"MVP HIGH DEDUCTIBLE HEALTH PLAN PREFERRED PROVIDER ORGANIZATION"

Certificate of Coverage

Issued by

MVP Health Insurance Company
P.O. Box 1076, Schenectady, NY 12301-1076
518/370-4793

This Certificate of Coverage ("Certificate") is evidence of the health services and benefits available to eligible Group Members and their Eligible Dependents under the Contract entered into between the "Group" and MVP Health Insurance Company ("MVP"). This Certificate is not a contract between you, the Group Member or Eligible Dependent of such Group Member, and MVP. Please read this entire Certificate carefully. It is your responsibility to understand and comply with all terms and conditions contained within this Certificate.

NOTICE

THIS POLICY OR CERTIFICATE DOES NOT MEET THE REQUIREMENTS OF A CONTINUING CARE RETIREMENT CONTRACT. AVAILABILITY OF THIS COVERAGE WILL NOT QUALIFY A RESIDENTIAL FACILITY AS A CONTINUING CARE RETIREMENT COMMUNITY.

NOTICE

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IF THE MEMBER IS ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM THE COMPANY.

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MVP HEALTH INSURANCE COMPANY

ARTICLE I - GENERAL INFORMATION

A. Introduction

This Certificate explains the health services and benefits available under your Group's High Deductible Health Plan (HDHP) Preferred Provider Organization (PPO) Contract. In this Certificate, when we use the word(s) "we," "us," "our" and "the Plan" we mean MVP. "You," your" and "your" refers to you, the Subscriber. If you have Family Coverage, in most cases, the word "you" shall also include any member of your family covered under this Contract. Use of the word "he" in this Certificate refers to he or she. Use of the word "his" refers to his or her.

B. Definitions

1. **Allowable Amount or Allowable Charge** is the maximum Benefit available under this Contract. The Allowable Amount or Charge may be established in accordance with a fee agreement, "usual, customary and reasonable charges" or by statute or regulation. Allowable Amount or Allowable Charge for Prescription Drugs obtained at a Participating Pharmacy shall be equivalent to the negotiated rate charged to MVP by the Participating Pharmacy. Allowable Amount or Allowable Charge for Prescription Drugs obtained at a Non-Participating Pharmacy shall be the lesser of: (1) the amount MVP would have been charged had Covered Drugs been obtained at a Participating Pharmacy; or (2) your out-of-pocket costs for the Covered Drug.

2. **Benefits and Benefit Payments** refers to the payments made to you or on your behalf to the provider by MVP after you have received Covered Services.

3. **Calendar Year** means the twelve (12) month period beginning on January 1 and ending on December 31. However, if you were not covered under this Contract for the entire period, Calendar year means the period from your effective date until December 31.

4. **Certificate or Certificate of Coverage** refers to this document.

5. **Coinsurance** is a dollar amount, expressed as a stated percentage of the "Allowable Charge," which must be satisfied by the Covered Person. You must pay any Coinsurance directly to the Provider.

6. **Contract or Group Contract** refers to the agreement between MVP and Group for which this Certificate of Coverage and the attached Schedule make up a part.

7. **Coverage** refers to the Covered Services and Benefits available under the terms and conditions of this Contract. Family Coverage refers to the Covered Services and Benefits available under the terms and conditions of this Contract to your eligible family members.

8. **Covered Drug** refers collectively to FDA approved prescription drugs and devices, enteral formulas, and modified solid food products (including prescription drugs and devices for infertility - see- Article VIII, Section C(4)(l) of this Contract).

9. **Covered Person** means you, the Subscriber, and your covered family members as defined in Article II, Section A ("Who is Covered") of this Certificate.

10. **Covered Service** is a service or supply specified in this Contract for which we will pay Benefits.

11. **Custodial Care** means services primarily designed to help in transferring, eating, dressing, toileting, and other such related activities.

12. **Deductible** is a predetermined dollar amount, which must be satisfied before we will pay Benefits for In-Network Services, Out-of-Network Services, or both (see the Schedule attached to this Certificate), under this Contract. You must pay any Deductible directly to the Provider.

13. **Eligible Dependent** means a person other than the Subscriber, listed on the Subscriber's Enrollment Application submitted to MVP, together with any additional requested documentation, who meets all eligibility requirements, and for whom the required premium has been received by MVP.

14. **Effective Date** means the date Coverage under this Contract begins. Coverage begins at 12:01 a.m., Eastern Time, on that date.

15. **Emergency Care.** MVP defines Emergency Care as care necessary to treat a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

a. Placing the health of the afflicted person in serious jeopardy, or in the case of a behavioral condition placing the health of the person or others in serious jeopardy;

b. Serious impairment to the person's bodily functions;

c. Serious dysfunction of any bodily organ or part of the person; or

d. Serious disfigurement of the person.

16. **Expenses**. There are two types of Expenses: Deductible Expenses and Annual Out of Pocket Maximum Expenses. Deductible Expenses mean expenses incurred by you, up to the Allowable Charge, for Medically Necessary Covered Services. Deductible Expenses do not include any Coinsurance. Annual Out of Pocket Expenses mean Deductible Expenses plus Coinsurance. Expenses do not include premium payments, out of pocket costs for Non-Covered Services, and expenses incurred by you prior to your Effective Date and/or after the termination of your coverage under this Contract.

17. **Experimental or Investigational** means that the treatment, procedure, drug, device or any hospitalization in connection with same is:

a. not of proven benefit for the particular diagnosis or treatment of the Covered Persons particular condition; or

b. not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the Covered Person's particular condition.

18. **Fee Agreement or Fee Schedule** refers to the arrangement between MVP and Participating Providers to provide Covered Services to Covered Persons under this Contract.

19. **Group or Group Policyholder** refers to the entity (e.g. employer or association group) to whom this Contract has been issued. A large Group is a Group with 51 or more employees eligible for health insurance coverage.

20. **Hospital**, means a short-term, acute, general hospital, which:

a. is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;

b. has organized departments of medicine and major surgery;

c. has a requirement that every patient must be under the care of a physician or dentist;

d. provides twenty-four (24) hour nursing service by or under the supervision of a registered professional nurse (R.N.);

e. if located in New York State has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 USCA 1395x[k]);

f. is duly licensed by the agency responsible for licensing such hospitals; and

g. 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 of convalescent, custodial educational or rehabilitory care.

21. **In-Network Benefits** refers to the Benefits paid by MVP when Covered Services are accessed "In-Network," and pursuant to the terms and conditions of this Contract.

22. **In-Network Services.** See Article II, Section F.

23. **Medical Necessity.** See Article II, Section K.

24. **Out-of-Network Benefits** refers to the Benefits paid by MVP when Covered Services are accessed "Out-of-Network," and pursuant to the terms and conditions of this Contract.

25. **Out-of-Network Services.** See Article II, Section F.

26. **Participating Providers** use of the word "participating" before Provider means that the provider has participating agreement with MVP to provide Covered Services under this Contract.

27. **Pre-Certification** refers to the required approval that a Covered Person must receive from MVP before accessing certain Covered Services in order to receive the maximum Benefits available under this Contract. (**See Article II, Section M**).

28. **Premium** means the dollar amount, which the Group is required to pay to MVP in order to commence and continue coverage under this Contract for each Covered Person.

29. **Prior Notice** means the notice you must give to MVP prior to receiving certain Covered Services in order to receive the maximum Benefits available under this Contract. (**See, Article II, Section L**).

29. **Providers,** except as otherwise indicated, are health care institutions, health care professionals, and entities that provide additional health services as follows:

    a. Institutional Providers. Institutional Providers are: acute care general hospitals; ambulatory surgery centers; birth centers; skilled nursing facilities; psychiatric hospitals; home health agencies; hospices; inpatient alcoholism and/or substance abuse treatment facilities; and outpatient alcoholism and/or substance abuse treatment facilities.

    b. Professional Providers. Professional Providers are: physicians and other health care professionals who are licensed to provide the Covered Services under this Contract. We will only pay for those Covered Services performed by Providers the New York Insurance Law requires us to recognize. Also, we only pay for Covered Services that are usually billed by the Provider.

    c. Providers of additional health services. Providers of additional health services are suppliers of: durable medical equipment; prosthetic devices; medical supplies; ambulance service; kidney dialysis; and retail, mail and specialty pharmacies. We will only pay for Covered Services that are usually billed by the Provider.

30. **Schedule** refers to the document attached to this Certificate which describes the applicable Deductible, Coinsurance, annual out of pocket maximum, lifetime maximum and other Coverage information.

31. **Subscriber, Group Member or Certificate Holder** each of these terms refer to the individual to whom this Certificate is issued.

32. **Usual, Customary and Reasonable (UCR) Charges** are established based on a percentile of national prevailing charge data compiled for a specific procedure and adjusted for geographic differences. When you obtain Covered Services from a Non-Participating Provider who does not have a Fee Agreement with MVP, the Allowable Amount will be determined by UCR Charges. In these cases, the Covered Person will be responsible for one-hundred (100) percent of all provider charges in excess of the Allowable Amount.

ARTICLE II - HOW THIS POLICY WORKS

A. Who is Covered

In order to obtain Coverage under this Contract you must complete and file with MVP an Application on a form provided by MVP. This Application must include your name and, if you are applying for Family Coverage, the names of all members of your family group for whom you seek Coverage. Coverage under this Contract is contingent upon MVP's acceptance of your completed Application.

Upon acceptance, you shall be covered pursuant to the terms and conditions of this Contract. If you have applied for Family Coverage, then the following members of your family group may also be covered:

1. Spouse: your husband or wife - unless divorced or unless the marriage is annulled.

2. Children: For purposes of this Contract, "Children" are defined as your natural or legally adopted children; a child for whom you are the legal guardian or for whom you have legal custody; or your stepchild who is dependent upon you for support. **Foster Children and Grandchildren are not included in MVP's definition of Children.** As consistent with the above definition, and the other terms and conditions of this Contract, the following Children may be included under your family coverage:

   a. Your unmarried dependent children who are under the age of nineteen (19). Coverage shall last until the end of the month in which the child turns nineteen (19).

   b. Your unmarried children who are unable to work to support themselves because of mental illness, developmental disability, mental retardation (all as defined in the mental hygiene law) or physical handicap. To be eligible, their disability must have started before the date Coverage would otherwise have terminated under this Contract by virtue of the dependent reaching the limiting age. Both the disability, and when it started, must be certified by a physician and the certification must be submitted to MVP within thirty-one (31) days of the dependent child reaching the limiting age. In addition, we may periodically check to see whether the dependent child is and continues to be qualified for Coverage as a disabled child. Eligibility for Continued Coverage under this Subpart will end for any such dependent child over the age at which Coverage would have terminated by virtue of reaching the limiting age, who marries, or becomes able to earn a living.

If you become or remain an eligible member of your group and are covered under this Contract after becoming eligible for Medicare, you will continue to receive benefits for which you are eligible under this Contract. Your benefits for Covered Services, however, will be reduced by the amount you receive from Medicare for the same service, except to the extent that federal law requires Medicare benefits be considered secondary.

B. When Coverage Begins

Coverage is subject to the conditions set forth in Article II, Section A, above, as well as, all other terms and conditions set forth in this Contract.

1. If you file an Application with us before becoming eligible for Coverage, then your Coverage will start on the date you become eligible.

2. If you marry after the start of Coverage, then Coverage for the eligible members of your family group will start on the date of your marriage, provided that you notify us within thirty (30) days after the marriage that you want to add Family Coverage. If you fail to notify MVP within thirty (30) days, Coverage for the eligible members of your family group will not start until the next open enrollment period for your Group.

3. If you have Family Coverage, your newborn child will be covered from the date of birth, provided that you notify and advise us within thirty (30) days of the birth of your intent to add such newborn to your Family Coverage. If you do not have Family Coverage, your newborn child may still be covered from date of birth, if you notify and advise us within thirty (30) days from date of birth of your intent to add Family Coverage.

4. If you have Family Coverage or switch to Family Coverage, pursuant to subsection "3" above, we will cover your proposed adoptive newborn child from date of birth, provided that you notify and advise us within thirty (30) days from the date of birth of your intent to add Family Coverage, subject to the following conditions:

    a. You take physical custody of the infant as soon as the infant is released from the hospital after birth;

    b. You file a petition pursuant to Section 115-c of the New York State Domestic Relations Law within thirty (30) days of the infant's birth;

    c. And, provided further that no notice of revocation of the adoption has been filed pursuant to Section 115-b of the New York State Domestic Relations Law and consent to the adoption has not been revoked.

Notwithstanding the foregoing, we will not cover the initial hospital stay for your adopted newborn child, if one of the child's natural parents has health insurance coverage available to cover the initial hospital stay. Additionally, if we pay Benefits to cover an adopted newborn and the notice of the adoption is revoked, or one of the natural parents revokes consent, we shall be entitled to recover from you any sums paid by us for care of the adopted newborn.

C. Open Enrollment.

You may enroll or add Eligible Dependents for any reason during your Group’s open enrollment period. If we receive and accept your enrollment application during the open enrollment period your Coverage shall commence on your Group’s next effective date for new enrollees. If you do not enroll either yourself or an Eligible Dependent during your Group’s open enrollment period, then you will be required to wait until the next open enrollment period as established by your Group to enroll, unless you or your Dependents meet the conditions for special enrollment described below.

D. Special Enrollment

If you do not initially enroll or enroll during an open enrollment period, then you will in most instances be required to wait until the next open enrollment period before you may enroll (either for yourself or your dependents) for coverage with MVP, unless you or your dependents qualify for a special enrollment period. To qualify for special enrollment period each of the following conditions must be met:

1. You and/or the dependent[s] you seek to enroll must have been covered under a group health plan or had other health insurance coverage at the time coverage was previously offered.

2. You must have stated in writing that other coverage was the reason for declining enrollment at the time it was offered. This condition, however, must only be met if the plan sponsor for your Group required that this statement be made in writing and provided you with notice of this requirement (and the consequences of such requirement) at the time coverage was offered.

3. Coverage was provided in accordance with the continuation coverage required by state or federal law and was exhausted; or coverage under the other group health plan or health insurance contract was terminated because you and/or the dependent[s] that you seek to enroll have lost eligibility for one or more of the following reasons:

    a. Termination of employment;

    b. Death of the spouse;

c. Legal separation, divorce or annulment;

d. Reduction in the number of hours worked; OR

e. The employer or other group ceased its contribution toward the premium for the other plan or contract; AND

4. You submit an enrollment application on your own behalf or on behalf of your eligible dependents to MVP within thirty (30) days after the loss of coverage of termination for any of the reasons set forth in Subsection “3” immediately above.

When enrolling pursuant to this paragraph, coverage under this Contract will commence as of the first date of loss of coverage following the qualifying event, provided we receive timely premium payment on your behalf from your Group.

E. Obligation to Provide Information.

You must give us information needed to determine your initial and continuing eligibility status. This information must be provided within thirty (30) days of our request, unless a longer period is required by law. We have the right to verify this information. You must immediately notify us of any event that affects your eligibility. Such events include, but are not limited to, divorce or annulment, death of your spouse, Medicare eligibility or coverage under another contract, policy or certificate, a child marrying or reaching the age at which eligibility terminates, and a change or termination of any medical support order.

F. Covered Services

The services for which we may provide Benefits are described in Articles III, IV, V, VI, VII, VIII, IX, X and XI of this Certificate. Coverage is subject to all of the terms and conditions of this Contract, as well as, the conditions set forth in this Section.

Some services are referenced both under Article IV as "Outpatient Hospital/Facility Services" and, in Article VI as "Medical/Surgical Services" (e.g. physical therapy, mental health care and annual cervical cytology). This is done to clarify that these services may be accessed in multiple locations on an outpatient basis and, should not be understood to represent Coverage for additional services (e.g. additional days or visits).

