychological/neuropsychological testing, intensive outpatient and partial hospitalization programs, Transcranial Magnetic Stimulation (TMS), and Electroconvulsive Therapy (ECT). You must pay the Cost Share listed on your SBC.

D. Outpatient Alcohol or Substance Use Disorder Services. We will provide Benefits for outpatient treatment of alcohol or Substance Use only when such services are provided by a licensed or certified substance use provider. Covered services include outpatient individual, group, and family therapies, medication management, Medication Assisted Treatment (MAT), opioid treatment programs, and intensive outpatient and partial hospitalization programs. You must pay the Cost Share listed on your SBC for each visit.

We will not provide benefits for the following services: adventure-based activities and wilderness programs that focus on education, socialization or delinquency, and Custodial Services (see Section XIV – Exclusions and Limitations, paragraph 4).

SECTION XIII – Prescription Drug Coverage

Please refer to Your SBC for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.

We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Certificate.

- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription drugs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification and maintenance treatment, all buprenorphine products, methadone, and long-acting injectable naltrexone, and opioid overdose reversal medication, including when dispensed over-the-counter.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at **mvphealthcare.com**. You may inquire if a specific drug is Covered under this Certificate by contacting Us at the number on Your MVP Member ID card.

B. Refills. We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in Your SBC.

C. Benefit and Payment Information.

Cost-Sharing Expenses. You are responsible for paying the costs outlined in Your SBC when Covered Prescription Drugs are obtained from a retail or mail order pharmacy.

You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent Prescription Drug is available on a lower tier unless We approve coverage at the higher tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance. The cost difference does not apply toward Your Deductible or Out-of-Pocket Limit.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

Coupons and Other Financial Assistance. We will apply any third-party payments, financial assistance, discounts, or other coupons that help You pay Your Cost-Sharing towards Your In-Network Deductible and In-Network Out-of-Pocket Limit.

This provision only applies to: 1) a Brand-Name Drug without an AB-rated generic equivalent, as determined by the FDA; 2) a Brand-Name Drug with an AB-rated generic equivalent, as determined by the FDA, and You have accessed the Brand-Name Drug through Preauthorization or an Appeal, including step-therapy protocol; and 3) all Generic Drugs.

Participating Pharmacies. For Prescription Drugs purchased at a retail or mail order Participating Pharmacy, You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.) In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your MVP Member ID card or visit Our website at **mvphealthcare.com** to request approval.

Non-Participating Pharmacies. We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above. If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases, You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy.

Mail Order. Certain Prescription Drugs may be ordered through Our mail order supplier. You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Physician to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order supplier regardless of the number of days' supply written on the Prescription Order or Refill. Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

We will provide benefits that apply to Prescription drugs dispensed by a mail order pharmacy to Prescription drugs that are purchased from a retail pharmacy when that retail pharmacy is a Participating Pharmacy and agrees to the same terms and conditions as a participating mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at **mvphealthcare.com** or by calling the number on Your MVP Member ID card.

Formulary Changes. Our Formulary is subject to Our periodic review and modification. However, a Prescription Drug will not be removed from Our Formulary more than twice per year, except when the FDA determines that such Prescription Drug should be removed from the market. Before We remove a Prescription Drug from Our Formulary, We will provide at least 90 days' notice. We will also post such notice on Our website at **mvphealthcare.com**.

We will not add utilization management restrictions (e.g., step therapy or Preauthorization requirements) to a Prescription Drug on Our Formulary during the year unless the requirements are added pursuant to FDA safety concerns.

Tier Status. A Prescription Drug will not be moved to a tier with a higher Cost-Sharing during the year, except a Brand-Name Drug may be moved to a tier with higher Cost-Sharing if an AB-rated generic equivalent or interchangeable biological product for that Prescription Drug is added to the Formulary at the same time.

Before We move a Prescription Drug to a different tier, We will provide at least 90 days' notice prior to the start of the year. We will also post such notice on Our website at **mvphealthcare.com**. You may access the most up to date tier status on Our website at **mvphealthcare.com** or by calling the number on Your MVP Member ID card.

When a Brand-Name Drug Becomes Available as a Generic Drug. When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a Generic Drug becoming available, You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in the Utilization Review and Grievances and Independent External Review sections of this Certificate.

Brand/Generic Difference. If you have a covered prescription filled with a brand name drug, as defined by MediSpan® and there is a generic equivalent drug for that brand name drug, and you have not obtained an exemption based on the medical necessity for the brand name drug, you must pay the generic drug cost share, plus the difference in cost between the generic and the brand name drug, not to exceed the cost of the drug. The amount you pay for the difference between generic and brand will not apply to any maximum benefit, out of pocket maximum or deductible.

Formulary Exception Process. If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the Grievances and Independent External Review section of this Certificate. Visit Our website at **mvphealthcare.com** or call the number on Your MVP Member ID card to find out more about this process.

Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 72 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 24 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

Supply Limits. Except for contraceptive drugs, devices, or products, We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply.

You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing when provided by a Participating Pharmacy.

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two and a half (2.5) Cost-Sharing amounts for a 90-day supply.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at **mvphealthcare.com** or by calling the number on Your MVP Member ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and the Grievances and Independent External Review sections of this Certificate.

