MVP PREFERRED
EXCLUSIVE PROVIDER PLAN

VERMONT

CERTIFICATE OF COVERAGE

MVP Health Insurance Company
625 State Street
Schenectady, New York 12305
(800) 777-4793

MVP PREFERRED
EXCLUSIVE PROVIDER PLAN
VERMONT

Certificate of Coverage

Issued by
MVP Health Insurance Company
625 State Street, Schenectady, New York 12305
(800) 777-4793

Your employer or organization ("Group") has purchased a fully insured group health benefits plan from MVP Health Insurance Company (“MVP”).

This Certificate of Coverage (“Certificate” or "COC") is proof of the health benefits available to you under a contract between MVP and your Group. This COC is not a contract between you and MVP. Amendments, riders or endorsements may be delivered with this COC or added thereafter. Read all of the COC and any amendments, riders or endorsements carefully. You must make sure you understand and comply with all of the terms and conditions therein.

The terms We, Us, and Our mean MVP, or any designated agents of MVP.

The terms You and Your mean the Subscriber and his or her Dependents Covered under this COC unless otherwise specified.

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SECTION ONE – INTRODUCTION

1. Understanding Your Benefits.

A. Definitions. The capitalized words in this COC are defined in Section Two or within the Section that they are used.

B. Pre-Existing Conditions. This COC has a Pre-Existing Condition Exclusion. Read Section Four to know whether and to what extent this exclusion applies to you.

C. Covered Services and Exclusions. Covered Services means the services specified in this COC as eligible for Benefits. Covered Services are described in Sections Six through Twelve. Covered Services must be Medically Necessary. Exclusions are described in Section Thirteen. MVP has protocols to help determine if a service is a Covered Service.

Some Covered Services are listed in more than one Section. These services are listed this way to make clear that they may be received in different settings. It does not mean that you get Benefits for additional services, such as additional days or visits. Also, where Covered Services have day or visit limits, these limits are total limits on the number of days, visits or dollars.

D. Preferred Providers. Except as described in paragraph 1(F), MVP provides Benefits for Covered Services only when you use a provider who participates in the network for your plan and you get services as described in paragraph 1(E). Providers who participate in the network for your plan are referred to in this COC as Preferred Providers. For more information about Mental Health and Substance Abuse Preferred Providers, call [PrimariLink] at [1-800-320-5895]. For more information about Chiropractic Preferred Providers, call [Landmark] at [1-800-638-4557].

It is up to you to ensure that you get services from Preferred Providers who participate in the network for your plan and that you meet the requirements set forth in paragraph 1(E) below.

E. Getting Services.

1. Inpatient Services. To get Benefits for Inpatient Services described in Section Six, you must be admitted by a Preferred Provider to a Preferred Hospital or facility.

2. Outpatient Services. Except for Emergency Services, to get Benefits for Outpatient Services described in Section Seven, you must get such services from a Preferred Hospital or facility.

3. Skilled Nursing Facility Services. To get Benefits for Skilled Nursing Facility Services described in Section Eight, you must be admitted by a Preferred Provider to a Preferred Skilled Nursing Facility.

4. Home Health Agency Services. To get Benefits for Home Health Agency Services described in Section Nine, the Home Health Agency Services must be provided in accordance with a written treatment plan that is supervised by a Preferred physician. You must also get such services from a Preferred Home Health Agency.

5. Hospice Services. To get Benefits for Hospice Services described in Section Nine, a Preferred Provider must certify your prognosis. The Hospice Services must be provided in accordance with a written Hospice care plan that is supervised by a Preferred physician. You must also get such services from a Preferred Hospital or a Preferred Hospice.

6. Preventive Care. To get Benefits for Preventive Care described in Section Eleven, you must get such services from a Preferred Provider.

7. Professional Services. Except as described in paragraph F below, to get Benefits for Professional Services described in Section Twelve, you must get such services from a Preferred Provider.

8. Transplant Services/Donor Costs. To get Benefits for Transplant Services/Donor Costs, described in Section Twelve, the services must be provided by a Preferred Provider. The services must be performed at a facility within MVP's Transplant Network.

9. Supplies. To get Benefits for the supplies described in Section Twelve, you must have a prescription written by a Preferred Provider for such items and you must have the prescription filled by a Preferred pharmacy or by a Preferred supplier.

F. **MVP will provide Benefits for Covered Services you get from Non-Preferred Providers ONLY in the following cases:**

1. Emergency Care Services. MVP will provide Benefits for Emergency Services provided by Non-Preferred Providers. MVP's Allowable Charge for Out-of-Network Emergency Care Services will be based upon the Non-Preferred Provider's Charges. You must pay the Copayment, Deductible, and/or Coinsurance as set forth on your Schedule.

2. Out-of-Network Specialty Physician Services. If there is no qualified Preferred physician in the network for your plan available to provide Specialty Physician Services to you, MVP may provide Benefits for such

services provided by a Non-Preferred physician, subject to the following conditions:

i. You must get prior written approval from MVP before you get such services. To get prior written approval for such services, you must comply with the Prior Authorization requirements set forth in Section Five.

ii. MVP's Allowable Charge for such prior approved Out-of-Network Services will be based upon the Non-Preferred physician's Charges. You must still pay the Copayment, Deductible and/or Coinsurance that applies.

iii. MVP will only provide Benefits for the Out-of-Network Specialty Physician Services expressly authorized in MVP's written prior authorization letter. MVP will not provide Benefits for other Out-of-Network Services even if such services are provided in connection with authorized Out-of-Network Specialty Physician Services.