Throughout this Contract we will distinguish between those Covered Services accessed In-Network and those accessed Out-of-Network. This is an important distinction as it will affect, among other things, your Benefits.

1. In-Network Inpatient Hospital/Facility Services. In order to obtain the In-Network Benefit for Inpatient Hospital/Facility Services described in Article

III of this Certificate, you must be admitted by a Participating Professional Provider to a Participating Institutional Provider.

2. In-Network Outpatient Hospital/Facility Services. Except for Emergency Care, in order to obtain the In-Network Benefit for Outpatient Services described in Article IV, you must receive such care from a Participating Institutional Provider.

3. In-Network Outpatient Dialysis Services. In order to obtain the In-Network Benefit for Outpatient Dialysis Services described in Article V, Covered Services must be provided in the out-patient department of a hospital or freestanding facility, which has an operating certificate issued by the New York State Department of Health pursuant to Article Twenty-Eight of the New York State Public Health Law and must be a Participating Provider with MVP.

4. In-Network Medical/Surgical Services. In order to obtain the In-Network Benefit for Medical/Surgical Services described in Article VI, you must obtain such Covered Services from a Participating Professional Provider.

5. In-Network Transplant Services. In order to obtain the In-Network Benefit for Transplant Services, described in Article VII, you must comply with MVP's Pre-Certification requirements; the services must be provided by a Participating Provider with MVP or by a provider who has been approved by MVP; and, the services must be performed at a facility within MVP's Transplant Network. **Transplant Benefits are available In-Network Only.**

6. In-Network Supplies and Prescription Drugs. In order to obtain the In-Network Benefit for Supplies and Equipment for the Treatment of Diabetes and Durable Medical Equipment, External Prosthetic Devices and Ostomy Supplies (Supplies) and Prescription Drugs described in Article VIII, you must have a Prescription/Script for such Supplies from a Professional Provider and purchase these Supplies from a Participating Pharmacy.

7. In-Network Home Health Care/Hospice Care/Skilled Nursing Care. In order to obtain the In-Network Benefit for Home Health Care, Hospice Care and Skilled Nursing Care Services described in Articles IX, X, and XI respectively, you must obtain such Covered Services from a Participating Institutional Provider.

8. Out-of-Network Services. Covered Services that fail to meet the definition of Sections 1-7 above shall be paid as Out-of-Network Benefits, unless otherwise excluded under the terms and conditions of this Contract. Please note, some health services may only be covered on an In-Network basis. When this is the case it will be indicated in **bold print** at the bottom of the individual health service description.

Where day and visit limitations are indicated with regard to Covered Services, these contractual limitations apply whether the Covered Service is accessed In-Network or Out-of-Network. For example, this Contract provides Benefits for up to thirty (30) visits, combined, for Outpatient Physical Therapy, Speech Therapy and Occupational Therapy per Calendar Year, whether accessed In-Network or Out-of-Network. This means that Covered Persons may receive Benefits for up to thirty (30) visits on an In-Network basis; thirty (30) visits on an Out-of-Network basis; or any combination thereof but in no event will such person receive Benefits for visits that exceed the overall contractual limitation of thirty (30) visits.

G. Your Payments

Each Covered Person under this Contract shall be required to pay any applicable Deductible and Coinsurance before receiving Benefits under this Contract. The applicability and amount of such payments depends upon the type of Coverage purchased by your Group and is listed on the Schedule attached to this Certificate.

1. <u>In-Network Deductible.</u> This Contract requires you to pay an In-Network Deductible for all In-Network Services except for the preventive care services identified on your Schedule of Benefits. The In-Network Deductible amount is the predetermined dollar amount that is listed on your Schedule of Benefits. If you have Single Person Coverage, you must meet the In-Network Single Person Coverage Deductible each Calendar Year. The amount of the Subscriber's Deductible Expenses for In-Network Services will apply toward the Single Person Coverage Deductible. If you have Family Coverage, the Subscriber and/or his Dependents must meet the In-Network Family Coverage Deductible each Calendar Year. The Deductible Expenses of the Subscriber and/or his Dependents for In-Network Services will apply toward the In-Network Family Coverage Deductible. The applicable Deductible must be met before MVP will make any Benefit payments under this Contract. If the applicable Deductible has been met, no further In-Network Deductible payments will be required for the rest of that Calendar Year. You must still pay any applicable Coinsurance and the Out-of-Network Deductible if you get Out-of-Network Services.

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

        i. Any penalties you must pay under this Contract.
        ii. Any Coinsurance.
        iii. Any Charges you incur if you have exhausted any Benefit maximums or that are otherwise incurred for non-Covered Services.

2. In-Network Coinsurance. This Contract requires you to pay a Coinsurance for all In-Network Covered Services except those Covered Services identified on your Schedule of Benefits as not requiring Coinsurance. After the applicable Deductible amount is subtracted, MVP will pay a pre-established percentage of the Allowable Charges. The percentage of Allowable Charges that MVP does not pay is your Coinsurance amount. Your Coinsurance for each Covered Service is set forth on the attached Schedule.

3. Out-of-Network Deductible. This Contract requires you to pay a Out-of-Network Deductible for all Out-of-Network Services except for the preventive care services identified on your Schedule of Benefits. The Out-of-Network Deductible amount is the predetermined dollar amount that is listed on your Schedule of Benefits. If you have Single Person Coverage, you must meet the Out-of-Network Single Person Coverage Deductible each Calendar Year. The amount of the Subscriber's Deductible Expenses for Out-of-Network Services will apply toward the Single Person Coverage Deductible. If you have Family Coverage, the Subscriber and/or his Dependents must meet the Out-of-Network Family Coverage Deductible each Calendar Year. The Deductible Expenses of the Subscriber and/or his Dependents for Out-of-Network Services will apply toward the Out-of-Network Family Coverage Deductible. The applicable Deductible must be met before MVP will make any Benefit payments under this Contract. If the applicable Deductible has been met, no further Out-of-Network Deductible payments will be required for the rest of that Calendar Year. You must still pay any applicable Coinsurance and the In-Network Deductible if you get In-Network Services.

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

      i. Any penalties you must pay under this Contract.
      ii. Any Coinsurance.
      iii. Any Charges you incur if you have exhausted any Benefit maximums or that are otherwise incurred for non-Covered Services.
      iv. The difference, if any, between the Non-Participating Provider's Charge and the Allowable Charge.

4. Out-of-Network Coinsurance. This Contract requires you to pay a Coinsurance for all Out-of-Network Covered Services except those Covered Services identified on your Schedule of Benefits as not requiring Coinsurance. After the applicable Deductible amount is subtracted, MVP will pay a pre-established percentage of the Allowable Charges. The percentage of Allowable Charges that MVP does not pay is your Coinsurance amount. Your Coinsurance for each Covered Service is set forth on the attached Schedule.

Please note, Non-Participating Providers have not entered into a Fee Agreement with MVP and, therefore, are not required to accept the Allowable Amount as payment in full. In such cases, you may be held responsible by the Non-Participating Provider for one-hundred (100) percent of the difference, if any, between the Allowable Amount and the Provider's actual charges.

H. Annual Out of Pocket Maximums

This Contract has the following Out of Pocket Annual Maximums: In-Network Single Person, In-Network Family, Out-of-Network Single Person, and Out-of-Network Family. These are the maximum amounts of expenses Covered Persons must pay during any one (1) Calendar Year. These are listed on your Schedule. **Some payments do not count toward Annual Out of Pocket Maximums**. These are described in paragraph C below.

A. Single Person Annual Out of Pocket Maximums.

1. In Network. After you pay In-Network expenses up to the In-Network Single Person Annual Out of Pocket Maximum in any one (1) Calendar Year, you do not have to pay any further In-Network expenses for the rest of that Calendar Year. You must still make any payments that are not counted toward the annual Out of Pocket Maximum. The In-Network Single Person Annual Out of Pocket Maximum applies each Calendar Year. If you have met your In-Network Single Person Annual Out of Pocket Maximum, you must still pay Out of Network expenses up to the Out of Network Single Person Annual Out of Pocket Maximum if you get services Out-of-Network.

2. Out-of-Network. After you pay Out-of-Network expenses up to the Out-of-Network Single Person Annual Out of Pocket Maximum in any one (1) Calendar Year, you do not have to pay any more Out-of-Network expenses for the rest of that Calendar Year. You must still make any payments that are not counted toward the Annual Out of Pocket Maximum, and the difference, if any between the Non-Participating Provider's Charge and the Allowable Charge. The Out of Network Single Person Annual Out of Pocket Maximum applies each Calendar Year. If you have met your Out of Network Single Person Annual Out of Pocket Maximum, you must still pay In Network Expenses up to the In Network Single Person Annual Out of Pocket Maximum if you get services In Network.

B. Family Annual Out of Pocket Maximums.

1. In Network. If you have family coverage, you and your covered family members may apply the amount of each person's In Network expenses toward the In Network Family Annual Out of Pocket Maximum. If you and your covered family members have met the In Network Family Annual Out of Pocket Maximum in any one (1) Calendar Year, you and your covered family members do not have to pay any further In Network Expenses for the rest of that Calendar Year. You must still make any payments that are not counted toward the annual Out of Pocket Maximum. The In Network Family Annual Out of Pocket Maximum applies each Calendar Year. If you and your family have met your In Network Family Annual Out of Pocket Maximum, you must still pay Out of Network Expenses if you get services Out of Network.

2. Out of Network. If you have family coverage, you and your covered family members may apply the amount of each person's Out of Network Expenses toward the Out of Network Family Annual Out of Pocket Maximum. If you and your covered family members have met the Out of Network Family Annual Out of Pocket Maximum in any one Calendar Year, you and your covered family members do not have to pay any further Out of Network Expenses for the rest of that Calendar Year. You must still make any payments that are not counted toward the Annual Out of Pocket Maximum, and the difference, if any between the Non-Participating Provider's Charge and the Allowable Charge. The Out of Network Family Annual Out of Pocket Maximum applies each Calendar Year. If you and your family have met your Out of Network Family Annual Out of Pocket Maximum, you must still pay In Network Expenses if you get services In Network.

C. The following **DO NOT** Count Toward Annual Out of Pocket Maximums. Even if you have met the Annual Out of Pocket Maximum for a Calendar Year, you must still make these payments.

1. The difference, if any, between the Non-Participating Provider's Charge and the Allowable Charge.
2. Any penalties you must pay.
3. Any Charges you incur if you have exhausted any Benefit maximums or that are otherwise incurred for non-Covered Services

I. Benefits, Claim Submission & Proof of Loss

The following describes how we pay Benefits and your obligations with respect to claim and proof of loss filing under this Contract. You must comply with the

requirements listed below in order to obtain the maximum Benefits available under this Contract.

1. <u>In-Network Services</u>.

   a. Benefit Payments. When you obtain Covered Services In-Network, in most instances, the Participating Provider will bill MVP directly. We will subtract any applicable Deductible and Coinsurance amounts from MVP's Benefit payment to the Participating Provider. The Participating Provider will bill you directly for such amounts.

   b. Claim Submission. As described above, in most instances, when you obtain Covered Services In-Network the Participating Providers will bill MVP directly and you will not be required to submit your claim to MVP for reimbursement. In the event that you are billed directly for health services, which you believe were properly accessed In-Network, you should contact MVP Member Services Department at (888) MVP-MBRS within twenty-four (24) hours of receipt of the bill for instructions.

   c. Proof of Loss. MVP's timely receipt of the bill for the health services from your Participating Provider will be deemed a proper filing of Proof of Loss on your behalf.

2. <u>Out-of-Network Services.</u>

   a. Benefit Payments. When you obtain Covered Services Out-of-Network, in most instances, you will be billed directly by the Non-Participating Provider for the health services provided. You must then submit your claim to MVP, in the manner described in Subpart "b" below in order to receive your Benefit Payment from MVP. We will subtract any applicable Deductible and Coinsurance amounts from MVP's Benefit payment to you. **You and not MVP are responsible to the Non-Participating Provider for all provider charges.**

   b. Claim Submission. Before we make any payments to you for Out-of-Network Services you must:

      i. Submit your claim[s] to MVP on an MVP Claims Form. You can obtain claim forms by contacting MVP Member Services at (888) MVP-MBRS or by downloading the form from MVP's web site at www.mvphealthcare.com.

      ii. Submit your claim[s] to MVP at:

MVP Health Insurance Company
P.O. Box 1076
Schenectady, NY 12301-1076

iii. Submit your claim[s] to us for payment within **sixty (60) days** of your receipt of the bill for such Covered Services from the Provider. Where, your bill is subject to coordination of benefit rules, as described in Article XIII of this Certificate, and MVP is deemed the "secondary plan," claims must be submitted to us within **sixty (60) days** after you receive a final statement from the primary plan.

c. Proof of Loss. For purposes of Article XIX, Section D ("Actions Brought Against MVP"), proper and timely claim submission is deemed a filing of proof of loss.

3. In-Network Prescription Drug Services.

a. Benefit Payments. When you obtain Covered Services In-Network, in most instances, the Participating Pharmacy will bill MVP directly. We will subtract any applicable Deductible and Coinsurance amounts from MVP's Benefit payment to the Participating Pharmacy. The Participating Pharmacy will bill you directly for such amounts.

b. Claims Submission. Have your provider write a prescription. You must ensure that you or your provider has completed any required Pre-Certification requirements. Bring your prescription along with your MVP ID Card to an MVP Participating Retail Pharmacy or, as applicable, complete a Mail Order Pharmacy Order Form or Specialty Pharmacy Order Form and mail the completed order form along with your prescription to the address listed on the form. The Participating Pharmacist will make an immediate benefit inquiry to MVP. If the pharmacist's benefit inquiry indicates that you have met all eligibility and coverage requirements, the pharmacist will fill your prescription and you will have completed the Claim filing process. If the pharmacist's benefit inquiry indicates that you have not met all eligibility and coverage requirements, the pharmacist will tell you and you may do one of the following:

i. You may elect to have the pharmacist fill the prescription and submit a Post Service Claim for benefits to MVP as described in Paragraph 4 Subparagraph (b) below; or

ii. You may decline to have the pharmacist fill your prescription (i.e. not obtain the Covered Drug) and

immediately submit a Pre-Service Claim or Urgent Care Claim directly to MVP as described in subparagraphs (a) and (b) immediately below.

a. How to file a Pre-Service Claim for Pharmacy Benefits. To file a Pre-Service Claim you, your designee or the prescribing provider must first call MVP's Member Services Department at (888) 687-6277, and make a benefit inquiry. If MVP's Member Services Department is unable to resolve this inquiry, and you still wish to submit a Claim, then you, your designee or the prescribing provider may submit a Pre-Service Claim to MVP by faxing or mailing a Pre-Service Claim Form to the fax number or address listed on the form. You may request a copy of the form from MVP's Member Services Department or download the form from MVP's web site at www.mvphealthcare.com. MVP will make a decision on your Pre-Service Claim within the timeframe set forth in Article XVII of this Contract.

b. How to file an Urgent Care Claim for Pharmacy Benefits. To file an Urgent Care Claim you, your designee or your prescribing provider must call MVP's Member Services Department at (888) 687-6277 and provide your name, the name of the drug requested, your pharmacy, the name of the prescribing provider, a description of your condition and a description of the circumstances that make this an Urgent Care Claim. MVP will make a decision on your Urgent Care Claim within the timeframe set forth in Article XVII of this Contract.