Cost-Sharing for Orally-Administered Anti-Cancer Drugs. Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the SBC or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under the Outpatient and Professional Services section of this Certificate.

Insulin Drugs. Your total out-of-pocket responsibility for prescription insulin medications will not be more than $100 per 30-day supply, regardless of the amount, type, or number of insulin medications being prescribed. This Out-of-Pocket Maximum will apply even if you have not met your deductible.

D. Medical Management.
This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

Preauthorization. Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, ask Your Provider to complete a Preauthorization form. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement. Drugs that must be Pre-Authorized before they are filled are identified on the Formulary. They are also listed by therapeutic categories on our Formulary. MVP notifies Providers, in writing, when we change these requirements. New FDA approved prescription medications are subject to Pre-Authorization for a minimum of six (6) months. All compounded prescriptions over $100 require Pre-Authorization. Compounds containing non-FDA approved drugs may also require Pre-Authorization. Please refer to Section XVII – Utilization Review for additional information regarding Pre-Authorization requests.

For a list of Prescription Drugs that need Preauthorization, please visit Our website at **mvphealthcare.com** or call the number on Your MVP Member ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, Including if a Prescription Drug or related item on the list is not Covered under Your Certificate. Your Provider may check with Us to find out which Prescription Drugs are Covered.

Step Therapy. Step therapy is a process in which You may need to use one type of Prescription Drug before We will Cover another as Medically Necessary. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list.

In cases where MVP requires step therapy protocols for coverage, MVP will:

(i) Not require failure on the same medication on more than one occasion for insured who are continuously enrolled in the plan.

(ii) Grant an exception to its step therapy protocols upon request within 24 hours for urgent request or 2 business days for nonurgent requests if and one of the following apply:

(a) the prescription drug required under the step-therapy protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;
(b) the prescription drug required under the step-therapy protocol is expected to be ineffective based on the insured's known clinical history, condition, and prescription drug regimen;
(c) the insured has already tried the prescription drugs on the protocol, or other prescription drugs in the same pharmacologic class or with the same mechanism of action, which have been discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, regardless of whether the insured was covered at the time on a plan offered by the current insurer or its pharmacy benefit manager;
(d) the insured is stable on a prescription drug selected by the insured's treating health care professional for the medical condition under consideration; or
(e) the step-therapy protocol or a prescription drug required under the protocol is not in the patient's best interests because it will:
    1. pose a barrier to adherence;
    2. likely worsen a comorbid condition; or
    3. likely decrease the insured's ability to achieve or maintain reasonable functional ability.

Therapeutic Substitution. Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at **mvphealthcare.com** or call the number on Your MVP Member ID card.

E. Limitations/Terms of Coverage.
1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Compounded Prescription Drugs will be Covered only when the primary ingredient is a Covered legend Prescription Drug, and are obtained from a pharmacy that is approved for

compounding. All compounded Prescription Drugs over $100 require Your Provider to obtain Preauthorization.

4. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of Prescription Drugs. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate.

6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient and Professional Services section of this Certificate.

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs for which there is a written order, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF for which there is a written order, or as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and the Grievances and Independent External Review sections of this Certificate.

11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

F. General Conditions.
1. You must show Your MVP Member ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours.

2. Drug Utilization, Cost Management and Rebates. We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage.

We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

Definitions.
Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Certificate).

1. Brand-Name Drug: A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.

2. Covered Drugs in this Section shall mean Medically Necessary Food and Drug Administration (FDA) approved self-administered prescription drugs under The Federal Food, Drug, and Cosmetic Act (FFDCA). This includes prescription drugs for bone mineral density not excluded by the terms and conditions of this Section of your Contract. Covered Drugs must also be recognized as safe and effective for treatment of the prescribed indication in prevailing Peer Reviewed Medical Literature or the Standard Medical Reference Compendia listed below:

- The American Hospital Formulary Service Drug Information); or
- Thomson Micromedex DrugDex with a strength of recommendation at least Class IIa, Strength of evidence at least Category B and Efficacy at least Class Iia.

This also includes the routine costs for off-label drugs used in connection with approved cancer clinical trials.

3. Experimental or Investigational Drugs means drugs that are either not generally 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. However, we will provide benefits, to the extent required by law, to cover routine costs for off-label drugs used in connection with approved cancer clinical trials.

4. Formulary: The list that identifies those Prescription Drugs for which coverage may be available under this Certificate. To determine which tier a particular Prescription Drug has been assigned, visit Our website at **mvphealthcare.com** or call the number on Your MVP Member ID card.

5. Generic Drug: A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, pharmacy or Your Physician may not be classified as a Generic Drug by Us.

6. Medically Appropriate Off-label Use of a Drug means the use of a Covered Drug, pursuant to a valid prescription by a health care provider, for other than the particular condition(s) for which approval was given by the U.S. Food and Drug Administration in circumstances in which the medically appropriate off-label use is reasonably calculated to restore or maintain the member's health, prevent deterioration of or palliate the member's condition, prevent the reasonably likely onset of a health problem or detect an incipient problem; and that is informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition.