3. Other Professional Services. MVP may provide Benefits for Covered Services provided by Non-Preferred Anesthesiologists, Pathologists, Radiologists and Laboratories, if the services are performed in connection with a properly accessed Preferred Inpatient Hospital/facility service or Preferred Outpatient Hospital/facility service. MVP's Allowable Charge for these services shall be based upon the Non-Preferred Provider's Charges. You must still pay the Copayment, Deductible and/or Coinsurance that applies.

4. Transition Care.

i. Termination of Preferred Providers. A provider's participation with MVP may be terminated at any time by MVP or the provider. In such event, MVP shall provide notice to affected members within fifteen (15) days after we get a notice of termination. Covered Services rendered by the provider to Members between the date of notice of termination or the date of termination and ten (10) business days after notice is mailed, shall continue to be Covered Services. Thereafter, we will not provide benefits for services rendered by the terminated provider. It is up to you to ensure that a provider is a Preferred Provider at the time you receive services. Yet, in order to ensure an orderly transfer to a Preferred Provider, we will provide Benefits for services provided by a terminated Provider as provided below:

(a) Members with a life threatening, disabling or degenerative condition, who are receiving an active course of treatment for

an acute episode of chronic illness or acute medical condition from the terminated provider shall be allowed to continue to see their providers for sixty (60) days from the date of termination or until accepted by a Preferred Provider; and

(b) Women in their second or third trimester of pregnancy shall be allowed to continue to get care from their previous provider until the completion of postpartum care.

We will not provide these benefits when a provider has terminated or been terminated based on competence or professional conduct, which affects or could affect adversely the health or welfare of a member or members. We also will provide these benefits only if the terminated provider agrees:

(1) to continue to treat the member for an appropriate period of time based on the written transition plan goals;
(2) to abide by MVP's payment rates, quality of care standards and protocols, including utilization management protocols;
(3) to provide MVP with any necessary clinical and treatment plan information; and
(4) to not charge the member for amounts beyond any required Copayment.

ii. Use of Non-Preferred Providers by New Members. We will allow new members to continue to use their previous providers under the following circumstances:

(a) Members with a life threatening, disabling or degenerative condition, who are receiving an active course of treatment for an acute episode of chronic illness or acute medical condition from the previous provider shall be allowed to continue to see their providers for sixty (60) days from the date of enrollment or until accepted by a Preferred Provider; and
(b) Women in their second or third trimester of pregnancy shall be allowed to continue to get care from their previous provider until the completion of postpartum care.

We will provide these benefits only if the provider agrees:

(1) to continue to treat the member for an appropriate period of time based on the written transition plan goals;
(2) to abide by MVP's payment rates, quality of care standards and protocols, including utilization management protocols;
(3) to provide MVP with any necessary clinical and treatment plan information; and

(4) to not charge the member for amounts beyond any required Copayment, Deductible and/or Coinsurance.

5. Other Use of Non-Preferred Providers. If a Preferred Provider with appropriate training and experience to meet the health care needs of a Member is not available to provide Covered Services to the Member, MVP will ensure that the Member may obtain a referral to a Non-Preferred Provider for the provision of Covered Services. You must comply with the prior authorization requirements set forth in Section Five. You will not be responsible for any additional costs incurred by MVP for such services other than the applicable Copayment, Coinsurance or Deductible.

G. Coordination of Benefits. In order to get Benefits from this plan, you must follow the instructions in this COC, even if your MVP coverage is secondary to your other health care coverage. Read Section Sixteen.

2. Payments under this COC.

A. Your Payments.

1. Deductibles. Some plan Benefits have Individual and/or Family Deductibles. These are listed on your Schedule.

A. Individual Deductibles.

You must pay the Individual Deductible before MVP will pay any Benefits. If you have met your Individual Deductible, you do not have to pay any Individual Deductible for the rest of that Contract Year. The Individual Deductible applies to each Member each Contract Year. You must still pay the Coinsurance or Copayment that applies. There is no additional deductible for the first 31 days of a newborn baby's coverage.

B. Family Deductibles.

If you have family coverage, you and your Dependents may apply the amount of each person's Deductible toward the Family Deductible. You and your Dependents cannot apply more than the amount of each person's Individual Deductible toward the Family Deductible. If you and your Dependents have met the Family Deductible, you and your Dependents do not have to pay any further Deductible for the rest of that Contract Year. You must still pay the Coinsurance or Copayment that applies. The Family Deductible applies each Contract Year.

C. No Deductible Services. You do not have to pay any Deductible for certain Covered Services. These services are identified on your Schedule. Also, a Deductible does not apply to services requiring a Copayment, and services that are noted as Covered in Full in this COC and on your Schedule of Member Payments.

D. Carry Over Deductible. You may incur expenses for Covered Services in the last three months of any Contract Year that apply to your Individual and/or Family Deductible. These expenses will also be applied to your next Contract Year's Individual and Family Deductibles, if there is no break in your MVP coverage.

E. The following payments do not count toward your Individual or Family Deductible:

(1) Any Copayments and Coinsurance.