4. Out-of-Network Prescription Drug Services.

a. Benefit Payments. When you obtain Covered Services Out-of-Network, in most instances, you will be billed directly by the Non-Participating Pharmacy for the Covered Drug. You must then submit your claim to MVP, in the manner described in Subpart "b" below in order to receive your Benefit Payment from MVP. We will subtract any applicable Deductible and Coinsurance amounts from MVP's Benefit payment to you. **You, and not MVP, are responsible to the Non-Participating Provider for all provider charges**

b. Claims Submission. To file a Post Service Claim you, your designee or your prescribing provider, must mail a completed MVP Claim Form to the address listed on the form. To complete the form, you must fill in all required information; you must have the pharmacist sign the form; and, you must attach the original receipt for the prescription to the form. You may obtain MVP Claim Forms by contacting MVP's Member Services Department at (888) 687-6277 or you may download the form from MVP's web site at www.mvphealthcare.com. Post Service Claims must be properly submitted to MVP within one (1) year from the date the prescription was filled. MVP will make a decision on your Post Service Claim within the timeframe set forth in Article XVII of this Contract.

5. How to File a Claim for Covered Modified Solid Food Products. To file a claim for benefits for covered modified solid food products, you must contact MVP's Member Services Department at (888) 687-6277, and follow the instructions provided.

J. Lifetime Maximum Benefit

This Contract may establish a maximum dollar amount that we will pay out in Benefits for Covered Services received during the lifetime of each Covered Person under this Contract. Any applicable lifetime maximum dollar amount shall be set forth in your Schedule of Benefits. The lifetime maximum amount includes any amount we pay for Benefits to or on behalf of a Covered Person under this Contract. Additionally, a separate lifetime maximum benefit may also be established and included in your Schedule of Benefits for Durable Medical Equipment/External Prosthetic Devices and Ostomy and includes any amount we pay under this Contract.

K. Medical Necessity

No Benefits will be provided for services, which in MVP's judgment are not Medically Necessary. Services will be deemed Medically Necessary only if:

1. they are recommended by your treating physician; and

2. they are determined by MVP's Medical Director or physician designee to meet the following criteria:

   a. the services are appropriate and consistent with the diagnosis and treatment of your medical condition;

   b. the services are not primarily for your convenience, the convenience of your family, or your provider;

c. the services are required for the direct care and treatment or management of that condition;

d. the services are provided in accordance with general standards of good medical practice, as evidenced by, reports in peer reviewed medical literature; reports and guidelines as published by nationally recognized health care organizations that include supporting scientific data; and any other relevant information brought to our attention; and

e. the services are rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you, the member.

L. Prior Notice

Prior Notice means the notice you must give to MVP prior to receiving certain Covered Services in order to receive the maximum Benefits available under this Contract. MVP does not review, approve, or deny Benefits at this time. Your call is necessary for MVP to assign a length of stay or other concurrent review schedule. It is up to you to make certain that Prior Notice is given. If you fail to give Prior Notice when required, MVP may review the admission and/or service(s) retroactively. If we determine retroactively that any admission and/or service(s), whether received In-Network or Out-of-Network, was not Medically Necessary, we will not provide Benefits.

1. When Prior Notice is required. Prior Notice is required for the following:

   a. In-Network or Out-of-Network Non Emergency Hospital Admissions.
   b. In-Network or Out-of-Network outpatient Mental Health and Substance Abuse Services.

2. How to give Prior Notice. You must contact [MVP's Utilization Management Department] at [(800) 568-0458] at least five (5) days before you get the services listed above. You must provide us with your name, MVP ID number, your Provider's name and address, the services you will be receiving, dates of service and your diagnosis.

3. MVP's Response to Prior Notification. MVP will provide you with a written notice confirming your call.

4. Failure to give Prior Notice. If you fail to give Prior Notice when required, MVP may review the admission and/or service(s) retroactively. If we determine retroactively that any admission and/or service(s), whether received In-Network or Out-of-Network, was not Medically Necessary, we will not provide Benefits.

M. Pre-Certification

Pre-Certification refers to the required approval that must be obtained from MVP by the Covered Person prior to receiving certain Covered Services in order to receive the maximum Benefits available under this Contract. MVP reviews information about your medical condition and the proposed services in order to determine whether such services are Medically Necessary Covered Services. **It is up to you to make sure that Pre-Certification is obtained.** If you do not obtain Pre-Certification from us before you get certain Covered Services, your Benefits will be reduced.

1. When Pre-Certification is Required. Pre-Certification is required for the following Covered Services:

    a. In-Network or Out-of-Network Non-Emergency Ambulance Services
    b. In-Network or Out-of-Network Skilled Nursing Facility Services
    c. In-Network or Out-of-Network Home Health Care Services
    d. In-Network or Out-of-Network Hospice Care
    e. In-Network or Out-of-Network Surgery, except office surgery
    f. Transplant Services **Covered In-Network Only**
    g. In-Network or Out-of-Network Durable Medical Equipment, External Prosthetic Devices and Ostomy Supplies
    h. In-Network or Out-of-Network Inpatient Mental Health Services.
    i. In-Network Inpatient Substance Abuse Services **Covered In-Network Only**
    j. In-Network or Out-of-Network Inpatient Rehabilitation Care
    k. In-Network or Out-of-Network Outpatient Cardiac Rehabilitation, if you use more than 12 visits in any one Calendar Year.
    l. In-Network or Out-of-Network Imaging Services (CT Scans, MRAs, MRIs, PET Scans, Nuclear Cardiology)
    m. In-Network or Out-of-Network Genetic Testing
    n. In-Network or Out-of-Network Treatment of Infertility Services
    o. Bariatric Surgery **Covered In-Network Only**
    p. Covered Drugs identified on MVP's Formulary as requiring Pre-Certification/Prior Approval
    q. Enteral Formulas
    r. Modified Solid Food Products

2. How to obtain Pre-Certification.

    a. Generally. To request Pre-Certification, you must contact MVP's Utilization Management Department at 1 (800) 568-0458. You must provide us with your name, MVP ID number, your Provider's name and address, the date that Services are requested, and your

diagnosis. You must contact us at least five (5) days prior to your proposed admission or service date. You must notify us if your admit or service date changes. A family member or Provider may call for you. **However, it is up to you to make sure that Pre-Certification is obtained.** If the request is Urgent or involves Urgently-Needed Care as defined in Article XVII, you must tell us and describe the circumstances that make it Urgent.

b. In-Network and Out-of-Network Mental Health Services and Substance Abuse Services. To request Pre-Certification, you must contact MVP at 1 (800) 568-0458. You must provide us with your name, MVP ID number, your Provider's name and address, the date(s) that services are requested and your diagnosis. You must contact us at least five (5) days prior to your proposed admission or service date. You must notify us if your admit or service date changes. A family member or Provider may call for you. **However, it is up to you to make sure that Pre-Certification is obtained.** If the request is Urgent or involves Urgently-Needed Care as defined in Article XVII, you must tell us and describe the circumstances that make it Urgent.

c. In-Network and Out-of-Network Imaging Services. To request Pre-Certification, you must contact MVP at 1 (800) 568-0458. You must provide us with your name, MVP ID number, your Provider's name and address, the date(s) that services are requested and your diagnosis. You must contact us at least five (5) days prior to your proposed admission or service date. You must notify us if your admit or service date changes. A family member or Provider may call for you. **However, it is up to you to make sure that Pre-Certification is obtained.** If the request is Urgent or involves Urgently-Needed Care as defined in Article XVII, you must tell us and describe the circumstances that make it Urgent.

3. Failure to obtain Pre-Certification. If you fail to obtain Pre-Certification when required, **MVP will reduce to fifty (50) percent the Benefit otherwise payable to you.** Additionally, if we determine retroactively that any admission and/or service(s), whether received In-Network or Out-of-Network, was not Medically Necessary, we will not provide Benefits.

4. Emergency Admissions. While Pre-Certification is not required for admissions following Emergency Care, you must call MVP within two (2) business days after an emergency admission, or as soon as reasonably possible if there is extenuating circumstances.

ARTICLE III - IN-PATIENT HOSPITAL/FACILITY SERVICES

A. **Hospital Services Period**. The hospital services described in this section, except where otherwise indicated, are provided for up to a maximum of three hundred sixty five (365) days per "single confinement."

B. **Single Confinement**. MVP defines "single confinement" as consecutive days of inpatient services or successive confinements, when discharge and readmission occur within a period of not more than ninety (90) days. To measure a hospital stay we count the day of admission and each day after until the day of discharge. The day of discharge does not count. Any hospital stay due to accidental injury counts as a separate "service period," unless there was a hospital stay for the same or related injury less than ninety (90) days earlier. In that case, the new stay is part of a continuing "service period" for the accidental injury. A hospital stay for an accidental injury never counts as part of a "service period" for any other unrelated injury or illness.

C. **Qualification**. To qualify for in-patient services you must:

1. be a registered bed patient in the hospital;

2. need to stay in the hospital for proper treatment of an illness or injury; and

3. be under the care of a licensed physician.

D. **Basic in-patient services provided**. Hospital services include all those patient care services customarily provided by the hospital. These services vary and do not include services charged for by a private practitioner. Covered Services consist of:

1. Bed and board, including special diet and nutritional therapy. Benefits will be paid for a semi-private room or ward of a hospital, unless a private room is found to be Medically Necessary.

2. General, special and critical care nursing service, but not private duty nursing service.

3. Services, supplies, and equipment related to surgical operations; recovery facilities; anesthesia; and facilities for intensive or special care.

4. Oxygen and other inhalation therapeutic services and supplies.

5. Drugs and medications, which are listed and approved for use by the Food and Drug Administration (FDA).

6. Sera; biologicals; vaccines; intravenous preparations; dressings; casts; and materials for diagnostic studies.

7. Services, supplies and equipment related to the administration of blood, blood products, and blood derivatives.

8. Services, supplies, and equipment related to physical and occupational therapy and rehabilitation.

9. Services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to: laboratory; pathology; cardiographic; endoscopic; radiologic; and electroencephalographic studies and examinations.

10. Social, psychological, and pastoral services.

11. Services, supplies and equipment related to radiation and nuclear therapy.

12. Services, supplies, and equipment related to emergency medical care.

13. Cancer chemotherapy (including medications) provided in the hospital; provided that the medication must be provided by the hospital in the hospital as part of the treatment or by prescription filled by the hospital pharmacy.

14. Any additional medical, surgical, or related services, supplies, and equipment which are customarily furnished by hospitals, except to the extent that such are excluded by this Contract.

E. **Additional In-patient Services**

1. Mental Health Care. You may receive mental health care for acute conditions, which in the judgment of MVP are susceptible to significant improvement through short-term treatment. You may receive up to a maximum of thirty (30) inpatient hospital days per Calendar Year. We will not provide Benefits for care in a residential treatment facility. Mental health care conditions do not include motor disorders, communication disorders, mental retardation, pervasive developmental disorders, and dementia. For Covered Services accessed within New York State, for purposes of this subsection, "hospital" is defined as the inpatient services of a psychiatric center under the jurisdiction of the office of mental health or other psychiatric in-patient facility in the department, a psychiatric in-patient facility maintained by a political subdivision of the state for the care or treatment of the mentally ill, a ward, wing, unit, or other part of a hospital, as defined in Article 28 of the Public Health Law, operated as part of such hospital for the purpose of providing services for the mentally ill pursuant to an operating certificate issued by the Commissioner of Mental Health, or other facility providing an operating certificate by the Commissioner. For Covered Services accessed outside New York State, comparable legislation will be reviewed.

2. <u>Maternity Care Coverage</u>. Benefits are available to covered females for the following maternity care inpatient services:

   a. For vaginal deliveries, inpatient hospital coverage for the mother and newborn for a minimum of forty-eight (48) hours after childbirth;

   b. For cesarean section deliveries, inpatient hospital coverage for the mother and newborn for a minimum of ninety-six (96) hours after childbirth;

   c. The services either of a physician or a certified nurse-midwife to perform the delivery and any necessary follow-up treatment; and

   d. If additional hospital services are determined to be medically necessary in connection with maternity care, they will be provided to the member and covered under this Contract to the same extent that this Contract provides and covers such services in connection with illness or disease.

3. <u>Physical Rehabilitation Care</u>. Rehabilitation hospital admissions, not related to substance abuse (e.g. following stroke) will be covered for acute conditions subject to significant clinical improvement over a relatively short term, but not to exceed thirty (30) days of care per condition.

4. <u>Breast Cancer Care</u>. Benefits are available for the following breast cancer care inpatient services:

   a. For a mastectomy or a lymph node dissection or a lumpectomy for the treatment of breast cancer, inpatient hospital coverage for such period as is determined by the attending physician in consultation with the Covered Person to be medically appropriate.

   b. For all stages of reconstruction of the breast on which the mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance, inpatient hospital coverage for such period as is determined by the attending physician in consultation with the Covered Person to be medically appropriate.

   c. Prostheses and the treatment of physical complications resulting from the mastectomy, including lymphedemas are covered. Coverage is available only to Covered Persons who elect breast reconstruction in connection with the mastectomy. Replacement external breast prostheses are covered once every two (2) years, if Medically Necessary.

5. Detoxification Treatment for Alcohol Dependence and/or Substance Dependence. We will provide Benefits for active treatment for detoxification needed because of alcohol dependence or substance dependence up to a maximum of seven (7) days per Covered Person per Calendar Year. Within New York State, MVP will only provide benefits for inpatient services obtained at a Participating Hospital. For purposes of this subsection, Hospital shall mean an appropriately certified Participating facility, certified by the New York State Office of Alcohol and Substance Abuse Services (OASAS). Outside New York State, care must be received in a facility whose alcoholism and/or substance abuse treatment program has been approved by the Joint Commission of Accreditation of Hospitals. **Covered In-Network Only.**

6. Bariatric Surgery. We will provide Benefits for bariatric surgery only when such surgery is performed at a Hospital participating in MVP's Bariatric Surgery Network. You may obtain a description of this Network by calling the MVP Member Services Department at 1-888-MVP-MBRS. **Covered In-Network Only.**

7. Infertility Services. MVP shall not exclude coverage for inpatient services solely because the medical condition relates to infertility. Benefits are available for surgical or medical procedures, necessary to correct malformation, disease or dysfunction resulting in infertility. These Benefits are not subject to paragraphs 1 and 2 below.

   Benefits are also available for diagnostic tests and procedures that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments. Diagnostic tests and procedures include, but are not limited to, hysterosalpingrogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound. In addition to all other terms, conditions and exclusions set forth in this Contract, Coverage for the infertility services set forth above, with the exception of Benefits for surgical or medical procedures, necessary to correct malformation, disease or dysfunction resulting in infertility, is subject to the following conditions:

   1. Diagnosis and treatment of infertility must be prescribed as part of a physician's overall plan of care and must be consistent with the guidelines established by MVP. MVP's guidelines shall be consistent with regulations established or hereafter adopted by the New York State Department of Insurance.

   2. Coverage shall only be available for Covered Persons between twenty-one (21) and forty-four (44) years of age.

   3. Coverage shall not include the diagnosis and treatment of infertility in connection with:

a. In-Vitro Fertilization
b. Gamete Intrafallopian Tube Transfers
c. Zygote Intrafallopian Tube Transfers
d. The reversal of elective sterilization
e. Sex change procedures
f. Cloning
g. Medical or surgical services that are deemed to be experimental
h. Gender Selection
i. Sperm Banking
j. Surrogate Services

Refer to Article VIII, Paragraph C.4.l. for Prescription Drug Benefits relating to Infertility Services.