7. Non-Participating Pharmacy: A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

8. Participating Pharmacy: A pharmacy that has:
- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- Been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

9. Prescription Drug: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

10. Prescription Drug Cost: The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

11. Prescription Order or Refill: The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of their practice.

12. Usual and Customary Charge: The cash price that an individual without insurance would pay for the drug and quantity prescribed, as determined by the pharmacy

SECTION XIV - Exclusions and Limitations

No coverage is available under this Certificate for the following:

1. **Alternative Services**. We will not provide Benefits for alternative or complementary health services, products, remedies, treatments and therapies. This includes, but is not limited to, biofeedback (except for treatment of urinary incontinence), 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; unless listed as a Covered Service on Your SBC.

2. **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 provide Benefits for administration and processing charges.

3. **Caffeine Cessation Services**. We will not provide Benefits for programs and services to help You alleviate caffeine dependence.

4. **Convalescent and Custodial Care.**
   We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

5. **Conversion Therapy.**
   We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

6. **Certification Examinations**. Except as provided in Section Eleven, paragraph 1(B)(Annual Adult Health Evaluations), we will not provide Benefits for any services related to routine physical examinations, immunizations and/or testing to certify health status. This includes, but is not limited to, examinations required for school, employment, insurance, marriage, divorce, adoption, custody, divorce, medical research, licensing, insurance, travel, camp, or sports.

7. **Communication Aids**. We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of communication aids. Communication aids that do not generate speech are not covered. Examples of non-covered communication ides include the following: telecommunication devices for the deaf (TDDs), teletype machines (TTYs), Braille typewriters, flashcards, devices that allow the patient to communicate messages to others with writing/typing rather than with synthesized speech.

8. **Consultations**. We will not provide Benefits for consultations except when they are between Participating Providers. Such Providers must attach a written report to Your medical record.

9. **Court-Ordered Services**. We will not provide Benefits for court-ordered services, other than a court ordered to provide dependent health insurance coverage pursuant to a qualified medical support order, or for administratively-ordered services, such as by the Department of Motor Vehicles. Such services include, but are not limited to, special medical reports not directly related to treatment and reports prepared for legal actions.

10. **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 insurrection or illegal occupation. The felony, riot, insurrection or illegal occupation will be determined by the law of the state where the criminal behavior occurred.

11. **Dietician Services**. Except as provided, we will not provide Benefits for dietician services, homemaker services, home delivered meals, or other food or food-related services.

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

13. **Educational Services**. We will not provide Benefits for services required to determine appropriate educational placements or services or for other educational testing. We will not provide Benefits for special education and related services, and assistive technology

devices and assistive technology services determined to be needed as a result of such educational evaluations. This includes, but is not limited to therapy services, cognitive retraining and rehabilitation, behavioral modification, services for remedial education, evaluation and treatment of learning disabilities, interpreter services and lessons in sign language.

14. **Employer Services**. We will not provide Benefits for any services furnished by a medical department or clinic provided by Your employer.

15. **Home Modifications and Fixtures**. We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of home modifications and fixtures. For example: 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, home appliances, 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.

16. **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 not submitted to MVP as soon as is reasonably possible after the date of service, except when coordination of benefits applies and MVP is the secondary payor.

17. **Cosmetic Services.**
    We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified. Cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary.

18. **Coverage Outside of the United States, Canada or Mexico.**
    We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

19. Dental Services.

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Certificate.

20. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and the Grievances and Independent External Review sections of this Certificate for a further explanation of Your Appeal rights.

21. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

22. Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

23. Non-Medically Necessary services.

In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

24. Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are

covered by Medicare, We will reduce Our benefits by the amount Medicare paid for the Covered Services.

25. **Military Service.**
    We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

26. **No-Fault Automobile Insurance.**
    We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

27. **Non-Provider Services**. We will not provide Benefits for any services provided by a person or entity that we do not approve for the given service or who is not defined as a Provider. We will not provide Benefits for services provided by a person who provides services as part of their education or training program.

28. **Non-Participating Provider Services**. Except as provided herein, or as required by state law or regulation, we will not provide Benefits for Services from a Non-Participating Provider.

29. **Non-Standard Allergy Services**. We will not provide Benefits for non-standard allergy services. This includes, but is not limited to, skin titration, cytotoxicity testing, and treatment of non-specific candida sensitivity and urine auto injections.

30. **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 services in a Participating Hospital, through covered Participating Home Care or Hospice Services, or for covered immunizations; (ii) medical foods prescribed for the Medically Necessary treatment for an inherited metabolic disease and (iii) drugs prescribed for the Medically Necessary treatment of diabetes.

31. **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. This includes, but is not limited to, massage services, spa services, and other provider services, central or unit air conditioners, air or water purifiers, furniture such as reclining chairs, 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.

32. **Private Duty Nursing**. We will not provide benefits for this service.

33. **Self-Help Education and Training**. Except as provided, we will not provide Benefits for biofeedback, self-diagnosis, self-treatment or self-help training and/or materials.

34. **Special Charges**. We will not provide Benefits for stand-by services, missed appointments, new patient processing, interest, copies of Provider records, completion of claim forms, Provider's time to write reports, or postage, shipping, handling or tax.

35. **Support Therapies.** Except as provided for Hospice Services, we will not provide Benefits for support therapies. This includes, but is not limited to, marriage counseling, pastoral or religious counseling, sex counseling, or other social counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy and play therapy.