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

2. Coinsurance. This COC has Coinsurance. Required Coinsurance payments are listed on your Schedule.

3. Preferred Providers. When you get Medically Necessary Covered Services from a Preferred Provider, you must, in most cases, pay the Copayment, Deductible and/or Coinsurance that applies to the Preferred Provider before MVP provides benefits. The Copayment, Deductible and/or Coinsurance for each Covered Service is listed on your Schedule.

4. Preventive Care by Preferred Providers. When you get designated Preventive Care Covered Services from Preferred Providers, you do not pay any Copayment, Deductible or Coinsurance to the Preferred Provider. These Preventive Care Covered Services are covered in full. They are described in this COC and listed on your Schedule.

5. Annual Out of Pocket Maximums. Some plan Benefits have Individual and/or Family Out of Pocket Annual Maximums. These are the maximum amounts of eligible expenses each Member must pay during any Contract 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 and are identified on your Schedule.

A. Individual Annual Out of Pocket Maximums.

After you pay eligible expenses for Covered Services up to the Individual Annual Out of Pocket Maximum in any one Contract Year, you do not have to pay any further eligible expenses for

Covered Services for the rest of that Contract Year. You must still make any payments that are not counted toward the annual Out of Pocket Maximum. The Individual Annual Out of Pocket Maximum applies to each Member each Contract Year.

B. Family Annual Out of Pocket Maximums.

If you have family coverage, you and your Dependents may apply the amount of each person's eligible expenses for Covered Services toward the Family Annual Out of Pocket Maximum. You and your Dependents cannot apply more than the amount of each person's Individual Annual Out of Pocket Maximum toward the Family Annual Out of Pocket Maximum. If you and your Dependents have met the Family Annual Out of Pocket Maximum in any one Contract Year, you and your Dependents do not have to pay any further eligible expenses for Covered Services for the rest of that Contract Year. The Family Annual Out of Pocket Maximum applies each Contract Year.

C. The following expenses **Do NOT** Count Toward Annual Out of Pocket Maximums. Even if you have met the Annual Out of Pocket Maximum for a Contract Year, you must still make these payments. These are also identified on your Schedule.

1. Any Copayment, Coinsurance and/or Deductible for Durable Medical Equipment, External Prosthetic Devices (other than Artificial Limb Devices), Breast Prostheses and Ostomy Supplies
2. Any Copayment, Coinsurance and/or Deductible for Diabetic Supplies and Equipment.
3. Any Copayment, Coinsurance and/or Deductible for Medical Foods
4. Copayments for Covered Services.
5. Copayments for Prescription Drugs (if you have a Prescription Drug rider to this COC).
6. Any Charges you incur if you have exhausted any Benefit maximums or that are incurred for non-Covered Services.

B. MVP's Payments.

1. Preferred Providers. MVP will pay Preferred Providers the Allowable Charge minus any Member Copayment, Coinsurance and Deductible responsibilities. Preferred Providers will accept MVP's payment, plus the Copayment or Deductible and/or Coinsurance paid by you, as payment in full.

2. Annual Benefit Maximums. These are the maximum amounts of days, visits or Benefits available during any one Contract Year. After we have paid any Annual Benefit Maximum for a Covered Service in any Contract Year, you must pay all Charges for that Covered Service. After you exceed the amount of days or visits available for a Covered Service during any one Contract Year, you must pay all Charges for that Covered Service. Additionally, this COC may have a maximum amount payable by MVP under this COC for each Member during any one Contract Year. If such maximum applies to you, the amount is listed on your Schedule. After you have reached this maximum, you must pay all Charges for the remainder of that Contract Year.

3. Lifetime Benefit Maximums. This COC may have a Lifetime Benefit Maximum. This is the maximum amount of Benefits payable by MVP under this COC during each Member's lifetime. There are two different Lifetime Benefit Maximums, described below. The amount of each Lifetime Benefit Maximum is listed on your Schedule. After you have reached the Lifetime Benefit Maximum, you must pay all Charges.

   a. General Lifetime Benefit Maximum. This includes all Benefits paid by MVP.

   b. Lifetime Benefit Maximum for Durable Medical Equipment, External Prosthetic Devices and Ostomy Supplies. This includes any Benefits paid by MVP for Durable Medical Equipment, External Prosthetic Devices and Ostomy Supplies. This Lifetime Maximum Benefit does not apply to Artificial Limb Devices and External Breast Prostheses.

SECTION TWO – DEFINITIONS

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

   A. Acute Services means treatment of an illness, injury or condition, marked by a sudden onset or abrupt change of your health status that requires prompt medical attention. Acute Services may range from outpatient evaluation and treatment to intensive inpatient care. Acute Care is intended to prevent deterioration of or palliate the member's condition and to produce measurable improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time, or that is moving the member toward a less restrictive setting, or that is expected (according to generally accepted professional standards) to provide or sustain significant, measurable clinical improvement within a reasonable and medically predictable period of time.

   B. Adult Preventive Care. Preventive Care services provided to members 18 and older, or as applicable pursuant to the mandated benefit.

C. Allowable Charge. The established amount payable for Covered Services under this COC. The Allowable Charge may be established in accordance with a Fee Agreement; Usual, Customary and Reasonable Charges or by law.