F. **When Services are Not Available**. In addition to the "Limitations and Exclusions" provisions found later in this Contract, in-patient services are further subject to the following limitations:

1. care rendered on any day when, in our judgment, acute hospital care was not necessary;

2. more than thirty (30) days per Calendar Year for a hospital stay whose primary purpose is physical therapy, physical medicine or rehabilitation, or a combination thereof;

3. care rendered for the diagnosis or treatment of alcoholism or substance abuse, except that MVP will cover up to seven (7) days per Calendar Year for detoxification services at a licensed detoxification hospital facility;

4. private duty nursing;

5. whole blood, blood plasma, packed blood cells or other blood derivatives if participation in a volunteer blood replacement program is available to the member; (administration and processing costs are covered;)

6. non-medical items such as telephone or television rental;

7. medication, supplies and equipment which the member takes home from the hospital.

ARTICLE IV - OUT-PATIENT HOSPITAL/FACILITY SERVICES

A. **Emergency Care**

Benefits are available for a visit to the emergency room at a hospital for Emergency Care, as defined in this Contract.

B. **Surgery**

Benefits are available for hospital or facility charges for surgery, which includes closed reduction of fractures, dislocations of bones and endoscopies requiring use of the surgical facilities of the hospital or facility. It does not include inoculation, vaccination, collection of blood, drug administration, injections or artificial insemination.

C. **Pre-admission/Pre-Surgical Testing**

Benefits are available for pre-admission testing on an outpatient basis, when performed at the hospital where the surgery is scheduled to take place, and the following requirements are satisfied:

1. The tests were ordered by a licensed physician;
2. The tests are necessary for the diagnosis and treatment of the condition;
3. Reservations for a hospital bed and an operating room were made prior to performance of the tests;
4. Surgery occurs within seven (7) days of such tests; and
5. You are physically present at the hospital for the tests.

If surgery is cancelled because of these pre-surgical test findings, the cost of these pre-surgical tests are still covered.

D. **Cervical Cancer Screening**

This Contract covers an annual cervical cytology screening in the outpatient department of a hospital or facility for females eighteen (18) years of age or older. This includes an annual pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

E. **Mammography Screening**

This Contract covers mammography screening for occult breast cancer performed in the outpatient department or ambulatory surgery department of a hospital or other facility, subject to the following limits:

1. upon the recommendation of a physician, a mammogram at any age if you have a prior history of breast cancer or if you have a first degree relative with a prior history of breast cancer;

2. a single baseline mammogram if you are thirty-five (35) to thirty-nine (39) years of age; and

3. an annual mammogram if you are age forty (40) or older.

In no event shall we provide Coverage for more than one (1) annual mammography screening.

F. **Outpatient Physical Therapy (PT), Speech Therapy (ST) and Occupational Therapy (OT)**.

Benefits are available in the out-patient department of a Hospital or facility for PT, ST and OT to treat short-term acute conditions, which in our judgment are subject to significant clinical improvement through relatively short-term therapy. This is a combined benefit for PT, ST and OT, not to exceed a total of thirty (30) visits per Calendar Year for combined In-Network and Out-of-Network Coverage.

G. **Chemotherapy and Cancer Hormone Therapy**

Benefits are available in the outpatient department of a hospital or facility for chemotherapy, including related medications. The medications must be provided by and administered in the hospital as part of the treatment or by prescription filled by the hospital pharmacy.

H. **Radiation Therapy**

Benefits are available in the outpatient department of a hospital or facility for radiation therapy, including related medications. The medications provided by the hospital and administered in the hospital as part of the treatment or by prescription filled by the hospital pharmacy.

I. **Laboratory Services**

Benefits are available for laboratory services provided in the outpatient department of a hospital or other facility.

J. **Diagnostic X-ray and other Imaging Services**

Benefits are available for diagnostic X-ray and other imaging services performed in the outpatient department of a hospital or other facility.

K. **Diagnostic Screening for Prostate Cancer.**

This Contract covers diagnostic screening for prostate cancer performed in the outpatient department of a hospital, facility, or Provider's office subject to the following limits:

1. Standard diagnostic testing including, a digital rectal examination and a prostate specific antigen test at any age for men having a prior history of prostate cancer; and

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

L. **Alcoholism and/or Substance Abuse Treatment.**

Benefits are available for the diagnosis and treatment of alcoholism and/or substance abuse for up to sixty (60) visits per Calendar Year, provided at a facility or practitioner's office. We will not provide Benefits for day treatment. Of the sixty (60) visits, up to twenty (20) visits may be used for family counseling, provided the person in need of treatment is a Covered Person under this Contract; the family members receiving therapy are Covered Persons; and no more than twenty (20) family visits are used by all family members combined. These family counseling visits are eligible for Coverage even if the person in need of treatment has not yet begun that treatment. Benefits for family counseling are limited to one (1) visit per day.

Within New York State, coverage is limited to facilities certified by the Office of Alcoholism and Substance Abuse Services or licensed by such Office as outpatient clinics or medically supervised ambulatory substance abuse programs. In other states, coverage is limited to those facilities accredited by the Joint Commission on Accreditation of Hospitals as alcoholism or chemical dependence substance abuse treatment programs.

M. **Outpatient Mental Health Care**

The following Benefits are available for the diagnosis and treatment of acute mental health care conditions, which in the judgment of MVP are both Medically Necessary and susceptible to significant improvement through short term treatment:

1. Up to twenty (20) outpatient visits per Calendar Year;

2. Up to three (3) outpatient psychiatric emergency visits per Calendar Year. A psychiatric emergency is defined as a situation in which a person

appears to have a mental illness for which immediate observation care and treatment is appropriate and the absence of treatment is likely to result in serious harm to him or others. These three (3) outpatient psychiatric emergency visits are included within and not in addition to the twenty (20) outpatient visits available under this Contract.

We will not provide Benefits for continuous day treatment. Benefits shall be paid for the above-mentioned Services ONLY when such Services are performed and billed by a facility operated by the Office of Mental Health; a facility issued an operating certificate by the Commissioner of Mental Health pursuant to the provisions of Article 31 of Mental Hygiene Law; or a psychiatrist, psychologist, or duly certified social worker who are certified pursuant to the requirements of Section 4303(n) of the New York State Insurance law or comparable legislation outside the State of New York.

N. **Primary and Preventive Obstetric and Gynecologic Services**

Covered Persons (females) shall have direct access to primary and preventive obstetric and gynecologic services from a qualified provider of such services of her choice for no fewer than two (2) examinations annually for such services or to any care related to pregnancy. Additionally, Covered Persons (females) shall have direct access to primary and preventive obstetric and gynecological services required as a result of such annual examinations or as a result of an acute gynecologic condition.

O. **Bone Mineral Density Measurements or Tests**

Benefits are available for bone mineral density measurements or tests for Covered Persons who meet the criteria under the Federal Medicare Program or the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, Covered Persons qualifying for Coverage shall include:

1. Covered Persons previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

2. Covered Persons with symptoms or conditions indicative of the presence of osteoporosis, or the significant risk of osteoporosis; or

3. Covered Persons on a prescribed drug regimen posing a significant risk of osteoporosis; or

4. Covered Persons with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

5. Covered Persons of such age, gender and/or other physiological characteristics, which pose a significant risk for osteoporosis.

P. **Infertility Services**

Benefits are available for surgical or medical procedures, necessary to correct malformation, disease or dysfunction resulting in infertility. These Benefits are not subject to paragraphs 1 and 2 below.

Benefits are also available for diagnostic tests and procedures that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments. Diagnostic tests and procedures include, but are not limited to, hysterosalpingrogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound. In addition to all other terms, conditions and exclusions set forth in this Contract, Coverage for the infertility services set forth above, with the exception of Benefits for surgical or medical procedures, necessary to correct malformation, disease or dysfunction resulting in infertility, is subject to the following conditions:

1. Diagnosis and treatment of infertility must be prescribed as part of a physician's overall plan of care and must be consistent with the guidelines established by MVP. MVP's guidelines shall be consistent with regulations established or hereafter adopted by the New York State Department of Insurance.

2. Coverage shall only be available for Covered Persons between twenty-one (21) and forty-four (44) years of age.

3. Coverage shall not include the diagnosis and treatment of infertility in connection with:

    a. In-Vitro Fertilization
    b. Gamete Intrafallopian Tube Transfers
    c. Zygote Intrafallopian Tube Transfers
    d. The reversal of elective sterilization
    e. Sex change procedures
    f. Cloning
    g. Medical or surgical services that are deemed to be experimental
    h. Gender Selection
    i. Sperm Banking
    j. Surrogate Services

Refer to Article VIII, Paragraph C.4.l. for Prescription Drug Benefits relating to Infertility Services.

Q. **Outpatient Cardiac Rehabilitation Care**

We will provide Benefits for up to thirty-six (36) visits per Calendar Year for Cardiac Rehabilitation Care for acute conditions subject to significant clinical improvement over a relatively short term.

ARTICLE V - OUTPATIENT DIALYSIS SERVICES

A. **Services Available**

Benefits are available for hemodialysis or peritoneal dialysis, when provided in a hospital based or free standing facility, which has an operating certificate issued by the New York State Department of Health, pursuant to Article Twenty-Eight (28) of the New York State Public Health Law or, if provided outside the State of New York, a comparable certificate or license for the state where services were rendered, as follows:

1. Dialysis treatment on a walk-in basis if the program is approved by the appropriate governmental authorities.

2. For home treatment, we cover the reasonable rental cost of equipment as determined by us, plus all appropriate and necessary supplies required for home dialysis treatment when ordered by your physician. Coverage will not include any furniture, electrical or other fixtures or plumbing needed to perform the dialysis treatments at home.

   For these home and facility based Services to be covered, the treatments must be provided, supervised or arranged by the physician and the Covered Person must be a registered patient of an MVP approved kidney disease treatment center.

   The Benefits for ambulatory and home dialysis have no time limit, and continue while enrollment is in good standing until the Covered Person becomes eligible for Medicare.

ARTICLE VI - MEDICAL/SURGICAL BENEFITS

A. **Office Visits**

Benefits are available for office visits for the diagnosis and treatment of an illness or disease, unless otherwise excluded or limited under this Contract**.**

B. **Adult Annual Physical**

This Contract covers one (1) adult annual physical per Covered Person per Calendar Year for routine physical examinations for Covered Persons age 19 and

older. We will also provide Benefits for the following immunizations: Influenza, Pneumonia, Tetanus, Diphtheria, Hepatitis B, Hepatitis A, Polio, Measles, Mumps, Rubella, Varicella, and Meningitis.

C. **Primary and Preventive Obstetric and Gynecologic Services**

Primary and/or Preventive Gynecological Services. Female Members may obtain up to two (2) gynecological examinations per Calendar Year. We will provide benefits for additional gynecological services if Medically Necessary. Additionally, Covered Persons (females) shall have direct access to primary and preventive obstetric and gynecological services required as a result of such annual examinations or as a result of an acute gynecologic condition.

D. **Maternity Care**

Benefits are available to covered females for the following professional services:

1. Parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments.

   a. If the Covered Person opts to be discharged from the hospital earlier than the time periods set forth in Article III of this Certificate, she is entitled to at least one (1) home care visit. She must request this home care visit from her physician within forty-eight (48) hours of a vaginal delivery, or within ninety-six (96) hours of a cesarean section delivery. If such request is timely made, MVP will provide this home care visit within twenty-four (24) hours after discharge from the hospital or from the time of her request, whichever is later. **This home visit will be provided to the Covered Person without charge and shall be in addition to any home care coverage to which the member may otherwise be entitled under this Contract.**

   b. If additional medical or surgical services are determined to be medically necessary in connection with maternity care, they will be provided to the Covered Person and covered under this Contract to the same extent that this Contract provides and covers such services in connection with illness or disease.

E. **Surgical Care**

Benefits are available for surgical services. Covered services include operating and cutting procedures for the treatment of a sickness or injury and closed reduction of fractures and dislocation of bones, endoscopies, collection of blood, incisions or punctures of the skin. It does not include inoculation, vaccination or drug administration.

F. **Allergy Testing and Treatment**

Benefits are available for the diagnosis of allergies and desensitization treatments to alleviate allergies.

G. **Anesthesia**

Benefits are available for consultation before anesthesia is given, administration of anesthesia during covered surgery or maternity care, and the provider's services during and after such covered surgery or maternity care. We will not provide anesthesia for services not covered under this Contract.

H. **Laboratory Services**

Benefits are available for laboratory services provided in the provider's office.

I. **Diagnostic X-ray and other Imaging Services**

Benefits are available for diagnostic X-ray and other imaging services performed in the provider's office.

J. **Ambulance Services**

Benefits are available for professional ambulance service when used locally to transport a Covered Person to the nearest hospital in connection with an emergency inpatient admission or to obtain emergency outpatient care.

K. **Inpatient Visits by a Physician**

Benefits are available for visits by a Professional Provider when you are a registered inpatient in a hospital, psychiatric care facility or registered bed patient in a skilled nursing facility; provided the care is not in connection with surgery or maternity service.

L. **Casts and Dressings**

Benefits are available for casts and dressings.

M. **Well Child Care**

Benefits are available for well child care services for covered children from the date of birth to attainment of age nineteen (19). Services must be provided under the supervision of a physician or other professional licensed under Article 139 of the Education Law, whose scope of practice includes the authority to provide these services. Services must be rendered in a hospital, in the office of a physician, or in

the office of a provider licensed under Article 139 of the Education Law whose scope of practice includes the authority to provide these Services.

Well child care includes an initial newborn check-up in the hospital and well child visits including a medical history, a complete physical examination, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit which are performed in the office or in a clinical laboratory.

All well child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics. Well Child Care also includes necessary immunizations against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type B, and hepatitis B, as well as other immunizations specified by the Superintendent of Insurance by regulation.

Child care services not expressly described above, or which exceed the frequency levels described above are not covered under the Well Child Care benefit.

N. **Cervical Cancer Screening**

This Contract covers an annual cervical cytology screening for females eighteen (18) years of age or older. This includes an annual pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

O. **Mammography Screening**

This Contract covers mammography screening for occult breast cancer performed in the outpatient department or ambulatory surgery department of a hospital or other facility, subject to the following limits:

1. upon the recommendation of a physician, a mammogram at any age if you have a prior history of breast cancer or if you have a first degree relative with a prior history of breast cancer;

2. a single baseline mammogram if you are thirty-five (35) to thirty-nine (39) years of age; and

3. an annual mammogram if you are age forty (40) or older.

In no event shall we provide Coverage for more than one (1) annual mammography screening.

P. **Mastectomy or lymph node dissection or lumpectomy**

Benefits are available for the treatment of breast cancer; all stages of reconstruction of the breast on which the mastectomy was performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance. Prostheses and the treatment of physical complications resulting from the mastectomy, including lymphedemas are covered. These Benefits are available only to Covered Persons who elect breast reconstruction in connection with the mastectomy. Replacement external breast prostheses are covered once every two (2) years, if Medically Necessary.

Q. **Second Medical Opinions**

Benefits are available for a second medical opinion from a qualified physician on the need for elective surgery

Benefits are available for a second medical opinion from a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer.

R. **Chiropractic Services**

Benefits are available for chiropractic services, provided by a licensed chiropractic physician. Chiropractic Services are defined as detecting or correcting by manual or mechanical means structural imbalance, distortion, or subluxations 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 or in the vertebral column.

S. **Outpatient Mental Health Care**

The following Benefits are available for the diagnosis and treatment of acute mental health care conditions, which in the judgment of MVP are both Medically Necessary and susceptible to significant improvement through short term treatment:

1. Up to twenty (20) outpatient visits per Calendar Year;

2. Up to three (3) outpatient psychiatric emergency visits per Calendar Year. A psychiatric emergency is defined as a situation in which a person appears to have a mental illness for which immediate observation care and treatment is appropriate and the absence of treatment is likely to result in serious harm to him or others. These three (3) outpatient psychiatric emergency visits are included within and not in addition to the twenty (20) outpatient visits available under this Contract.