36. **Terminated Coverage**. Except as provided in Sections XIV Fourteen and XV Fifteen, we will not provide Benefits for any services provided after the termination date of Your coverage under this COC.

37. **Travel and Transportation Costs**. Except as provided, we will not provide Benefits for this service or related expenses such as meals and lodging.

38. **Unlicensed Provider**. We will not provide Benefits for services provided by an unlicensed Provider or for services that are outside of a Provider's scope of practice.

39. **Services Not Listed.**
    We do not Cover services that are not listed in this Certificate as being Covered.

40. **Services Starting Before Coverage Begins**. We will not provide Benefits for any services You get:
    - prior to Your Effective Date; or
    - on or after Your Effective Date if the service is covered or required to be covered under any other health benefits contract, certificate, program or plan.

    If the service is not covered and is not required to be covered under any other health benefits certificate, program or plan, MVP will provide Benefits beginning on Your Effective Date only if You comply with the terms of this COC.

41. **Services Provided by a Family Member.**
    We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law. Sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

42. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

43. Services with No Charge.
We do not Cover services for which no charge is normally made.

44. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

45. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

46. Treatment of Obesity. We do not Cover services for the treatment of obesity, except surgical treatment when determined Medically Necessary.

47. We will not provide Benefits for the following Hospital facility and Skilled Nursing Facility services:

- 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;
- Any inpatient days that are mostly for diagnostic purposes, such as x-rays, laboratory tests, or physical checkups, unless Medically Necessary;
- An inpatient stay while You are waiting for a different level of care, such as Skilled Nursing Facility or home care, when such care is available to You;
- Any charges because You did not leave Your room at the discharge time;
- Any services provided by a private duty nurse.
- Any non-medical items including, but not limited to, telephone, television, beauty and barber services, guest trays, guest services and accommodations; and
- Any items that You take home from the Hospital.

SECTION XV - Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your MVP Member ID card or visiting Our website at **mvphealthcare.com**. Completed claim forms should be sent to the address Your on Your MVP Member ID card. You may also submit a claim to Us electronically by sending it to the e- mail address in the How Your Coverage Works section of this Certificate; on Your MVP Member ID card or visiting Our website at **mvphealthcare.com**.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 180 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 180-day period, You must submit it as soon as reasonably possible. In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.

D. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievances and Independent External Review section of this Certificate.

SECTION XVI - 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 Contract, 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 1-800-348-8515 in order to designate a representative. If English is not Your primary language, You may call MVP's Customer Care Center for help 1-800-348-8515 or to get information in Your primary language about how to file a grievance and how to participate in the grievance process. You may also call either the Vermont Department of Financial Regulation's Consumer Service at 1-800-964-1784 or the Vermont Office of Health Care Advocate at 800-917-7787 for assistance. If You are unable to file a written grievance, You may notify MVP of a grievance orally or through another alternative mechanism. MVP shall be responsible for documenting such grievances and providing copies to You upon Your request for Your use, or the use of Your appointed' representative. If You have a disability, You shall be provided with reasonable accommodations for filing grievances and for participating in the grievance process. Your decision as to whether or not to submit a grievance has no effect on Your rights to any other benefits under this Contract. At Your request and free of charge, MVP will, within two (2) business days, provide You with reasonable access to and copies of documents, records, and other information relevant to Your grievance. You must commence and complete a First Level Grievance before You may seek any other internal or external remedy, including Independent External Review or court action.

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. First Level Grievances - General Information.

A. In deciding a first level grievance of an adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, or based in whole or in part on any other adverse benefit determination that is an appealable decision pursuant to Vermont's independent external review laws, the reviewers shall include at least one (1) clinical peer of the Member's treating provider.

B. 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..

C. MVP's medical director or the medical director's designee shall offer to, and if the offer is accepted, shall directly communicate with Your treating provider or the treating provider's designee before a resolution of the grievance is made;

D. For any grievances relating to an adverse benefit determination, we shall promptly authorize and/or otherwise arrange for coverage for any covered service that had been denied or restricted and as to which a reversal has been made by its reviewers under this section.

E. No fees or costs are imposed on You as part of the Mandatory First Level or Voluntary Second Level Grievance.

F. 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 1-800-348-8515. You may submit a written grievance to MVP Health Plan, Inc., 625 State Street, Schenectady, New York 12305.

4. First-Level Concurrent Review Grievance - Timeframe for Completion and Notification:

A. A grievance related to a request to continue or extend a course of treatment shall be decided as soon as possible consistent with the medical exigencies of the case. MVP shall notify You and Your treating provider of our determination (whether adverse or not) as soon as possible consistent with the medical exigencies of the case, but not later than twenty-four (24) hours after receipt of the grievance.

B. In the case of a grievance related to an adverse concurrent review determination, neither You nor the provider shall be liable for any services provided before notification to You of the adverse determination and the final outcome of any grievance or independent external review, unless the treating provider or designee has refused or repeatedly failed to engage in communication with MVP when it has been offered at a time in a manner reasonably convenient for the provider, in which case the provider, not You, shall be liable for any services provided.

C. We shall notify the treating provider and You of the determination orally as soon as the determination has been made. Written (either hard copy or, if elected by Your or Your treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider and You within twenty-four (24) hours of the oral notification.