D. Benefits. Payments made by MVP to you or a Provider for Covered Services.

E. Calendar Year. The twelve month period beginning at 12:01 a.m. on January 1 and ending at 12:00 midnight on December 31. If you were not covered under this COC for this whole period, then Calendar Year means the period from your Effective Date until 12:00 midnight on December 31.

F. Charge. The total amount billed by a Provider for a service.

G. Coinsurance. A dollar amount, expressed as a stated percentage of the Allowable Charge, that you must pay for Covered Services. You must pay any Coinsurance directly to the Provider.

H. Contract Year. A period of twelve (12) months commencing at 12:00 a.m., Eastern Time, on your Group's effective date (or the anniversary thereof) and ending at 11:59 p.m., Eastern Time, on the last day of the twelve (12) month period

I. Copayment. A fixed dollar amount you must pay for Covered Services. You must pay any Copayment directly to the Provider. Copayments are not required for "Well Child Care Services" and "Adult Preventive Care Services" described in this COC

J. Creditable Coverage includes:

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

Creditable coverage does not include:

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

K. Custodial Services. Services mainly for maintenance or meant to help you in your daily living activities. Some examples of Custodial Services are:

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

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

L. Deductible. A dollar amount, other than any premium payments or contributions, that you must pay each Contract Year before we provide any Benefits. You must pay any Deductible directly to the Provider.

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

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

O. Eligible Individual. As used in Sections Four and Fourteen and as defined by federal law, means a person on the effective date of this COC:

i. who has eighteen (18) or more months of creditable coverage;
ii. whose most recent prior creditable coverage was: under a group health plan; health insurance coverage, including individual coverage; Medicare or Medicaid; CHAMPUS/TriCare; a medical program of the Indian Health Service Act or of a tribal organization; a state health benefits high risk pool; the Federal Employees Health Benefits Program; a public health plan; or a health benefit plan under section 5(e) of the Peace Corps Act;
iii. who is not eligible for coverage under a group health plan, or Medicare and does not have other health insurance coverage;
iv. whose most recent prior creditable coverage was not terminated based upon nonpayment of premiums or fraud; and
v. who has elected and exhausted any available COBRA or state continuation coverage.
vi. Any person who gives proof of continuous health benefit coverage during the nine (9) months just prior to his or her effective date under this contract that is substantially equivalent to the coverage provided under this contract.
vii. A child placed with you for adoption, or an adopted child.

viii. A newborn natural child or a newborn child placed with you for adoption for the first 31-days of coverage. The newborn shall remain an Eligible Individual after the 31st day if the child is enrolled by the 31st day of the date of birth.

P. Emergency Medical Condition. The sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson to result in:

i. placing the member's physical or mental health in serious jeopardy; or
ii. serious impairment to bodily functions; or
iii. serious dysfunction of any bodily organ or part.

Q. Emergency Services. Covered Services provided to diagnose and treat an Emergency Medical Condition. With respect to care from a Non-Preferred Provider, but within the service area, we shall cover emergency services necessary to screen and stabilize the member and shall not require prior authorization of such services if a prudent layperson would have reasonably believed that use of a Preferred Provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider.

R. Experimental or Investigational Services. Services that are either generally not accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed. Routine costs for patients who participate in approved cancer clinical trials as required by Vermont law are *not* Experimental or Investigational Services.

S. Hospital. An institution operated pursuant to law that primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a pre-arranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made. It must provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s). The following are ***not*** Hospitals:

- Convalescent homes;
- Convalescent, rest or nursing facilities;
- Facilities primarily affording custodial or educational care;
- Health resorts, spas or sanitariums;
- Infirmaries at schools, colleges or camps;
- Facilities for the aged;

- Any military or veterans hospital or soldiers home, or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered for Emergency Medical Conditions, where a legal liability exists for charges made to the individual for such services; and
- Residential Care Facilities.

T. Member. The Subscriber or his or her Dependents.

U. Mental Health Condition. Any condition or disorder involving mental illness or alcohol or substance abuse that falls under any diagnostic category listed in the Mental Disorders Section of the International Classification of Disease (ICD-9-CM), as periodically revised, and the following conditions listed in the "V Codes" Section of the International Classification of Disease:

1. Personal history of mental disorder (ICD-9-CM codes V11.00 through V11.99);
2. Psychological trauma (ICD-9-CM code V15.40);
3. Psychiatric condition (ICD-9-CM code V17.00);
4. Other family circumstances and other psychosocial circumstances (ICD-9-CM codes V61.00 through V62.99, except V61.10 (marital counseling));
5. Observation for suspected mental condition (ICD-9-CM code V71.00);
6. Alcohol and drug psychoses (ICD-9-CM codes 291.00 through 292.99);
7. Alcohol dependence syndromes (ICD-9-CM codes 303.00 through 303.99);
8. Drug dependence (ICD-9-CM codes 304.00 through 304.99); and
9. Non-dependent abuse of drugs (ICD-9-CM codes 305.00 through 305.99), except tobacco use disorder (ICD-9-CM code 305.10) and other, mixed or unspecified drug abuse (ICD-9-CM code 305.90).

Mental Health Condition does not include:

1. Hyperkinetic Syndrome of Childhood (ICD-9-CM codes 314.00 through 314.99); provided however that we will provide Benefits for Acute Mental Health Services when other diagnoses are present;
2. Specific Delays in Development (ICD-9-CM codes 315.00 through 315.99);
3. Psychic Factors associated with diseases classified elsewhere in the ICD-9-CM (ICD-9-CM code 316.00); and

4. Mental retardation (ICD-9-CM codes 317.00 through 319.99), Autistic Disease of Childhood (ICD-9-CM Code 299.00) provided however that we will provide Benefits for Acute Mental Health Services when other diagnoses are present.