Benefits shall be paid for the above-mentioned Services ONLY when such Services are performed and billed by a facility operated by the Office of Mental Health; a facility issued an operating certificate by the Commissioner of Mental Health pursuant to the provisions of Article 31 of Mental Hygiene Law; or a psychiatrist, psychologist, or duly certified social worker who are certified pursuant to the requirements of Section 4303(n) of the New York State Insurance law or comparable legislation outside the State of New York.

T. **Outpatient Physical Therapy (PT), Speech Therapy (ST) and Occupational Therapy (OT)**.

Benefits are available in the outpatient department of a Hospital or facility, or in a physician's office for PT, ST and OT to treat short-term acute conditions, which in our judgment are subject to significant clinical improvement through relatively short-term therapy. This is a combined benefit for PT, ST and OT, not to exceed a total of thirty (30) visits per Calendar Year for combined IN and OUT of NETWORK.

U. **Diagnostic Screening for Prostate Cancer.**

This Contract covers diagnostic screening for prostate cancer performed in the outpatient department of a hospital, facility, or Provider's office subject to the following limits:

1. Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate specific antigen test at any age for men having a prior history of prostate cancer; and

2. An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age fifty (50) and over who are not symptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.

V. **Bone Mineral Density Measurements or Tests**

Benefits are available for bone mineral density measurements or tests for Covered Persons who meet the criteria under the Federal Medicare Program or the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, Covered Persons qualifying for Coverage shall include:

1. Covered Persons previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

2. Covered Persons with symptoms or conditions indicative of the presence of osteoporosis, or the significant risk of osteoporosis; or

3. Covered Persons on a prescribed drug regimen posing a significant risk of osteoporosis; or

4. Covered Persons with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

5. Covered Persons of such age, gender and/or other physiological characteristics, which pose a significant risk for osteoporosis.

W. **Infertility Services**

Benefits are available for surgical or medical procedures, necessary to correct malformation, disease or dysfunction resulting in infertility. These Benefits are not subject to paragraphs 1 and 2 below.

Benefits are also available for diagnostic tests and procedures that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments. Diagnostic tests and procedures include, but are not limited to, hysterosalpingrogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound. In addition to all other terms, conditions and exclusions set forth in this Contract, Coverage for the infertility services set forth above, with the exception of Benefits for surgical or medical procedures, necessary to correct malformation, disease or dysfunction resulting in infertility, is subject to the following conditions:

1. Diagnosis and treatment of infertility must be prescribed as part of a physician's overall plan of care and must be consistent with the guidelines established by MVP. MVP's guidelines shall be consistent with regulations established or hereafter adopted by the New York State Department of Insurance.

2. Coverage shall only be available for Covered Persons between twenty-one (21) and forty-four (44) years of age.

3. Coverage shall not include the diagnosis and treatment of infertility in connection with:

   a. In-Vitro Fertilization
   b. Gamete Intrafallopian Tube Transfers
   c. Zygote Intrafallopian Tube Transfers
   d. The reversal of elective sterilization
   e. Sex change procedures
   f. Cloning
   g. Medical or surgical services that are deemed to be experimental
   h. Gender Selection
   i. Sperm Banking
   j. Surrogate Services

ARTICLE VII - TRANSPLANT SERVICES

A. **Services Available**

Benefits are available for prior approved Transplant Services, which shall include transplant surgeries. These services shall be **Covered In-Network Only.**

B. **MVP's Transplant Network**

MVP shall only provide Benefits for services obtained through MVP's Transplant Network. For a description of this Network, contact MVP's Member Services Department at (888) MVP-MBRS.

C. **Pre-Certification**

MVP will only provide Benefits for Transplant Services, which have been Pre-Certified by MVP. (See Article II, Section M.)

D. **Additional Exclusions**

In addition to all of the other terms, conditions and exclusions found in this Contract, MVP does not provide Benefits for donor costs associated with transplant surgeries, unless, both the recipient and the donor are covered by us and legally related. We will not provide Benefits for any expenses incurred for travel, food and lodging for either the recipient or donor or costs related to searches or screenings of a donor.

ARTICLE VIII – SUPPLIES AND PRESCRIPTION DRUGS

A. **Supplies and Equipment for the Treatment of Diabetes**

Benefits are available for the following equipment and supplies required for the treatment of diabetes if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe:

1. blood glucose monitors;
2. blood glucose monitors for the visually impaired;
3. data management systems;
4. test strips for glucose monitors and visual reading;
5. urine testing strips;

6. insulin; injection aids;

7. cartridges for the visually impaired;

8. syringes;

9. insulin pumps and appurtenances thereto;

10. insulin infusion devices; and

11. oral agents for controlling blood sugar.

Benefits are also available for additional items of equipment and supplies as may be required by the Department of Health. Items are limited to a thirty-one (31) day supply per dispensing. Coverage will also be provided for diabetes education for proper self-management and treatment, limited to: visits medically necessary upon diagnosis of diabetes; where a physician diagnoses a significant change in a patient's condition which necessitates changes in self-management; or where reeducation or refresher education is necessary. Coverage for education will include home visits when medically necessary. Such education may be provided by a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the New York Education Law, or their staff; as part of an office visit for diabetes diagnosis or treatment; or by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician; upon the referral of a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the New York Education Law; provided that education provided by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician shall be limited to group settings wherever practicable.

B. **Durable Medical Equipment, External Prosthetic Devices, and Ostomy Supplies.**

Benefits are available for the purchase or rental of standard durable medical equipment. (The option of whether to rent or purchase authorized durable medical equipment is solely within MVP's discretion.) Durable medical equipment means equipment that is primarily and customarily used only for a medical purpose. Such equipment is designed for use in the home, and is designed for prolonged and repeated use. Durable medical equipment items include, but are not limited to: wheelchairs, walkers, respiratory equipment and oxygen supplies. Additionally, Benefits will be provided for the cost of replacements, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement, if functionally necessary. External prosthetic devices, such as artificial limbs and medical appliances (including ostomy supplies), that replace all or part of a body organ or that replace all or some of the functions of a permanently inoperative and/or malfunctioning body organ are covered when prescribed by a licensed physician. External prosthetic devices also include speech generating devices for Covered

Persons who have lost the ability to speak. Additional Benefits will be provided for replacements, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement, if functionally necessary Custom prosthetics will not be covered if a standard device exists, unless a custom device is Medically Necessary. This Coverage does not include eyeglasses, hearing aids, elastic stockings, arch supports, corrective shoes, wigs and other orthopedic equipment. A separate lifetime maximum benefit may apply. Refer to your Schedule of Benefits.

C. **Prescription Drugs.**

Benefits are available for Covered Drugs as defined in Article I and as described below.

1. Conditions of Coverage. MVP will provide coverage for Covered Drugs that are:

   a. Prescribed pursuant to a written order by a provider who is authorized to write prescriptions; AND

   b. For prescriptions drugs, obtained from an MVP Participating Retail Pharmacy or other retail pharmacy authorized to fill prescription in the applicable jurisdiction where the prescription is dispensed, with two exceptions:

      i. prescription drugs listed on MVP's Mail Order List may also be obtained through MVP's Mail Order Pharmacy. You or your prescribing provider may obtain a copy of MVP's Mail Order List or inquire as to whether a particular prescription drug is available through MVP's mail order pharmacy program by contacting MVP's Member Services Department at (888) 687-6277 or by contacting us online at www.mvphealthcare.com and following the instructions provided.

      ii. prescription drugs listed on MVP's Specialty Pharmacy List may also be obtained through MVP's Specialty Pharmacy Vendor, upon prior approval from MVP. Drugs on MVP's Specialty Pharmacy List are identified on MVP's Formulary. You or your prescribing provider may obtain a copy of MVP's Specialty Pharmacy List or inquire as to whether a particular prescription drug is listed on MVP's Specialty Pharmacy List by contacting MVP's Member Services Department at (888) 687-6277 or by contacting us online at www.mvphealthcare.com and following the instructions provided.

c. For enteral formulas upon Pre-Certification from MVP and obtained from an MVP Participating Retail Pharmacy or other retail pharmacy authorized to fill such order in the jurisdiction where the order is dispensed. MVP will only provide coverage for enteral formulas taken for home use that are:

i. Medically Necessary;

ii. Taken under a written order by a provider, who is authorized to write such order;

iii Proven as an effective treatment for individuals who, without these enteral formulas, would suffer from malnourishment, chronic disability, mental retardation or death. Specific diseases for which enteral formulas have been proven an effective treatment include, but are not limited to:

(a) Crohn's disease;

(b) gastroesophageal reflux with failure to thrive;

(c) disorders of gastrointestinal motility, such as chronic intestinal pseudo-obstruction; and

(d) multiple severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation, or death.

d. For modified solid food products, obtained at an MVP Participating Retail Pharmacy or other provider or vendor upon Pre-Certification from MVP. MVP will only provide coverage for Medically Necessary modified solid food products that are low protein or which contain modified protein, when taken pursuant to a written order prepared by a qualified provider for the treatment of certain inherited diseases of amino acid and organic metabolism.

2. Benefits Available.

a. Retail Pharmacy Benefit. For covered prescription drugs obtained at a Retail Pharmacy, MVP will provide coverage subject to our Allowable Charge for up to a thirty (30) day supply per dispensing.

b. Mail Order Pharmacy Benefit. For covered prescription drugs listed on MVP's Mail Order List and obtained at MVP's Mail Order Pharmacy, MVP will provide coverage subject to our

Allowable Charge for up to a ninety (90) day supply per dispensing.

c. Specialty Pharmacy Benefit. For covered prescription drugs listed on MVP's Specialty Pharmacy Drugs List that are obtained through MVP's Specialty Pharmacy Vendor, MVP will provide coverage subject to our Allowable Charge for up to a thirty (30) day supply per dispensing.

d. Enteral Formula Benefit. For covered enteral formulas obtained at an MVP Participating Retail Pharmacy or other retail pharmacy authorized to fill such order in the jurisdiction where the order is dispensed, MVP will provide coverage subject to our Allowable Charge for up to a thirty (30) day supply per dispensing.

e. Modified Solid Food Product Benefit. For covered modified solid food products, MVP will provide coverage subject to our Allowable Charge for up to a thirty (30) day supply. Notwithstanding, MVP shall not provide benefits for modified solid food products in excess of twenty-five hundred dollars ($2,500.00) during any Calendar Year.

3. MVP Prescription Drug Formulary. MVP's Pharmacy and Therapeutics Committee, which includes physicians, pharmacists, and other health care professionals, evaluates FDA approved drugs and devices and determines the drugs and devices that MVP will include in its list of approved drugs. The list of approved drugs is called a Formulary. Drugs that MVP has not approved are called Non-Formulary Drugs. At least two drugs in each therapeutic class will be included in MVP's Formulary, unless there are clinically equivalent over-the-counter products readily available. If there are clinically equivalent over-the-counter product(s) available, then at least one drug in such therapeutic class will be included in MVP's Formulary **which may be the over-the-counter product**. MVP's Pharmacy and Therapeutics Committee reviews and must approve new drugs prior to such new drugs being included in or excluded from the Formulary. MVP provides regularly updated copies of its Formulary to its Participating Providers. Additionally, you or your prescribing provider may at any time obtain a copy of MVP's Formulary by contacting MVP's Member Services Department at (888) 687-6277 or by visiting MVP's website at www.mvphealthcare.com

4. Exclusions. In addition to all other conditions, limitations and exclusions contained in this Contract, MVP will not provide benefits for the following items:

a. Non-Medically Necessary drugs.

b. Experimental and/or Investigational drugs unless recommended pursuant to an external appeal in accordance with New York State law.

c. Compound prescriptions (prescriptions that require the mixing of two or more ingredients but do not contain at least one legend ingredient) or drug formulations compounded solely for the convenience or ease of administration of the Covered Person.

d. Over the counter drugs, including vitamins, not requiring a prescription, unless expressly listed on MVP's Formulary as a Covered Drug.

e. Drugs used in connection with a medical service that is not covered under this Contract.

f. Devices (including but not limited to hypodermic needles and syringes), except in connection with covered bone mineral density screenings covered under this Contract.

g. Refills of prescription drugs (or other items covered under this Contract) that exceed the Standard Supply or Mail Order Supply limitations. For example, refills requested because the Covered Person lost or misused his or her supply of prescription drugs will not be covered.

h. Nutritional Supplements.

i. Medication which is primarily intended to improve your appearance or lifestyle, subject to Medical Necessity review, including but not limited to:

    i. non-amphetamine anorexiants, unless Medically Necessary;

    ii. amphetamines prescribed for weight loss, unless Medically Necessary;

    iii. Rogaine and other products for hair growth and/or restoration, unless Medically Necessary;

    iv. Retinoic acid and similar products for the prevention of the wrinkling of the skin, unless Medically Necessary;

    v. Agents affecting the color, tone, pigmentation or texture of the skin, unless Medically Necessary; and

    vi. Smoking cessation products, unless Medically Necessary.

j. Vaccines and immunizations except as otherwise provided. Well child vaccines and immunizations are covered.

k. Prescription drugs not approved by the Food and Drug Administration (FDA) of the United States. MVP, however, will not exclude coverage of drugs approved by the FDA for the treatment of certain types of cancer on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. Provided, however, that such drug has been recognized for treatment of the specific type of cancer for which the drug has now been prescribed in one of the following established reference compendia:

   i. The American Medical Association Drug Evaluations:

   ii. The American Hospital Formulary Service Drug Information; or

   iii. The United States Pharmacopeia Drug Information; or recommended by review article or editorial comment in a major peer reviewed professional journal.

   The above provisions should not be interpreted to require coverage for any Experimental or Investigational drugs or any drug that the FDA has determined to be contra-indicated for the treatment of the specific type of cancer for which the drug has been prescribed.

l. Contraceptive Drugs and Devices.

ARTICLE IX - HOME HEALTH CARE

A. What Home Care Services are Available.

Benefits are available for up to sixty (60) visits per Calendar Year for the following home care services.

1. Nursing Care. Intermittent or part-time home nursing care. A registered nurse (R.N.) must give or supervise the care.

2. Health Aide Care. Intermittent or part-time care by home health aides. Their services must be mainly for patient care.

3. Physical/Occupational/Speech Therapy. Physical, occupational and/or speech therapy to treat acute conditions if provided by home health agency personnel.

4. Medical Needs. Supplies, drugs and medications your physician prescribes. Included also are laboratory services if proper treatment requires them and if they would have been provided had you been a registered bed patient in the hospital or a skilled nursing facility.

B. **When Home Care Services are Available**

The above-mentioned home care services are available only when:

1. You are under the care of a physician who certifies the need for home health care and approves a written plan for its provision; and

2. The care is provided by a home health care agency certified under Article 36 of the New York State Public Health Law or if provided outside the State of New York, under a similar certification process required by the State where such services are provided; and

3. You would otherwise need care in a hospital or a skilled nursing facility.

ARTICLE X - HOSPICE CARE

Up to two hundred and ten (210) days of hospice care is available in a hospice or hospital per lifetime.

A. **Qualification**

Home care and out-patient services provided by the hospice, including drugs and medical supplies, are covered to the same extent as other outpatient services; as long as:

1. You have been certified by your primary attending physician as having a life expectancy of six (6) months or less; and

2. The hospice care is provided by a hospice organization certified pursuant to Article 40 of the New York Public Health law; or if the hospice is located outside of this state, under a similar certification process required by the state in which the hospice organization is located.