5. First-Level Urgent, Pre-Service Grievance - Timeframe for Completion and Notification:

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 concurrent review or Pre Authorization request is urgent.

B. MVP shall notify the treating provider (if known) and You of the determination orally as soon as the determination has been made. Written (either hard copy, or if elected by You or treating provider, appropriately secure electronic)

confirmation of the determination shall be sent to the treating provider (if known) and to You within twenty-four (24) hours of the oral notification.

C. For purposes of this section, the following grievances shall be treated as urgent:

1. All pre-service grievances related to mental health and substance use conditions that were handled as urgent at the review level, unless:

a. You have authorization for the treatment in dispute such that treatment can continue uninterrupted for the duration of any non-expedited grievance(s) and independent external review, if any;

b. the request is for a service scheduled sufficiently in the future such that non-expedited grievance(s) and independent external review, if any, can be completed prior to the date scheduled for the service; or

c. the managed care organization otherwise has good cause to believe that it is not medically necessary to expedite the timeframe for grievance review, and You and provider agree;

2. All pre-service requests related to whether use of a prescription drug for the treatment of cancer is medically necessary or is an experimental or investigational use; and

3. Any grievance designated as urgent by Your health care provider or by You.

6. First-Level Non-Urgent, Pre-Service Grievance - Timeframe for Completion and Notification:

A. In the case of a grievance relating to a non-urgent, pre-service request, MVP shall notify You and the Your treating provider (if known) of our determination (whether adverse or not) no later than fifteen (15) calendar days after receipt of the grievance.

B. Written (either hard copy or, if elected by You or Your treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and to You.

7. First-Level Post-Service Grievance - Timeframe for Completion and Notification:

A. In the case of a post-service grievance, MVP shall decide and notify You and Your treating provider (if known) of our determination (whether adverse or not) within

a reasonable period of time but not later than fifteen (15) calendar days after receipt of the grievance.

B. Written (either hard copy or, if elected by You or Your treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and to You.

8. First-Level Grievance Unrelated to an Adverse Benefit Determination - Timeframe for Completion and Notification:

A. For grievances not related to adverse determinations, You shall be notified within fifteen (15) calendar days after receipt of the grievance.

B. Written (either hard copy or, if elected by You, appropriately secure electronic) confirmation of the determination shall be sent to You.

9. If You are not satisfied with MVP's decision in response to Your First Level Grievance, You may, in addition to any other legal remedy available to You:

A. Proceed directly to Independent External Review, as described in paragraph 17 below; or

B. Commence a Voluntary Second Level Grievance with MVP as described in paragraphs 11-16 below. If You do so, Your time to commence court action will not start until You receive MVP's response to the Voluntary Second Level Grievance

10. Additional Provisions.

A. MVP waives any right to assert that You failed to exhaust administrative remedies because You did not elect to make a Voluntary Second Level Grievance.

B. MVP agrees that any statute of limitations or other defense based on timeliness is tolled during the time that Your Voluntary Second Level Grievance is pending.

C. No fees or costs are imposed on You as part of the Mandatory First Level or Voluntary Second Level Grievance.

11. Voluntary Second Level Grievances - General Information.

A. If You are not satisfied with MVP's decision in response to the first level grievance, You may submit a voluntary second level grievance. You are not required to make a Voluntary Second Level Grievance in order to pursue any external remedy that may be available to You.

B. MVP Shall:

(i) Provide You the right to meet with one (1) or more of the reviewers, at Your request, before a final determination is made on the voluntary second level grievance.
(ii) Provide for either an in-person meeting or a telephone meeting; however, if it is inconvenient for You to participate in the manner offered by MVP, the other method of meeting must be made available to You.
(iii) Ensure that Your treating provider(s) and any other person(s) requested by You is (are) entitled but not required to participate in such a meeting or call.
(iv) Ensure that the meeting date shall be arranged in consultation with You.
(v) Not unreasonably deny a request for postponement of the review made by You.
(vi) Ensure that the right to have a voluntary second level grievance considered shall not be made conditional on Your appearance either in person or by telephone at such a meeting.
(vii) For any grievances relating to an adverse determination, we shall promptly authorize and/or otherwise arrange for coverage for any covered service that had been denied or restricted and as to which a reversal has been made by its reviewers under this section.

C. Submitting a Voluntary Second Level Grievance. You must submit this grievance within 90 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 1-800-348-8515. You may submit a written grievance to MVP Health Plan, Inc., 625 State Street, Schenectady, New York 12305. 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.

12. Voluntary Second-Level Concurrent Review Grievance - Timeframe for Completion and Notification:

A. A grievance related to a request to continue or extend a course of treatment shall be decided as soon as possible consistent with the medical exigencies of the case. MVP shall notify You and Your treating provider (if known) of our determination (whether adverse or not) as soon as possible consistent with the medical exigencies of the case, but not later than twenty-four (24) hours after receipt of the grievance.

B. In the case of a grievance related to an adverse concurrent review determination, neither You nor Your provider shall be liable for any services provided before notification to You of the adverse benefit determination and the final outcome of any grievance or independent external review, unless the treating provider or designee has refused or repeatedly failed to engage in communication with MVP when it has been offered at a time in a manner reasonably convenient for the provider, in which case Your provider and not You shall be liable for any services provided.