V. Mental Health Services. Services to diagnose or treat a Mental Health or Substance Abuse Condition.

W. Medical or Scientific Evidence means the following sources:

1. peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

2. peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);

3. medical journals recognized by the federal Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act;

4. the following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and the United States Pharmacopoeia-Drug Information;

5. findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and peer-reviewed abstracts accepted for presentation at major medical association meetings.

X. Medical Necessity/Medically Necessary Services. Covered Services including:

diagnostic testing, preventive services and aftercare appropriate in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

1 help restore or maintain the member's health; or

2. prevent deterioration of or palliate the member's condition; or

3. prevent the reasonably likely onset of a health problem or detect an incipient problem.

Y. Non-Preferred Provider. A Provider that does not participate in the network for your plan.

Z. Pre-existing Condition. Any physical or mental condition, illness, injury, disease, or ailment for which medical advice, diagnosis, care or treatment was recommended or received by a provider within the six (6) month period preceding your effective date under this contract. It does not include genetic information in the absence of a diagnosis of the condition related to such information and does not include pregnancy.

AA. Preferred Provider. A Provider who, directly or indirectly has an agreement with MVP to provide Covered Services to Members covered by this COC and has been credentialed to provide such Covered Services, and who participates in the network for your plan.

BB. Preventive Care. Health services provided by health care professionals to identify and treat asymptomatic individuals who have developed risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.

CC. Provider. Properly licensed or certified physicians and health care professionals performing services within their licensure or certification. It also means Hospitals, ambulatory surgery centers, birth centers, Skilled Nursing Facilities, mental health or substance abuse treatment facilities, Home Health Agencies, Hospices, Durable Medical Equipment and External Prosthetic/Artificial Limb Device suppliers, and Ambulance services. Some Providers must be Preferred Providers for their services to be Covered.

DD. Schedule of Member Payments or Schedule. The document attached to this COC that describes Copayments, Deductible, Coinsurance, Annual Out of Pocket Maximums, Annual Benefit Maximums, Lifetime Benefit Maximums and similar information.

EE. Single Confinement. Consecutive days of Inpatient Services. Successive confinements, when discharge and readmission for the same or related condition occur within a period of not more than 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.

FF. Specialty Physician Services. Physician services other than services provided by a physician engaged in family practice, general practice, internal medicine, obstetrics and gynecology, or pediatrics.

GG. Spouse. The Subscriber's spouse under a legally valid marriage or civil union as defined by Vermont law.

HH. Subscriber. The person to whom this COC is issued, who meets and continues to meet all eligibility requirements, and for whom the required premium has been received by MVP.

II. Therapeutic Services:

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

b. Chemotherapy. Prevention of the development, growth, or multiplication of malignant diseases by chemical or biological agents, and includes growth cell stimulating factor injections taken as part of a chemotherapy regimen;

c. Dialysis. Removal of waste materials when a Member has acute kidney failure or chronic, irreversible kidney deficiency.

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

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

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

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

LL. Utilization Management. The set of organizational functions and related policies, procedures, criteria, standards, protocols and measures we used to ensure that we are appropriately managing access to and the quality and cost of health care services provided to its members.

SECTION THREE – ELIGIBILITY AND ENROLLMENT

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

A. The Subscriber and his or her Dependents who meet the Group's eligibility requirements.

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

C. If Subscriber–plus-Spouse-only coverage, then only the Subscriber and his or her Spouse may be covered.

D. If Subscriber-plus-child or -children only, then only the Subscriber and his or her child(ren), as described below, may be covered.

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

2. Children Covered Under This COC. To be covered, the Subscriber's Dependent children must meet the requirements of paragraph A or B below. The Subscriber's children must also be related to the Subscriber in one of the ways set forth in paragraph C.

A. The Subscriber's unmarried Dependent children who are under age nineteen (19), or who are under age twenty-three (23) and are full-time students (enrolled in at least 12 credit hours per semester) at an accredited college or university, who live with the Subscriber, and are chiefly dependent upon the Subscriber for support and maintenance. If your child must leave school due to illness, you may be able to get an extension of coverage for up to a maximum of one (1) year from the last date of attendance in school. This extension depends on the following:

(i) The child must have been enrolled as a full time student before he seeks a medical leave of absence from such school. He or she must have applied for a medical leave of absence, before reaching the limiting age under this COC;

(ii) The child must provide MVP with medical documentation from a medical practitioner licensed to practice in Vermont confirming the Medical Necessity of such leave of absence; and

(iii) Your Group must make premium payments for such dependent child at the same rate as if the child had not reached the limiting age under the Contract.

B. The Subscriber's unmarried Dependent children who are over age nineteen (19) and incapable of self-sustaining employment because of developmental disability, mental retardation, or physical disability, if the incapacity occurred before the child reached age nineteen (19). The child must be chiefly dependent upon the Subscriber for support and maintenance. You must provide a physician's certification, within thirty-one (31) days after the child's nineteenth birthday, and each Contract Year thereafter, in order for the child's coverage to continue under this section. We can require you to provide documentation verifying that the child is qualified and continues to qualify under this section.