B. **Miscellaneous**

1. We provide Benefits for five (5) visits for bereavement counseling for your family either before or after your death.

2. The Benefits provided in this Article are available only once (1) during your lifetime.

ARTICLE XI – SKILLED NURSING CARE IN A NURSING HOME

Up tosixty (60) days of skilled nursing care provided in a skilled nursing facility is available per Calendar Year.

A. **SKILLED NURSING FACILITY**

A skilled nursing facility is a nursing home as defined in Section 2801 of the New York Public Health Law or a skilled nursing facility as defined in Subchapter XVIII of the federal Social Security Act, 42 U.S.C. § 1395 et. seq. Also included are those that are certified as a skilled nursing facility by the Joint Commission on Accreditation of Hospitals.

B. **To Qualify For Skilled Nursing Care Benefits:**

1. You must be under the care of a licensed physician;

2. The care must be provided in a skilled nursing facility as defined above;

3. You must have been in a hospital for at least three (3) days immediately preceding admittance to the nursing home or skilled nursing facility;

4. Further hospitalization would otherwise be necessary; and

5. Skilled nursing services are medically required to treat your condition.

ARTICLE XII - LIMITATIONS AND EXCLUSIONS

These limits and exclusions are in addition to any others discussed in this Contract. When they apply to a hospital stay, no Benefits are available for any part of the hospital charges to which they apply.

A. **Services Covered Under Government Programs**

We will not provide Benefits for any services for which payments are provided under Medicare, or any other federal, state, county or municipal law, except when required by state or federal law. When you are eligible for a government program, we will reduce our Benefits by the amount the government program paid for the services. This exclusion applies even if you fail to enroll, do not make a proper or timely claim, fail to pay the charges for the program, or otherwise do not claim the benefits available to you. If you are entitled to Medicare coverage, you must enroll for coverage under Part A and B of Medicare in order to be eligible for Benefits under this Certificate.

The above exclusion is not applicable under the following circumstances.

1. The government program is Medicaid.

2. You, the Subscriber, are entitled to payments for Medicare by reason of your age, and the following conditions are met:

   a. You are an active employee (working actively and not retired) of your Group.

   b. Your employer is subject to the provisions of the Tax, Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended.

3. You, the Subscriber, are entitled to payments under Medicare by reason of disability (other than end stage renal disease), and the following conditions are met:

   a. You are an active employee (working actively and not retired) of your Group.

   b. Your Group is "large group health plan" as defined in the Omnibus Budget Reconciliation Act of 1986 (COBRA).

4. You are entitled to Medicare by reason of end stage renal disease, and there is a waiting period before Medicare becomes effective. We will not reduce this Contract's Benefits, and we will provide Benefits before Medicare pays, during the waiting period. We will also provide Benefits before Medicare pays, during the coordination period with Medicare. After the coordination period, Medicare will make its payments benefits before we provide Benefits under this Contract.

B. **Government Hospital**

We will not provide Benefits for any service-connected disability that is provided in any hospital or other institution which is owned, operated or maintained by the Veterans Administration, the federal government or a state government. However, we will provide Benefits for otherwise Covered Services in such Hospital, facility or institution when provided to a veteran for non-service connected disability.

C. **Workers' Compensation or No-Fault Automobile Insurance**

No Benefits will be paid under this Contract for services that are available in whole or in part under a Workers' Compensation Act or similar law. We will not pay Benefits under this Contract for services for which Benefits are recovered or recoverable under the mandatory portion of a No-Fault automobile insurance policy. The exclusion also applies if, after receiving Workers' Compensation or No-Fault

benefits, you must repay them because you recovered money from a party who caused or was involved with your injury.

D. **Experimental or Investigational Treatments**

In general, MVP does not cover experimental or investigational treatments. However, MVP shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with Article XVIII of this Contract. If the External Appeal Agent approves an experimental or investigational treatment that is part of a clinical trial, MVP will only cover the costs of services required to provide treatment to you according to the design of the trial. MVP shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Contract for non-experimental or non-investigational treatments provided in such clinical trial.

E. **Services Usually Given Without Charge or Services Provided by a Member of the Covered Persons Immediate Family**

We will not provide Benefits for a service if it is usually provided without charge to the patient. For example, when a provider does not usually collect charges in the absence of insurance coverage. We will not provide Benefits for a service provided by a member of your immediate family. This exclusion applies even if charges are billed.

F. **Non-Acute Hospital Care**

We will not provide Benefits for the portion of a hospital stay that is primarily custodial or for convalescent or sanitarium-type care.

G. **Unapproved Radiation Therapy**

We will not provide Benefits for radiation therapy services provided at a hospital or facility, which has not been approved to provide those services by the appropriate government agency.

H. **Services Starting Before Coverage Begins**

We will not provide Benefits for any services received:

1. Prior to the Effective Date; or

2. On or after the effective date if the service is covered under any other health benefits contract, program or plan.

I. **Cosmetic Surgery**

Services in connection with cosmetic surgery, which is primarily intended to improve appearance are excluded. We will, however, pay for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the part of the body involved. We will also pay for reconstructive surgery due to congenital disease or anomaly of a child covered under this Contract, which has resulted in a functional defect.

J. **Dental Services**

We will not provide Benefits for any service related to dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within twelve (12) months of the accident or when a claim is made within twelve (12) months of the accident establishing that it is Medically Necessary for the care or treatment to be provided more than twelve (12) months from the date of the accident; and except for dental care or treatment necessary due to congenital disease or anomaly.

K. **War Injuries and Aviation**

We will not provide Benefits for any injuries or sickness resulting from war or any act of war (declared or undeclared). We will also not provide Benefits for injuries or sickness resulting from aviation, other than as a fare-paying passenger on a scheduled or chartered flight operated by a scheduled airline.

L. **Self Inflicted and/or Criminal Behavior**

We will not provide Benefits for any intentionally self-inflicted injury or for any illness, injury or condition arising out of your participation in a felony, riot or insurrection. The felony, riot or insurrection will be determined by the law of the state where the criminal behavior occurred.

M. **Home Modifications and/or Fixtures**

We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of home modifications and fixtures, including but not limited to elevators, escalators, ramps, seat lift chairs, stair glides, handrails, swimming pools, whirlpool baths, home tracking systems, exercise or physical fitness equipment, air or water purifiers, central or unit air conditioners, humidifiers, dehumidifiers, and emergency alert systems and equipment, and business or vehicle modifications, or for services for evaluation, fitting or modification of such fixtures. This Exclusion does not limit Benefits available for those items of Durable Medical Equipment (DME) described in Article VIII, Section B of this Certificate.

N. **Admission to a Hospital Before You Become Covered under this Contract**

If you are covered by an insurer other than MVP, and you are an inpatient when that policy terminates, then that insurer, and not MVP, shall be responsible until your discharge or until the benefits under that policy expire, whichever occurs first.

O. **Pre-Existing Conditions**

We will not cover health care services during the first twelve (12) months of this Contract that relate to pre-existing conditions. A pre-existing condition exclusion may only relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month (6) period ending on the enrollment date. For purposes of this Section, the Covered Person's enrollment date is his first day of Coverage, or if there is a waiting period, the first day of his waiting period. Notwithstanding the foregoing, the preexisting condition exclusion shall not be applied to (1) pregnancy; or (2) a newborn, adopted child under age eighteen (18), or a child under eighteen (18) placed for adoption as long as the child became covered under this Contract within thirty (30) days of birth, adoption or placement for adoption, and provided the child does not incur a subsequent sixty-three (63) day or longer break in Coverage. Additionally, genetic information will not be treated as a preexisting condition in absence of a diagnosis. In applying this provision, we will credit to the Covered Person the time he was covered under previous health insurance plans or policies or employer-provided health benefits arrangements whether insured or self-insured by an employer; if the previous coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date of this Contract.

P. **Custodial Care**

We will not provide Benefits for Custodial Care.

Q. **Coverage Outside the United States**

Except with respect to Emergency Care, we will not provide Benefits for services accessed outside the United States, its possessions or the countries of Canada and Mexico.

R. **Non-Covered Services**. We will not provide Benefits for any services not listed in this Certificate as a Covered Service or any service that is related to services not covered under this Certificate.

S. **Non-Medically Necessary Services**. We will not provide Benefits for any service, supply, test, device, drug or treatment that is not Medically Necessary.

T. **Alternative Services**. We will not provide Benefits for alternative or complementary health services, products, remedies, treatments and therapies including, but not limited to smoking cessation therapy, caffeine cessation therapy, acupuncture, biofeedback, massage therapy, osteopathic manipulation, hypnosis and hypnotherapy, naturopathy, homeopathy, play therapy, primal therapy, chelation therapy, carbon dioxide therapy, rolfing, psychodrama, psychoanalysis, megavitamin therapy, purging, bioenergetic therapy, aroma therapy, hair analysis, thermograms, thermography, swimming therapy and horseback riding therapy.

U. **Educational Services**. We will not provide Benefits for services required to determine appropriate educational placements or services or for other educational testing. We will also not provide Benefits for special education and related services, and assistive technology devices and assistive technology services determined to be needed as a result of such educational evaluations, including, but not limited to therapy services, cognitive retraining and rehabilitation, services for remedial education, evaluation and treatment of learning disabilities and disorders, interpreter services and lessons in sign language.

V. **Orthodontia Services**. We will not provide Benefits for orthodontia and orthodontia services.

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

X. **Support Therapies**. Except as specifically provided in this Contract, we will not provide Benefits for support therapies including, but not limited to, marriage counseling, pastoral or religious counseling, compulsive gambling, assertiveness training, music or art therapy or recreational therapy.

Y. **Personal or Comfort Items.** We will not provide Benefits for massage services, spa services, and other provider services, central or unit air conditioners, air or water purifiers, waterbeds, massage equipment, radio, telephone, telephone service, telephones, cellular phones, computer hardware and software, Internet service, television, beauty and barber services, hypoallergenic bedding, mattresses, waterbeds, dehumidifiers, humidifiers, hygiene equipment, saunas, whirlpool baths, exercise or physical fitness equipment, emergency alert systems and equipment, heat appliances, and business or vehicle modifications, or for services for evaluation, fitting or modification of such items.

Z. **Communication Devices**. Except as otherwise provided, we will not provide Benefits for the purchase, rental, repair, replacement or maintenance of devices for speaking, listening, or otherwise communicating. This includes, but is not limited to, telecommunication devices for the deaf (TDDs) and teletype machines (TTYs), and services for evaluation, fitting, or modification of such devices.

AA. **The Following Services are NOT Covered**:

1. Disposable Medical Supplies, except as noted for in Article VIII;

2. Reversals of elective vasectomies or tubal ligations;

3. Orthotic devices, such as orthopedic shoes and arch supports;

4. Ophthalmic services for vision correction or accommodations; or the expense of filling or purchasing eyeglasses or contact lenses;

5. Hearing aids or hearing aid evaluations; including procedures relating to prescribing and fitting the aids;

6. Costs for which the Covered Person is responsible if he fails to keep an appointment with a Professional Provider;

7. Routine foot care, including corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

8. The cost of referrals to radiology facilities, pharmacies or laboratories, which are prohibited under N.Y. Pub. Health Law § 238-a(1);

9. Whole blood, blood plasma, packed blood cells or other blood derivatives if participation in a volunteer blood replacement program is available to the member. Autologous blood donations are covered when medically necessary;

10. Travel Costs and related expenses such as meals and lodging, except for Covered Ambulance Services.

ARTICLE XIII - COORDINATION OF BENEFITS WITH ANOTHER CARRIER

A. Applicability

This section applies only to those Covered Persons who have health care coverage with another "Plan." When that is the case and a Covered Person receives services, we will coordinate benefits with any payment made under the other Plan. One Plan will pay its full benefit as the primary plan and the other will pay secondary benefits, if necessary, to cover some or all of his remaining expenses. This prevents duplicate payments and overpayments.

B. Definitions

For purposes of this Article ONLY, the following terms shall be defined as follows:

1. "THIS PLAN" is the group contract/certificate issued by MVP of which this section is a part.

2. "Plan" is another health benefits program not issued by MVP with which we will coordinate benefits. The term "Plan" includes:

   a. Health benefits insurance and group, blanket or group remittance health benefits insurance coverage, whether insured, self-insured, or self-funded. This includes HMO and other prepaid coverage. This does not include blanket school accident coverage or coverage's issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the policyholder (the school or organization) pays the premium.

   b. Medical benefits coverage in a group and/or individual mandatory automobile "no-fault" and traditional mandatory automobile "no-fault" type contracts.

   c. Hospital, medical and surgical benefits coverage of Medicare or a governmental plan offered, required or provided by law, except Medicaid. It also does not include any plan whose benefits are by law excess to any private insurance program or other non-governmental program.

C. Rules to Determine Payment

The first of the rules listed below (1-6) which applies shall determine which Plan shall be primary:

1. If the other Plan does not have a provision similar to this one, then it shall be primary.

2. If the Insured Person receiving the benefits is the person belonging to the group through which, or to which THIS PLAN was issued and he is only covered as a dependent under the other Plan, THIS PLAN will be primary.

3. If a dependent 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 shall be primary. For purposes of determining whose birthday falls earlier in the year, only the month and date are considered. If the other Plan does not have this

"birthday" rule but instead has a rule based on the gender of the parent and as a result the Plans do not agree on which is primary, then the father's Plan shall be primary.

4. If a dependent child is covered by both parents' plans, and the parents are separated or divorced, and there is no court decree which establishes financial responsibility for the child's health care expenses:

   a. The Plan of the parent who has custody (the custodial parent) shall be primary;

   b. If the custodial parent has remarried, and the child is also covered as a dependent under the step-parent's Plan, the custodial parent's Plan shall pay first, the step-parent's Plan second and non-custodial parent's Plan third.

5. If a dependent child is covered under both parents plan, and there is a decree, which specifies the parent whom is responsible for the child's health care expenses, and that parent's Plan has actual knowledge of the decree, then that parent's Plan shall be primary.

6. The Plan covering the Insured Person as an active employee or the dependent of an active employee shall be primary. The Plan covering the Insured Person as an inactive employee or the dependent of an inactive employee shall be secondary. If the other Plan does not have this rule in its coordination of benefits provision, and as a result the Plans do not agree on which shall be primary, this rule shall be ignored.

7. If none of the above rules determines which Plan shall be primary, the Plan that has covered the Insured Person for the longest period of time shall be primary.

8. Notwithstanding the foregoing, for any person age 65 or older who is a Medicare eligible employee or spouse of an employee, the benefits of this Contract will be considered primary to the benefits provided by Medicare, except as set forth in applicable law.

D. **Effects of Coordination**

When THIS PLAN is secondary, the Benefits of THIS PLAN will be reduced by the amount paid or provided by the primary Plan(s) for the same item of service. The amount THIS PLAN will pay or provide will not be more than the amount it would pay or provide if it were primary.

E. **Private Room Differential**

Regardless of whether THIS Plan is primary or secondary, THIS Plan will not pay or provide Benefits for the difference between the cost of a private hospital room and the cost of a semi-private hospital room unless a private room is medically necessary in accordance with accepted medical practice.

F. **Right to Receive and Release Necessary Information**

We may release or obtain information, which we need to carry out the purpose of this Plan. We need not tell you or obtain your consent to do this except as required by Article 25 of the New York General Business Law. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information we request. If you do not, we have the right to deny payments to you and any assigned provider.

G. **Payments to other Plans**

We may repay to any other Plan the amount it paid for your expenses and, which we decide we should have paid. These payments are the same as benefits paid to you and they satisfy our obligation to you under THIS Plan.