C. MVP shall notify the treating provider and You of the determination orally as soon as the determination has been made. Written (either hard copy, or, if elected by You or Your treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider and to You within twenty-four (24) hours of the oral notification.

13. Voluntary Second-Level Urgent, Pre-Service Grievance - Timeframe for Completion and Notification:

A. In the case of a voluntary second-level grievance relating to an urgent, pre-service request, 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 concurrent review or Pre Authorization request is urgent. MVP shall notify You and Your treating provider (if known) of our determination (whether adverse or not) as expeditiously as Your medical condition requires, but not later than twenty-four (24) hours after receipt of the voluntary second-level grievance. You will be notified of our decision by telephone and in writing.

B. MVP shall notify the treating provider (if known) and You of the determination orally as soon as the determination has been made. Written (either hard copy, or, if elected by You or Your treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider and You within twenty-four (24) hours of the oral notification.

14. Voluntary Second-Level Non-Urgent, Pre-Service Grievance - Timeframe for Completion and Notification:

A. In the case of a voluntary second-level grievance relating to a non-urgent, pre-service request, MVP shall notify You and Your treating provider (if known) of our determination (whether adverse or not) no later than fifteen (15) calendar days after receipt of the grievance.

B. Written (either hard copy or, if elected by You or Your treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and to You.

15. Voluntary Second-Level Post-Service Grievance - Timeframe for Completion and Notification:

A. In the case of a voluntary second-level post-service grievance, MVP shall notify You and Your treating provider (if known) of our determination (whether adverse or not) within a reasonable period of time but not later than fifteen (15) calendar days after receipt of the grievance.

B. Written (either hard copy or, if elected by You or Your treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and to You.

16. Voluntary Second-Level Grievance Unrelated to an Adverse Benefit Determination - Timeframe for Completion and Notification:

A. For voluntary second-level grievances not related to adverse determinations, You shall be notified within fifteen (15) calendar days after receipt of the grievance.

B. Written (either hard copy or, if elected by You, appropriately secure electronic) confirmation of the determination shall be sent to You.

If You are not satisfied with MVP's decision in response to Your Second Level Grievance, You may, in addition to any other legal remedy available to You, proceed directly to Independent External Review as described in paragraph 17 below.

17. Independent External Review.

A. You have the right to an "independent external review" of an appealable decision made by MVP to deny, reduce, or terminate coverage or to deny payment for a health care service. An independent external review is an independent review of our decision by a third party known as an independent review organization. Independent review organizations ("IRO") are selected by the DFR and must not have any conflict of interest associated with the review.

You have the right to request a review by a State approved IRO after the first level of internal appeal has been exhausted or after the voluntary second level of appeal where MVP has denied coverage based on medical necessity; experimental or investigational nature of the services; off-label use of a drug; choice of provider; treatment of a pre-existing condition; an adverse determination related to surprise medical billing, and for mental health and substance use reviews. You do not have the right to external review of any other decisions, even if those other decisions affect Your eligibility or benefits.

Exhaustion of the internal grievance process is not required when MVP has waived the internal grievance process or has been deemed to have waived the internal grievance process by failing to adhere to grievance process time requirements. (An expedited External Appeal can be made simultaneously with an expedited first level of internal appeal.) The right to independent external review is contingent on the Member's exhaustion of MVP's first level internal grievance process unless as noted above.

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. You may request an expedited external appeal even if Your internal appeal was non-expedited.

B. You must request this review within 120 days or 4 months, whichever is longer, from the date any of the following occur:

(i) You receive written documentation of MVP's final grievance decision and notice of appeal rights; or
(ii) MVP waives the required grievance process; or
(iii) MVP is deemed to have waived the grievance process by failing to adhere to grievance process time requirements.

To request an independent, external review, You must call the Vermont DFR at 800-964-1784.

C. You may request an independent external review only if the service that is the subject of the review is a Covered Service.

D. Your Right to an Immediate External Appeal. If we fail to adhere to the appeals process requirements described in Your Certificate, You will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in Your Certificate

18. Effect of Review Organization's Decision; Coverage.

The decision of the independent review organization is binding on MVP, the member, the provider, and the group. If the independent review 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 independent review organization decides in Your favor, we will provide benefits subject to all other terms and conditions of this Contract. We will not provide benefits for any service that is not a Covered Service. In addition, this section does not change any Cost Sharing responsibilities.

19. Assistance.

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the Vermont Department of Financial Regulations at 1-800-964-1784.

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Office of Health Care Advocate
264 North Winooski Avenue
Burlington, VT 05405
800-884-1955 or 802-863-2316

SECTION XVII - Utilization Review

This Contract requires concurrent review and Pre Authorization by MVP before You receive certain Covered Services. All other services are subject to retrospective review. MVP's approval of services through concurrent review, or Pre Authorization 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 concurrent review and Pre Authorization is requested. You and Your Provider will be notified, in writing, within 24 hours of the telephone notice.