C. The Subscriber's Dependent children must also be related to the Subscriber in one of the following ways:

1. natural child;
2. A child of the Subscriber's partner in a Civil Union, as defined by Vermont Law
3. legally adopted child;
4. A child for whom the Subscriber is the legal guardian or for whom the Subscriber has legal custody;
5. stepchild;
6. A child under age eighteen (18) who has been placed with the Subscriber for adoption and for whom the Subscriber has assumed and retains a legal obligation to support;
7. A child of the Subscriber's Dependent, from the moment of birth for thirty-one (31) days. Benefits are limited to benefits for covered services for injury, sickness, necessary care and treatment of medically diagnosed congenital defects or birth abnormalities, or any combination of these, and well child care; or
8. A child for whom the Subscriber has been ordered to provide dependent health insurance coverage pursuant to a qualified medical support order, even if the child was born out of wedlock; is not claimed as a dependent on the parent's federal tax return; or does not live with the Subscriber.
9. Any unmarried children under nineteen (19) years of age, who are supported by you and permanently residing in your home, provided the support and residence commenced before the child reached age nineteen (19).

Foster Children are not included in MVP's definition of Children.

3. Initial Enrollment. You must follow your Group's instructions for enrollment. Your Group will give your enrollment information to MVP in paper or electronic format. If on-line enrollment is available to you, you will complete an on-line enrollment form and transmit the form to MVP. If you have been enrolled electronically, MVP will also send you a paper form to sign. Your Spouse and your adult Dependents must also sign the paper form. By signing, you confirm your enrollment and provide written authorization for MVP to get your medical records and information so that we can administer your benefits, process your claims and conduct other health care operations as permitted by law.

4. Open Enrollment. You may enroll or add Dependents for any reason during your Group's open enrollment. If we get your enrollment form during your Group's open enrollment, your enrollment will be effective on your Group's designated open enrollment effective date. If you do not enroll either yourself or an Eligible Dependent during your Group's open enrollment, then you must wait until your Group's next open enrollment to enroll, unless you or your Dependents meet the conditions for special enrollment described below. If you belong to a Group of less than 50 Subscribers ("Small Group"), we do not impose open enrollment periods, but your Group may do so. Check with your Group.

5. Enrollment of Subscriber's New Family Members. You may add Dependents for any reason on Your Group's open enrollment date.

A. To add a Spouse. You and your Spouse must fill out and return an enrollment form, any requested documentation, and any required premium. If you return the completed form, requested documentation, and required premium within thirty (30) days of the marriage or civil union, your Spouse will be added to your coverage effective as of the date of the marriage or civil union. If you do not, your Spouse will be added to your coverage as of the first of the month following the next premium due date after the next open enrollment period when we get the completed form, requested documents and premium.

B. To add a child.

i. If you have Subscriber plus child or children coverage or family coverage, your newborn natural child or a newborn child placed with you for adoption, will be covered from the moment of birth for 31 days. Coverage is limited to benefits for otherwise covered services for injury, sickness, necessary care and treatment of medically diagnosed congenital defects or birth abnormalities, or any combination of these, and well child care. If you want to continue the child's coverage beyond 31 days, you must comply with paragraph (ii) below. If you do not follow this procedure, we will not provide coverage beyond 31 days.

ii. To continue the child's coverage beyond 31 days, you must complete and return an enrollment form, any requested documentation, and the required premium. If you do so within 31 days of the date of birth, adoption, placement for adoption, legal guardianship, legal custody, or within 31 days of the date the child became your step child, your child will be added to your coverage and will be covered effective as of the date of birth, adoption, placement for adoption, or legal guardianship, legal custody, or as of the date the child became your step child. If you do not do so within 31 days of the events described, you will not be able to add your child to your coverage until the first day of the month following the next premium due date after the next open enrollment period when we get the completed form, requested documents, and premium. Remember, a newborn child is always covered for the first 31 days. If you belong to a Small Group with no open enrollment period, your child will be added to your coverage as of the date MVP receives your completed enrollment form, any requested documents and premium. If you do not notify us, we will not provide coverage for the child beyond the first 31 days.

a. We will not provide benefits for a newborn child placed with you for adoption if a natural parent of the child has insurance coverage available for these services.

b. If a notice of revocation of adoption is filed or one of the natural parents revokes their consent to the adoption, we will be entitled to recover the amount of benefits provided by us.

iii. To add a child for whom a court has ordered you to provide dependent health insurance coverage pursuant to a qualified medical support order, you must mail us a copy of the order, by first class mail, postage prepaid. If the child is eligible for coverage, we will process the child's enrollment within ten (10) days of receiving the order. The child will be added to your coverage three (3) days from the date you mailed the order to us or on the date we receive the order, whichever is sooner. You must pay us any required premium for coverage to be effective.