H. **Our Right to Recover Overpayment**

In some cases we may have made payment even though you had coverage, which was primary, under another Plan. Under these circumstances, you agree to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover any overpayment from the other Plan and the Insured Person agrees to sign all documents necessary to help us recover any overpayment.

I. **Coordination with "Always Excess," "Always Secondary" or Non-Complying" Plans.**

We will coordinate benefits with Plans, which provide benefits, which are always excess or always secondary or use an order of benefit determination rules inconsistent with those described above ("non-complying Plans") in the following manner:

1. If THIS Plan is primary, we will pay or provide Benefits first;

2. If THIS Plan is secondary, we will still pay or provide Benefits first, but the amount paid or Benefits provided will be limited to what we will pay or provide if we were secondary; and

3. If we request information from a non-complying Plan and do not receive it within thirty (30) days of our request, we can calculate the amount we should pay or provide on the assumption that the non-complying Plan and THIS

Plan provide identical benefits. When the information is received, we will make the necessary adjustments.

ARTICLE XIV - SUBROGATION & DUTY OF COOPERATION

A. Subrogation

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and we pay Benefits as a result of that injury or illness, we will be subrogated and succeed to your right of recovery against the party responsible for your illness or injury to the extent of the Benefits we have paid. This means that we have an independent right to proceed against the party responsible for your injury or illness and to recover the Benefits we have paid.

B. Duty to Cooperate with Us - Possible Penalties for Failure to Cooperate

Under certain circumstance, we are also entitled to be reimbursed for the Benefits we have paid from a settlement or a judgment received by you from the party responsible for your illness or injury. This and other penalties, which apply under certain circumstances are noted below. Those circumstances are:

1. The settlement or judgment you receive from the party responsible for your illness or injury specifically identifies or allocates monetary sums directly attributable to expenses for which we have paid Benefits; or

2. You fail to cooperate with us in a proceeding against the party responsible for your illness or injury to recover the Benefits we have paid. We will pay all expenses associates with a legal action instituted on our initiative.

   The penalty for failing to cooperate with Subpart "2" immediately above is that you will be responsible to repay to us the amount of the Benefits we have paid. We agree to invoke Subpart "2" only when the illness or injury caused by a third party results in our expenditure on your behalf of an amount exceeding $500.00 under this Coverage.

ARTICLE XV - TERMINATION OF COVERAGE

A. Generally

Described below are the reasons why your Coverage under this Contract may terminate. Please note, your Coverage may terminate by virtue of the fact that the underlying Group Contract has terminated (for the reasons stated in Section B, immediately below) or for reasons independent of the Group (See Section C, below). It should be further noted, that in some instances you may have post termination Coverage options and rights. (See, Article XVI, "Post Termination Coverage"). All terminations are effective at 12:01 a.m., on the date specified.

B. **Termination of the Group Contract**

The Group Contract will continue for a period of one (1) year from the first Effective Date of Coverage and will automatically be renewed for one (1) additional year thereafter at each renewal date unless the Group Contract is terminated as set forth below.

1. At the option of your Group. At anytime for any reason during the Contract Year by providing MVP with thirty (30) days advance written notice.

2. At the option of MVP. For any of the following reasons:

   a. The Group has failed to pay premiums under the Contract. In this case, your Coverage will end on the date to which the premium has been paid;

   b. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract. In this case, your Coverage will terminate thirty (30) days from the date we provide you with notice of such event;

   c. The Group has failed to comply with a material term relating to the employer contribution and group participation rules as set forth in this Contract and as permitted under section 4235 of the Insurance Law. In this case, your Coverage will terminate thirty (30) days from the date we provide you with notice of such event;

   d. If we terminate the entire class of contracts to which this Contract belongs. In this case, your Coverage will terminate ninety (90) days from the date we provide you with notice of such event;

   e. If we withdraw from the applicable market through which you obtained Coverage under this Contract, and we cease offering any products in that market. In this case, your Coverage will terminate six (6) months from the date we provide you with notice of such termination;

   f. Group ceases to meet the requirements for a Group under Section 4235 of the Insurance Law or, if applicable, a participating employer, labor union, association or other entity ceases membership or participation in your Group;

   g. Any reason found to be acceptable to the New York State Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996 and any later

amendments or successor provisions or by any federal regulations or rules that implement the provisions of the Act.

C. **Termination of Your Coverage under this Contract**

In the following instances, the Group Contract will continue in force, but the Covered Persons Coverage will be terminated.

1. Upon your Election. Coverage shall terminate on the date to which premium has been paid.

2. The Subscriber is no longer an eligible member of Group. Coverage shall terminate for the Subscriber, and, if he has Family Coverage, his Eligible Dependents on the date to which premiums have been paid;

3. The Covered Person commits Fraud or makes an Intentional Misrepresentation in applying for Coverage or in Filing a Claim with MVP. Coverage will terminate thirty (30) days from the date we notify the Covered Person of our determination;

4. On your Death. Coverage under this Contract will automatically terminate on the date of your death. If you are covered as the Dependent of the Subscriber, then your Coverage shall also terminate automatically upon the death of the Subscriber.

5. Termination of Marriage. If you are the Subscriber to this Contract with Family Coverage and you become divorced or your marriage is annulled, the Coverage of your wife or husband will end automatically on the date the decree is actually filed. In such case, you should immediately notify your Group of the change in your marital status;

6. Termination of Coverage of a Child. Coverage of your dependent child under this Contract will automatically terminate on the date the child no longer qualifies as a dependent child as set forth in Article II, Section A of this Contract; or

7. Any reason approved by the Superintendent of Insurance.

ARTICLE XVI - POST TERMINATION COVERAGE

A. **Total Disability**

1. If your Coverage under this Contract ends because you are no longer actively employed; no longer eligible for Coverage under this Contract; or this Contract terminates, then we will provide an Extension of Benefits during a period of total disability for a hospital confinement or surgery performed

within thirty-one (31) days for the injury, sickness or pregnancy causing the total disability.

2. If your Coverage ends because you are no longer actively employed, we will provide Benefits during a period of total disability for up to twelve (12) months from the date such Coverage ends, for Covered Services to treat the injury, sickness, or pregnancy that caused the total disability; unless coverage is provided for services in connection with the total disability under another group health plan.

B. **Continuation Coverage under Federal Law**

Under the Continuation of Coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act 1985 (COBRA), most employer sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Covered Persons should call or write their Group or us to find out if they are entitled to temporary continuation of coverage under COBRA.

If you are not eligible for temporary continuation coverage under COBRA, then you may still be eligible for temporary continuation coverage under New York Law.

C. **Continuation Coverage under New York State Law**

If you have lost Coverage under this Contract because of termination of employment or membership in the class or classes eligible for Coverage, you may be eligible for Continuation Coverage for yourself and, if you have Family Coverage, your Eligible Dependents subject to the following conditions:

1. You are not entitled to Medicare; and you are not covered under or eligible for other group coverage, which does not exclude or limit coverage for pre-existing conditions.

2. You have requested Continuation Coverage within sixty (60) days after the later of: the date of termination or the date you are given notice of your right to Continuation Coverage by your Group. If you seek Continuation of Coverage as set forth in this Article XVI, Section C, Subsection 4, Subpart "d" immediately below, you must notify and submit a completed application to MVP within sixty (60) days after termination that you were disabled under the Social Security Act at the time of termination of your employment or membership.

3. You must pay the premium (not more frequently than monthly) when due. The first payment is due within sixty (60) days after the date Coverage

would otherwise terminate. The premium cannot exceed one-hundred and two (102) percent of the Group's rate.

4. Coverage will terminate at the earliest of the following:

   a. The date eighteen (18) months after your Coverage would have terminated because of termination of employment or membership.

   b. If you fail to make a timely payment, the date to which premiums were paid.

   c. If you are an Eligible Dependent, the date thirty-six (36) months after Coverage would have terminated due to: death of the subscriber; divorce or legal separation; the subscriber's eligibility for Medicare; your failure to meet the definition of a "dependent child" as defined in this Contract.

   d. The date twenty-nine (29) months after your Coverage would have otherwise terminated because of employment or membership if you are determined to have been disabled under the Social Security Act at the time of termination of employment or membership. However, if you are no longer disabled, Coverage will terminate the later of: eighteen (18) months after your Coverage would have terminated because of termination of employment or membership or the first day of the month that begins more than thirty-one (31) days after the determination that you are no longer disabled.

   e. The date your Group no longer provides Coverage to any of its employees or members.

D. When a Covered Person can Convert his Coverage

If your Coverage under this Contract ends, you may be entitled to purchase a direct pay statutory conversion product, subject to the conditions set forth below.

1. Eligibility. You may be eligible to convert this Contract if:

   a. You have lost eligibility for Coverage because of termination of employment or membership in the class or classes eligible for coverage under the policy;

   b. You are an eligible dependent and have lost eligibility due to: the death of the subscriber; divorce or annulment of the marriage from the subscriber; or attaining the limiting age of coverage.

2. We do not have to offer you Conversion Coverage if:

   a. The Group Contract from which you seek conversion has been replaced with similar and continuous coverage whether on an insured or self insured basis; or

   b. You have or have available to you other health benefits coverage that would result in over-insurance or duplication of benefits according to the standards on file with and approved by the New York State Superintendent of Insurance; or

   c. You have not been insured under the Group Contract from which you seek conversion for at least three (3) months; or

   d. You are covered by Medicare, by reason of age. Moreover, the converted policy may provide for termination of coverage thereunder on any person when he is or could be covered by Medicare, by reason of age;

   e. For such other reasons, including, but not limited to, prior termination of your Group Contract based upon acts of fraud or intentional misrepresentation, as the Superintendent of Insurance shall approve.

3. Notice: You must apply for Conversion Coverage within forty-five (45) days after Coverage under this Contract would otherwise terminate. If a notice is sent more than fifteen (15) days but less than ninety (90) days after the date of termination, you will have forty-five (45) days after receiving the notice to apply for Conversion Coverage. If no notice is given, the right to conversion expires at the end of ninety (90) days from the date of termination.

4. How to convert from this Contract. To convert this Contract and maintain Coverage, you must do two things: complete an application for a new direct payment contract, and pay us the premium for the new contract within forty-five (45) days after Coverage ends, except if the time is extended under section "3" above. If this is done, the new contract takes effect as soon as coverage under this Contract ends.

5. Conversion Contract: you may call or write MVP to find out about your conversion options.

ARTICLE XVII – UTILIZATION MANAGEMENT AND INTERNAL APPEALS

A. Utilization Management (UM)

Utilization Management is the process used by MVP to determine if a claim for benefits is covered under this Contract. MVP's Utilization Management Department can be reached at 1 (800) 568-0458.

For purposes of this Section, a "claim" is any request for benefits or services made pursuant to the requirements of this Contract. You or a designee appointed by you may submit a Claim. For purposes of this Section, any reference to "you" in this Contract shall refer to both you and your designee.

An "adverse determination" is any determination that results in the denial, reduction or termination of a service or that fails to provide or pay for a claimed benefit (in whole or in part); including determinations based upon eligibility to receive benefits, the Medical Necessity or the Experimental and/or Investigational nature of procedures, or failure to comply with MVP's UM procedures.

Any written Adverse Determination Notice sent to you shall be deemed delivered as of the date it is sent by mail to you by MVP at the address provided on your Enrollment Application or at the last address provided to MVP pursuant to our policies and procedures.

All UM determinations that pertain to clinical matters, shall be made by an appropriate licensed health care practitioner.

MVP shall make all UM determinations within the following timeframes:

1. Urgent Care Claims. An Urgent Care Claim refers to any Claim for medical care or treatment with respect to which the application of the time periods for making Non-Urgent Care determinations: (1) could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, as determined by MVP (this determination will be made by MVP applying the prudent layperson standard); (2) in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot adequately be managed without the care or treatment that is the subject of the Claim; (3) any Claim that a physician with knowledge of the Covered Person's medical condition determines is a Claim involving Urgent Care. MVP will make all UM determinations with respect to Urgent Care Claims within the following timeframes:

a. If we have all necessary information at the time the Urgent Care Claim is received, MVP will make a decision within seventy-two (72) hours after receipt of the Claim.

b. If we do not have all necessary information at the time the Urgent Care Claim is received, we will notify you within twenty-four (24) hours of receiving the Urgent Care Claim of any missing information. You will then have forty-eight (48) hours from receipt of this notice to provide us with the missing information. In such cases we will make a decision within forty-eight (48) hours after: (1) our receipt of the missing information or (2) the expiration of time to provide us with the missing information, whichever is earlier.

c. We will notify you of our decision either orally or in writing within the timeframe, set forth above. If oral notification is used, we will also notify you in writing within the earlier of three (3) days after the oral notification or three (3) business days of receipt of all necessary information. MVP's failure to notify you within the above timeframe may be considered an Adverse Determination, which may be appealed directly to MVP's Level One Expedited Appeal process

2. <u>Pre-Service Claims</u>. This involves any claim for Benefits that requires approval prior to obtaining care. (See, Article II, Section M, "Pre-Certification" for a list of Covered Services that require prior approval/pre-certification). MVP will make all UM determinations relating to Pre-Service Claims within the following timeframes:

a. If we have all necessary information at the time the Pre-Service Claim is received, MVP will make a decision within three (3) business days after receipt of the Claim.

b. If we do not have all necessary information at the time the Pre-Service Claim is received, we will notify you and your health care provider within fifteen (15) days after receiving the Pre-Service Claim of any missing information. You will then have forty-five (45) days after receipt of this notice to provide the missing information. In such cases, we will make a decision: (1) within three (3) business days of our receipt of the missing information; (2) within fifteen (15) days of the expiration of time to provide us with the missing information, whichever is earlier.

c. We will notify you and your health care provider of our decision both orally and in writing within the timeframe, set forth above. MVP's failure to notify you within the above timeframe may be

considered an Adverse Determination, which may be appealed directly to MVP's Level One Standard Appeal process.

3. Concurrent Care Claims. Concurrent Care Claims involve our review of continued or extended health care services, or additional services when you are undergoing a course of continued treatment prescribed by your health care provider. MVP will make all UM determinations relating to Concurrent Care Claims within the following timeframes:

   a. Any UM Determination related to an extended course of treatment that involves Urgent Care matter, shall be made within twenty-four (24) hours after receipt of the Concurrent Care Claim. If the Concurrent Care Claim does not involve an Urgent Care matter, then the UM Determination shall be made within one (1) business day after receipt of all necessary information or within the timeframe to make a Pre-Service UM Determination, whichever is earlier.

   b. Any Adverse Determination that results in a reduction or denial of a course of treatment before the end of the period of time or number of treatments that have been previously approved, shall be made at a time sufficiently in advance of such reduction or denial to allow you to commence an Expedited Level One Appeal (see "Expedited Level One Appeals" below) and to obtain a determination from such promptly commenced Expedited Level One Appeal before such benefit is reduced or denied.

   c. We will notify you and your health care provider of our decision both orally and in writing within the timeframe set forth above. MVP's failure to notify you within the above timeframe may be considered an Adverse Determination, which may be appealed directly to MVP's Level One Expedited Appeal process.

4. Post Service Claims. This involves determinations relating to services, which have already been provided. MVP will make UM determinations relating to Post-Service Claims within the following timeframes:

   a. If we have all necessary information at the time the Post Service Claim is received, MVP will make a decision within thirty (30) days after receipt of the Claim.

   b. If we do not have all necessary information at the time the Post Service Claim is received, we will notify you within thirty (30) days of receiving the Post Service Claim of any missing information that is needed to make a determination. You will then have forty-five (45) days after receipt of this notice to provide us with the missing information. In such cases, we will make a

decision: (1) within fifteen (15) days of our receipt of the missing information or (2) within fifteen (15) days of the expiration of time to provide us with the missing information, whichever is earlier.

c. We will notify you in writing of our decision within the timeframe set forth above. MVP's failure to notify you within the above timeframe may be considered an Adverse Determination, which may be appealed directly to MVP's Level One Standard Appeal process.