   B. In cases where:

      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

      (c) a physician with knowledge of Your medical condition determines that a concurrent review or Pre Authorization 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 Authorization**. 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. Pre-Authorization is not required for any admission, item, service, treatment, or procedure ordered by a Blueprint Primary Care Provider. Prescription Drugs and Out-of-Network services require Pre-Authorization regardless of ordering provider. We do not require Pre-Authorization for Emergency Medical Services.

A. When Pre Authorization is Required.

   i. For In-Network Services. Check with Your MVP Participating Provider. He or she will ask for Pre Authorization from MVP on Your behalf when it is needed for In-Network services. You need Pre-Authorization for services on our Prior Approval list, even if you use a Network Provider except for any admission, item, service, treatment, or procedure ordered by a Blueprint Primary Care Provider. MVP makes a list of these services available to Participating Providers. Go to MVP's website at **mvphealthcare.com** if You would like to see the list of In-Network services that need Pre Authorization. You may also call MVP's Customer Care Center at 1-800-348-8515 to ask if a service is on the list.

   ii. For Out-of-Network Services. You must get Pre Authorization from MVP for Yourself when the services are Out-of-Network regardless of the ordering provider.

   iii. For Prescription Drugs. You must get Pre-Authorization from MVP for Prescription Drugs regardless of ordering provider.

B. Urgent Pre-Authorization Requests.
   i. We shall approve, deny, or inform you or your health care provider if any information is missing from a pre-authorization request from your or your prescribing health care provider within 24 hours following receipt of the request.
   ii. If We inform You or your health care provider that more information is necessary for Us to make a determination on the request, You or your health care provider will have 45 days from the receipt of our notice to provide us with the missing information. We shall have 24 hours to approve or deny the request upon receipt of the necessary information.

C. Non-Urgent Pre-Authorization Requests.
   i. We shall approve or deny a completed Pre-Authorization request from You or Your prescribing health care provider within two business days following receipt of the request.
   ii. We shall acknowledge receipt of the Pre-Authorization request within 24 hours following receipt and shall inform You or Your health care provider at that time if any information is missing that is necessary for Us to make a determination on the request.
   iii. If We notify You or your health care provider that more information is necessary pursuant to paragraph ii above, You or your health care provider will have 45 days

from the receipt of our notice to provide us with the missing information. We shall have 24 hours to approve or deny the request upon receipt of the necessary information.

D. If We do not, within the time limits set forth above, respond to a completed Pre-Authorization request, acknowledge receipt of the request for Pre-Authorization, or request missing information, the Pre-Authorization request shall be deemed to have been granted.

E. Pre-Authorization approval for a prescribed or ordered treatment, service, or course of medication shall be valid for the duration of the prescribed or ordered treatment, service, or course of medication or one year, whichever is longer; provided, however, that for a prescribed or ordered treatment, service, or course of medication that continues for more than one year, a health plan shall not require renewal of the Pre-Authorization approval more frequently than once every five years.

F. If You are stable on a treatment, service, or course of medication, as determined by a health care provider, that was approved for coverage under a previous health plan, We shall not restrict coverage of that treatment, service, or course of medication for at least 90 days upon Your enrollment in this plan.

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 paragraph 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. If we deny benefits, You must pay all charges.

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 1-800-348-8515 within 48 hours, or as soon as reasonably possible, after receiving Emergency Services or Urgent Care Services that result in an 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 XVI (Sixteen).

7. **Appeal Assistance.** If You need Assistance filing an Appeal, You may contact the Department of Financial Regulation at:

   Consumer Services – Division of Insurance
   Department of Financial Regulation
   89 Main Street
   Montpelier, VT 05620-3101
   Toll free: 1-800-964-1784

   The Office of Health Care Advocate can also provide help to Vermonters who have problems or questions about health care and health insurance. You may contact them at:

   Office of Health Care Advocate
   264 North Winooski Avenue
   Burlington, VT 05401
   Toll free: 1-800-917-7787

SECTION XVIII - Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. **"Plan"** is other group health coverage with which We will coordinate benefits. The following are considered to be health plans:
    - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
    - Medical benefits coverage in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
    - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan required or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decides the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    - The plan of the parent who has custody will be primary;
    - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
    - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our

obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION XIX - Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.

4. For Spouses in cases of divorce or dissolution of Civil Union, the date of the divorce or dissolution.

5. For Children, until the end of the month in which the Child turns 26 years of age. A health insurance plan that provides dependent coverage of children shall continue to make that coverage available for an adult child until the child attains 26 years of age

6. For all other Dependents, the day in which the Dependent ceases to be eligible.

7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on their enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on their enrollment application, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. The date that the Group Contract is terminated. If We terminate and/or decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days' prior written notice.

10. If We elect to terminate or cease offering all hospital, surgical and medical expense coverage in the large group market in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.

11. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

12. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

13. The date there is no longer any Member who lives, resides, or works in Our Service Area.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage. See the Conversion Right to a New Contract after Termination section of this Certificate for Your right to conversion to an individual Contract.

SECTION XX - Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Contract terminates, or on the date Your coverage under this Certificate terminates, benefits may be extended for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, "total disability" means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When Your Benefits May be Extended.

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

B. Termination of Extension of Benefits.

Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the 12-month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

C. Limits on Extended Benefits.

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

SECTION XXI - Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the Vermont Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the Vermont Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the Vermont Insurance Law.