6. Special Enrollment. This applies to Members of Large Groups and to Members of those Small Groups who have elected one or more open enrollment periods. If you do not initially enroll or enroll during an open enrollment period, you and/or your Dependents may enroll at other times if all of the following conditions are met:

A. You and/or your Dependents were covered under another plan or contract when coverage was initially offered; or

B. A finding by the agency of human services that an eligible employee, member, or dependent qualifies for premium assistance or must participate in the group in accordance with the provisions of section 1974 of Title 33 (employer-sponsored insurance; premium assistance), and that entitles the employee, member, or dependent to a special enrollment period of

C. Coverage was provided in accordance with the continuation coverage required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you and/or your Dependents lost eligibility for one or more of the following reasons:
   i. termination of employment;
   ii. termination of the other plan or contract;
   iii. death of the spouse;
   iv. legal separation, divorce or annulment;
   v. reduction in the number of hours worked; or
   vi. the employer or other group ceased its contribution toward the premium for the other plan or contract.

D. You and/or your Dependents apply for coverage within 30 days from the date of notice of the agency finding set forth in Paragraph B above, or 30 days after termination for one of the reasons set forth in Paragraph C above.

If you belong to a Large Group, when enrolling pursuant to this paragraph, coverage will begin at 12:01 a.m. Eastern Time on the first of the month following the next premium due

date after loss of coverage. If you belong to a Small Group, when enrolling pursuant to this paragraph, coverage will begin as of the date MVP receives your completed enrollment form, any requested documents and premium.

7. Obligation to Provide Information. You must give us information needed to determine your initial and continuing eligibility status. This information must be provided within 30 days of our request. We have the right to verify this information.

8. When you, your Spouse or your child is no longer eligible. 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.

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

SECTION FOUR -- PRE-EXISTING CONDITIONS

1. We will not provide benefits during the first twelve months of this contract for any services for or related to a Pre-Existing Condition.

2. This Pre-Existing Condition exclusion does not apply to:

   B. Any person who is an Eligible Individual; or
   C. Pregnant Members, for pregnancy-related services; or
   D. Subscribers who enroll during Open Enrollment or a Special Enrollment period as defined in this COC.

   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 Member 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.

3. Creditable Coverage. If a Pre-Existing Condition exclusion applies to you, the exclusion period may be reduced. The time you were covered under Creditable Coverage before you became covered under this COC will be counted to reduce the excluded period. This is only

if there was not a break in coverage greater than 90 days between termination of the previous Creditable Coverage and your Effective Date under this COC.

SECTION FIVE -- UTILIZATION MANAGEMENT & CLAIMS FILING

This COC requires Prior Authorization, Notification and Concurrent Review before you get certain Covered Services. All services are subject to Retrospective Review. The purpose of Utilization Management is to determine whether and to what extent Benefits are payable by MVP. MVP's approval of services through Prior Authorization or Concurrent Review is not a guarantee of benefits. MVP may deny benefits in cases where there is material misrepresentation or fraud by a Member, and as otherwise permitted by law.

1. Prior Authorization. Prior Authorization means the required approval that you must get from MVP before you get certain Covered Services. 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 your Provider to get Prior Authorization.**

   A. When Prior Authorization is Required.

      Prior Authorization is required for the following In Network services:

      a. Inpatient Mental Health/Substance Abuse Services.
      b. Inpatient Physical Rehabilitation Care.
      c. Treatment of Infertility.
      d. Skilled Nursing Facility Services.
      e. Home Health Agency Services.
      f. Non-Emergency Ambulance Services.
      g. Hospice Services.
      h. Outpatient Mental Health/Substance Abuse Services whether in the outpatient department of a Preferred Hospital or Preferred Facility or in a Preferred Provider's office.
      i. Chiropractic Treatment if you use more than 8 visits in any one Contract Year.
      j. Transplant Services (Specialty Network Only).
      k. Durable Medical Equipment and External Prosthetic/Artificial Limb Devices.
      l. Non-Emergency Out-of-Network Services.
      m. High Tech Imaging Services.
      n. Genetic Testing.
      o. Out Patient Cardiac Rehabilitation after the 12th visit per Contract Year.

   B. How to get Prior Authorization.

      1. Generally. To request Prior Authorization your Preferred Provider must contact [MVP's Utilization Management Department] at [(800) 568-0458].

Your Provider must provide us with your name, MVP ID number, your Provider's name and address, the date that Services are requested, and your diagnosis. If the request is Urgent, your provider must tell us and describe the circumstances that make it Urgent. We must be contacted at least fifteen (15) days prior to your proposed admission or service date. Your Provider must notify us if your admit or service date changes. **It is up to your Provider to get Prior Authorization.**

2. Mental Health/Substance Abuse Services. To request Prior Authorization, your Provider must contact [Primarilink] at [1-800-320-5895] phone, [(802) 258-3749] fax, or [PO Box 803, Brattleboro, Vermont 05302] address. Your Provider must provide your name, MVP ID number, your Provider's name and address, the date(s) that services are requested, your diagnosis and a copy of your Provider's completed Outpatient Treatment Report.

3. Chiropractic Treatment. To request Prior Authorization, your Provider must contact [Landmark] at [1-800-638-4557] phone, [800-599-8350] fax, or [Landmark Healthcare, 1750 Howe Avenue, Sacramento, California 95825] address. Your Provider must provide your name, MVP ID number, your Provider's name and address, the date(s) that services are requested, your diagnosis and a copy of your Provider's completed Chiropractic Treatment Plan.