B. Internal Appeals

An "internal appeal" is an appeal submitted directly to MVP. You or a designee appointed by you may submit an Internal Appeal of any Adverse UM Determination.

In all cases, you have the right to designate a representative for the purpose of initiating an Internal Appeal. To appoint a designee, you should contact MVP's Member Services Department at 1-888-MVP-MBRS and follow the instructions provided.

You shall be afforded the opportunity to submit written comments, documents, records, and other information relating to your Internal Appeal. Moreover, upon request and free of charge you shall be allowed reasonable access to, and copies of all documents, records and other information relevant to your Internal Appeal.

Internal Appeals that pertain to clinical matters shall be reviewed by an appropriate licensed health care practitioner with appropriate training and experience in the field of medicine involved in your Internal Appeal.

Internal Appeals shall be reviewed by persons who were not involved in the UM determination process and who are not subordinate to those who made the prior UM determination. No deference shall be given to the determination made at the prior level of review.

Any written Adverse Determination Notice sent to you shall be deemed delivered as of the date it is sent by mail to you by MVP at the address provided on your Enrollment Application or at the last address provided to MVP pursuant to our policies and procedures.

You may submit your request for an Internal Appeal orally or in writing by either calling MVP at 1-888-MVP-MBRS or writing to MVP Health Insurance Company at 625 State Street, Schenectady, New York 12305.

There are two levels of Internal Appeal.

1. Level One Appeals - Mandatory Internal Appeals. Level One Appeals are "mandatory appeals." This means that you must commence and complete a Level One Internal Appeal (unless jointly waived in writing by you and MVP) before you may seek any other internal or external remedy, including External Review by the State of New York or civil action.

   MVP has two types of Level One Appeals:

   a. Expedited Level One Appeals. You may request an Expedited Level One Appeal if you are appealing an Adverse UM Determination related to Urgent Care or Concurrent Care Claims. You must submit your request for an Expedited Level One Appeal within one-hundred and eighty (180) days after your receipt of the Adverse Determination Notice.

      i. MVP will make a decision within forty-eight (48) hours after receipt of the Expedited Level One Appeal.

      ii. We will notify you of our decision in writing within the timeframe set forth above. If MVP fails to notify you within the above timeframe, then this may be considered satisfaction of your Mandatory Internal Appeals. Additionally, if MVP fails to notify you within the above timeframe, we will reverse any Adverse UM that was based upon Medical Necessity or because a service is deemed Experimental or Investigational.

      iii. Receipt of an Adverse Determination Notice from an Expedited Level One Appeal or expiration of MVP's time to make a decision regarding a properly commenced Expedited Level One Appeal shall satisfy your Mandatory Internal Appeal requirements.

      iv. In the event you receive an Adverse Determination Notice following your Expedited Level One Appeal, you may, **in addition to any other legal remedy available to you**:

         (a) Proceed directly to New York State External Review, if the Adverse Determination Notice is based upon Medical Necessity and/or because a service is Experimental or Investigational. In this case, the Adverse Determination Notice from MVP's Expedited Level One Appeal shall be deemed the Final Adverse Determination Notice for the purpose of initiating an NYS External Appeal;

(b) Commence a MVP Standard Level One Appeal. In this case, if you timely commence a Standard Level One Appeal the time to file a NYS External Appeal shall be stayed until you receive a Final Adverse Determination Notice from your Standard Level One Appeal;

(c) Commence a "voluntary" Expedited Level Two Appeal. Please be advised that commencing an Expedited Level Two Appeal does not stay your time to file a NYS External Appeal. In this case, the time to file a NYS External Appeal would run from your receipt of a Final Adverse Determination Notice from the Expedited Level One Appeal.

b. <u>Standard Level One Appeals</u>. You may request a Standard Level One Appeal if you are appealing an Adverse UM Determination related to Pre-Service or Post Service Claims. Additionally, you may elect to commence a Standard Level One Appeal following an Adverse Determination from an Expedited Level One Appeal. You must request a Standard Level One Appeal within one hundred and eighty (180) days after your receipt of a written Adverse UM Determination Notice or a written Adverse Determination Notice from an Expedited Level One Appeal.

i. MVP will make a decision regarding a Standard Level One Appeal within fifteen (15) days after receipt of the Appeal.

ii. We will notify you of our decision in writing within the timeframe set forth above. If MVP fails to notify you within the above timeframe, then this may be considered satisfaction of you Mandatory Internal Appeal requirements. Additionally, if MVP fails to notify you within the above timeframe, we will reverse any Adverse Determination that was based upon Medical Necessity and/or because a service is deemed Experimental or Investigational.

iii. In the event you receive an Adverse Determination Notice following your Standard Level One Appeal, you may, **in addition to any other legal remedy available to you**:

(a) Proceed directly to New York State External Review, if the Adverse Determination Notice (denial) is based upon Medical Necessity and/or

because a service is Experimental or Investigational. In this case, the Adverse Determination Notice from MVP's Standard Level One Appeal shall be deemed the Final Adverse Determination Notice for the purpose of initiating an NYS External Appeal;

(b) Commence a "voluntary" Standard Level Two Appeal. Please be advised that commencing a Standard Level Two Appeal does not stay your time to file a NYS External Appeal. In this case, the time to file a NYS External Appeal would run from your receipt of a Final Adverse Determination" Notice from the Standard Level One Appeal.

2. Level Two Appeals - Voluntary Internal Appeals. Level Two Appeals are "voluntary appeals." This means that you are not required to commence a Level Two Appeal in order to pursue any other external remedy that may be available to you. Notwithstanding, if you are dissatisfied with the results of the Level One Appeal, MVP provides for a voluntary second level of Internal Appeal.

You may submit your request for a Level Two Appeal in the same manner as a Level One Appeal.

Your decision as to whether or not to submit a Claim to Level Two Appeal will have no effect on your rights to any other benefits under this Contract.

Level Two Appeals are reviewed by persons who are not subordinate to persons who conducted the Level One Appeal.

For those appealing an Adverse Determination from a Level One Appeal based on Medical Necessity or because a service is deemed Experimental or Investigational, please be advised that initiating a Level Two Appeal does not stay the time period to file an External Appeal with the State of New York. Notwithstanding, MVP shall stay any other statute of limitation or other defense based on timeliness during the time that any Level Two Appeal is pending.

MVP has two types of Level Two Appeals:

a. Expedited Level Two Appeals. Expedited Level Two Appeals are only available if you have received an Adverse Determination from an Expedited Level One Appeal. You must submit your request for an Expedited Level One Appeal within one-hundred and eighty (180) days after your receipt of a written Adverse Determination Notice from Expedited Level One Appeal. MVP

will review and respond to Expedited Level Two Appeals within the following timeframes:

i. MVP will make a decision regarding the Expedited Level Two Appeal within forty-eight (48) hours after its receipt.

ii. We will notify you of our decision in writing within the timeframe set forth above.

b. Standard Level Two Appeals. Standard Level Two Appeals are only available following an Adverse Determination from Standard Level One Appeal. You must submit your request for a Standard Level Two Appeal within one-hundred and eighty (180) days after your receipt of a written Adverse Determination from Standard Level One Appeal. MVP will respond to Standard Level Two Appeals within the following timeframes:

i. MVP will make a decision regarding the Standard Level Two Appeal within fifteen (15) days after its receipt.

ii. We will notify you of our decision in writing within the timeframe set forth above.

ARTICLE XVIII -- EXTERNAL APPEAL

A. Your Right to External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of Coverage. Specifically, if MVP has denied Coverage on the basis that the health care service is not Medically Necessary or is an Experimental or Investigational treatment, you or a representative appointed by you may appeal that decision to an External Appeal Agent. An External Appeal Agent is an independent entity certified by the State of New York to conduct such appeals.

B. Your Right to Appeal a Determination that a Health Care Service is Not Medically Necessary

If MVP has denied Coverage on the basis that the health care service is not Medically Necessary, you may appeal to an External Appeal Agent if you can satisfy the following two (2) criteria:

1. The service, procedure or treatment must otherwise be a Covered Service under this Contract; and

2. You must have received a final adverse determination through MVP's internal appeal process and MVP must have upheld the denial or you and MVP must agree in writing to waive any internal appeal.

C. **Your Right to Appeal a Determination that a Health Care Service is Experimental or Investigational**

If you have been denied Coverage on the basis that the health care service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

1. The service must otherwise be a Covered Service under this Contract; and

2. You must have received a final adverse determination through MVP's internal appeal process and MVP must have upheld the denial or you and MVP must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by MVP or one for which there exists a clinical trial (as defined by law).

In addition, your physician must have recommended one of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation - your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or

2. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this Section, your physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

D. **The External Appeal Process**

If, through MVP's internal appeal process, you have received a final adverse determination upholding a denial of Coverage on the basis that the health care service is not Medically Necessary or is an Experimental or Investigational treatment, you have forty-five (45) days from receipt of such notice to file a written request for an external appeal. If you and MVP have agreed in writing to waive any internal appeal, then you have forty-five (45) days from receipt of such waiver to file a written request for an external appeal. MVP will provide an external appeal application with the final adverse determination issued through MVP's internal appeal process or our written waiver of the internal appeal process.

You may also request an external appeal application from New York State by contacting:

1. New York State Department of Insurance at 1-800-400-8882, or its website at (www.ins.state.ny.us); or

2. New York State Department of Health at (518) 486-6074, or its website at (www.health.state.ny.us).

You must submit the completed application to State Department of Insurance at the address indicated on the application. If you can satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with this request. If the External Appeal Agent determines that the information submitted represents a material change from the information on which MVP based its denial, the External Appeal Agent will share this information with MVP in order to allow us the opportunity to exercise our right to reconsider our decision. If we choose to exercise this right, we will amend or confirm our prior decision within three (3) business days. Please note that in the case of an expedited external appeal (described below), MVP does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or MVP. If the External Appeal Agent requests additional information, it will have five (5) business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the health care service that has been denied poses an imminent or serious threat to your health, then you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify

you and MVP by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns MVP's decision that the health care service is not Medically Necessary or approves Coverage of an Experimental or Investigational treatment, MVP will provide Coverage subject to the other terms and conditions of this Contract. Please note that if the External Appeal Agent approves Coverage of an Experimental or Investigational treatment that is part of a clinical trial, MVP will only cover the costs of health care services required to provide treatment to you according to the design of the trial. MVP shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Contract for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and MVP. The External Appeal Agent's decision is admissible in any court proceeding.

MVP will charge members a fee of fifty dollars ($50.00) for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. MVP will also waive the fee if we determine that paying the fee would pose an undue hardship. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

E. Your Responsibilities

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested health care service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you consent to this in writing.

Under New York State law, your completed request for appeal must be filed within forty-five (45) days of either the date upon which you receive written notification from MVP that it has upheld a denial of Coverage or the date upon which you receive a written waiver of any internal appeal. MVP has no authority to grant an extension of this deadline.

ARTICLE XIX - FURTHER TERMS OF THIS CONTRACT

A. Notices to You and to Us

Unless otherwise mutually agreed in writing, all notices given to you and your Eligible Dependents under this Contract shall sent to your address as it appears on the most recent Enrollment Application. All notices sent by Covered Persons to MVP will only be recognized if sent by **Certified Mail** to:

MVP Health Insurance Company
P.O. Box 1076
Schenectady, New York 12301-1076

B. **Release of Records, Authorizations and other Information**

Providers and other health related entities often have information we need to determine eligibility for Benefits under this Contract. For purposes of this Section, Providers and other entities shall include hospitals, doctors, clinics, other providers of health care, other insurers, payors of health claims, other medical or medically related facilities or government entities. By accessing Benefits under this Contract, you hereby grant access to us or our designee and permits us to use for our purposes all medical records and other information pertaining to any health related services, which you may receive or may have received in the past. Further, you hereby authorize all the Providers and other health related entities referred to above to furnish to us any and all records and other information pertaining to your eligibility under this Contract, your medical history, health services rendered and treatment received or payments made so we may review, investigate and evaluate all claims. If necessary, at any time requested by us, you agree to provide us with a signed authorization to obtain records, as set forth above, to carry out the purpose of this Plan.

1. You also authorize us to disclose to a hospital or health care service plan, self insurer or insurer any medical information obtained or benefits paid by us if such disclosures are necessary to allow the processing of any claim.

2. You also authorize us to make such disclosures to the Group for purpose of utilization review or audit and to make such other disclosures as may be permitted or required by law.

3. You also authorize the Health Care Financing Administration and Medicare intermediaries and carriers to provide medical information to us or its designee so that we can process Medicare-related claims and provide the Benefits of this Contract.

C. **Assignment**

This Contract is not assignable. Only Covered Persons can receive the Benefits provided under this Contract. Any attempt to assign Benefits will be void, and no Benefits or rights may be claimed under any attempted assignment.

D. **Actions Brought Against MVP**

1. <u>Time Limit for Legal Action</u>.

   a. No action at law or in equity shall be brought to recover on this Contract prior to the expiration of sixty (60) days after proof of loss

(i.e. claim submission) has been submitted by the Covered Person to MVP.

b. No action at law or in equity shall be brought to recover on this Contract after the expiration of two (2) years following the time proof of loss (i.e. claim submission) is required under this Contract.

2. Physical Examination. MVP may require you to undergo a physical examination as often as reasonably necessary in connection with any injury or illness, which results in a claim made under this Contract. MVP may also have the right and opportunity to make an autopsy in the case of death, where it is not prohibited by law.

3. Examination Under Oath. MVP shall have the right and opportunity to examine under oath the Covered Person for whom claim is made when and so often as we may reasonably require during the pendency of such claim made under this Contract.

4. Choice of Law. In any dispute between you and MVP, New York or federal law, as appropriate, shall be applied to determine your rights, your rights.

5. Non-cooperation. Failure to comply with the terms and conditions of this Contract shall result in forfeiture of any claim or action brought by you or your Group against MVP.

E. Right to Recover Overpayments

If we overpay you for a claim for Covered Services or if we determine that payment was made in error, we may, at our sole option, recover any overpayment or reduce other Benefits by the amount of such overpayment or payment in error. You agree to remit such amounts to us promptly upon request. In addition, if we overpay a Provider who or which renders covered services to you, or if we determine that payment to such a Provider was made in error, you agree to cooperate with us in recovering such overpayment.

F. No Vesting of Benefits

There is no vesting of Benefits or Covered Services under this Contract. This means that absent regulatory or contractual provisions to the contrary, as of the effective date of a reduction, modification or change in MVP Benefits or Covered Services, you are entitled to receive only the level and type of Benefits and Covered Services that are in effect as of that date, regardless of whether you previously had been receiving a higher level or type of MVP Benefits or Covered Services.

G. **Construction of Benefits**

We, in our sole discretion, shall have the authority to determine eligibility for Benefits and to construe the terms of this Contract.

H. **Statement of ERISA Rights**

If this plan is covered by the Federal Employee Retirement Income Security Act of 1974 ("ERISA"), you are entitled to certain rights and protections, described below:

ERISA provides that all plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible

for the operation of the employee benefit plan. The people who operate your plan, called ‘‘fiduciaries’’ of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

4. Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance with Your Questions. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

6. Newborns and Mothers Health Protection Act. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for

the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).