A. Qualifying Events.

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class that results in ineligibility for employer-sponsored coverage;
    - Divorce, dissolution, or legal separation from the Subscriber's spouse or civil union partner; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

B. Continuation Notice and Terms.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

C. Termination of Continuation Coverage.
Continued coverage under this section will terminate at the earliest of the following:

1. The date 18 months after the Subscriber's coverage would have terminated because of a qualifying event;
2. If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become covered by Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See the Conversion Right to a New Contract after Termination section of this Certificate.

SECTION XXII - Conversion Right to a New Contract after Termination

A. Circumstances Giving Rise to Right to Conversion.

You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.

1. **Termination of the Group Contract.** If the Group Contract between Us and the Group is terminated as set forth in the Termination of Coverage section of this Certificate, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as a direct payment member.

2. **If You Are No Longer Covered in a Group.** If Your coverage terminates under the Termination of Coverage section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.

3. **On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

4. **Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.

5. **Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

6. **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the Termination of Coverage section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.

B. When to Apply for the New Contract.

If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of coverage under this Certificate. You must also pay the first Premium of the new Contract at the time You apply for coverage.

C. The New Contract.

We will offer You an individual direct payment Contract that Covers all benefits required by state and federal law. You may choose among the available Contracts offered by Us. The coverage may not be the same as Your current coverage. If You are age 65 or over and enrolled in Medicare, We will also offer You contracts issued to Medicare-enrolled individuals.

SECTION XXIII - General Provisions

1. Agreements Between Us and Participating Providers.
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.
You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits to any person, corporation or other organization and any such assignment will be void and unenforceable. You cannot assign any monies due under this Certificate to any person or corporation or other organization.

Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in this Certificate.
We may unilaterally change this Certificate upon renewal, if We give the Group 30 days' prior written notice.

4. Choice of Law.
This Certificate shall be governed by the laws of the State of Vermont.

5. Clerical Error.
Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.
Any term of this Certificate which is in conflict with Vermont State law or with any applicable federal law that imposes additional requirements from what is required under Vermont State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from

covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Enrollment ERISA.
The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Certificate, and any other information required to confirm their eligibility for coverage.

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

The Group will provide Us with the enrollment form including Your name, address, age, and social security number and advise Us in writing when You are to be added to or subtracted from Our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date of the Group's Contract with Us. If the Group fails to so advise Us, the Group will be responsible for the cost of any claims paid by Us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of thirty (30) days.

9. Entire Agreement.
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

10. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

11. Furnishing Information and Audit.
The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's Vermont office.

12. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

13. Incontestability.
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

14. Input in Developing Our Policies.
Subscribers may participate in the development of Our policies by calling the customer Care Center at the number on Your Member ID card and speak with any of Our representatives.

15. Material Accessibility.
We will give the Group, and the Group will give You ID cards, Certificates, riders and other necessary materials.

16. More Information about Your Health Plan.
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Certificate.

17. Notice.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: the address on Your MVP Member ID card.

18. Premium Refund.
We will give any refund of Premiums, if due, to the Group.

19. Recovery of Overpayments.
On occasion, a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

20. Renewal Date.
The renewal date for this Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Certificate or by the Group upon 30 days' prior written notice to Us.

21. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

22. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, 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 owe You.

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

24. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

25. Time to Sue.
No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

26. Translation Services.
Translation services are available under this Certificate for non-English speaking Members. Please contact Us at the number on Your MVP Member ID card to access these services.

27. Venue for Legal Action.
If a dispute arises under this Certificate, it must be resolved in a court located in the State of Vermont. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to Vermont State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

28. Waiver.
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

29. Who May Change this Certificate.
This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO"); or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

30. Who Receives Payment under this Certificate.
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either the Subscriber or the Provider. However, We will directly pay a Provider instead of You for Emergency Services, including inpatient services following Emergency Department Care, pre-hospital emergency medical services, air ambulance services, and surprise bills.

31. Payment of Claims. We will pay the claim within 30 days of receipt if all required information to make a payment determination is present. If we request additional information, We will pay the claim within 30 days of receipt of all requested information. Member claims forms are available at this link: MVP Claim Reimbursement Request (mvphealthcare.com). Online member claim forms are available at mvphealthcare.com. To submit a claim form online, sign into your online account and select Medical Claim Reimbursement.

32. Workers' Compensation Not Affected.
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

33. Your Medical Records and Reports.
In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the Vermont Department of Banking, Insurance, Securities and Health Care Administration or other quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

34. Your Rights and Responsibilities.

As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits. You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

You have the right to be treated with respect and recognition of your dignity and your right to privacy.

You have the right to participate with practitioners in making decisions about your health care.

You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

You have the right to voice complaints or appeals about the organization or the care it provides.

You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

As a Member, You should also take an active role in Your care. We encourage You to:

- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Certificate. This may include information about other health insurance benefits You have along with Your coverage with Us; and

- Inform Us if You have any changes to Your name, address or Dependents covered under Your Certificate.

35. Physical Examination. We may require You to have a physical exam as often as necessary about any injury or illness which results in a claim made under this Contract. We may also have the right and opportunity to make an autopsy in the case of death, where it is not prohibited by law. Such exams and autopsy will be at MVP's cost.