4. Non-Emergency Out-of-Network Specialist Services. MVP will give Prior Authorization only when we do not have a qualified Preferred Specialist available to treat your condition. To request Prior Authorization of Non-Emergency Out-of-Network Specialist Services, **you** must contact MVP either by phone at 1-800-568-0458, by fax at (800) 280-7346or in writing at 625 State Street, Schenectady, New York 12305. You or your Provider must provide your name, MVP ID number, the Non-Preferred Provider's name and address, the type of service requested, the date that services are requested, your diagnosis and the reason why services must be provided out of network. A family member or Provider may call for you. For out-of-network services, it is up to **you** to get Prior Authorization.

C. MVP's Response to Requests for Prior Authorization.

1. Claims for Urgent Matters. If your request for Prior Authorization meets the requirements of paragraph 1(a) or 1(b) below and it has been properly identified to MVP that the request is Urgent, we will respond as described below. Requests and claims for Retrospective Review are excluded from this paragraph.

   a. In cases involving Urgently Needed Care, we will notify you and your Provider, by telephone, of our decision within 24 hours of the

time that Prior Authorization is requested. You and your Provider will be notified, in writing, within 24 hours of the telephone notice.

b. In cases where:

(i) application of the time periods described in paragraph 2 below:

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

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

(ii) a physician with knowledge of your medical condition determines that a Prior Authorization request is urgent, if all necessary information is received at the time of the request, we will notify your Provider, by telephone and you and your Provider in writing, of our decision within 24 hours after we get the request. If all necessary information is not received at the time of the request, we will notify you and your Provider within 24 hours after we get the request of any missing information that is needed to decide the request. You and your Provider will have 48 hours from the time you get our notice to provide us with the missing information. In such cases, we will notify you and your Provider, by telephone and in writing, of our decision within 24 hours after: (a) our receipt of the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner. If we deny Benefits, you must pay all Charges.

2. Non-Urgent Prior Authorization Requests. If all necessary information is received at the time of the Prior Authorization request, we will notify your provider of our decision, by telephone, within three (3) working days (two (2) working days for Mental Health and Substance Abuse Services). We will send written notice of our decision to you and your provider within twenty-four (24) hours of the telephone notice. If all necessary information is not received at the time of the Prior Authorization request, we will notify you and your Provider within five (5) days after we get the request of any missing information that is needed to decide the request. You and your Provider will have 45 days from the time you get notice to provide us with the missing information. In such cases, we will notify your Provider, by

telephone, of our decision within three (3) working days (two (2) working days for Mental Health and Substance Abuse Services) after: (a) our receipt of the missing information; or (b) five(5) days after the expiration of your time to provide the missing information, whichever is sooner. We will send written notice of our decision to you and your provider within twenty-four (24) hours of the telephone notice. If we deny Benefits, you must pay all charges.

D. If we conduct Retrospective Review and determine that any admission and/or service(s) was not Medically Necessary, we will not provide Benefits.

2. Notification. Notification 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 Notification is given. If you fail to give Notification when required, MVP may review the admission and/or service(s) retroactively. If we determine retroactively that any admission and/or service(s) was not Medically Necessary, we will not provide Benefits.

A. When Notification is required. Notification is required for the following:

a. In-Network Non Emergency Hospital Admissions.
b. In-Network Surgery, except office surgery.

B. How to give Notification. You must contact [MVP's Utilization Management Department] at [(800) 568-0458] at least 48 hours 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.

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

D. Failure to give Notification. If you fail to give Notification when required, MVP will review the admission and/or service(s) retroactively. If we determine retrospectively that any admission and/or service(s) was not Medically Necessary, we will not provide Benefits.

3. Concurrent Review. Concurrent Review means utilization review conducted during a Member's hospital stay or course of treatment. It is MVP's review of a request to extend a course of treatment beyond the period of time or number of treatments Prior Authorized, to determine whether such services continue to be Medically Necessary Covered Services.

A. Length of Stay Review. This is our Concurrent Review to determine whether it is Medically Necessary for you to continue receiving the following inpatient-based services.

1. Inpatient Services, including Emergency Inpatient Admissions, Inpatient Maternity and Newborn Care, and Detoxification Admissions

2. Skilled Nursing Facility Services

3. Hospice Services

B. Getting Length of Stay Review. MVP will contact your Provider. You must ensure that your Provider gives us the clinical information needed to conduct this review before the end of each period for which your benefits were Prior Authorized.

C. Review of Ongoing Outpatient and Professional Services. This is our review to determine whether the following ongoing services are Medically Necessary.

1. Home Health Agency Services

2. Hospice Services

3. Chiropractic Treatment

4. Mental Health and Substance Abuse Services

D. Getting Review of Ongoing Outpatient and Professional Services.

1. Home Health Agency Services and Hospice Services. You must ensure that your Provider calls [MVP's Utilization Management Department] at [1-800-568-0458] and gives the necessary clinical information to conduct the review.

2. Chiropractic Treatment. You must ensure that your Provider completes a written Chiropractic Treatment Plan that includes a request for a specific number additional of visits and submits it to [Landmark] for review at [1-800-638-4557] phone, [800-599-8350] fax, or [Landmark Healthcare, 1750 Howe Avenue, Sacramento, California 95825] address. The Chiropractic Treatment Plan must be submitted to [Landmark] at least 15 days before the additional proposed services are to be provided.

3. Mental Health/Substance Abuse Services. You must ensure that your Provider completes a written Outpatient Treatment Report that includes a request for a specific number additional of visits and submits the treatment plan to [PrimariLink] for review at [1-800-320-5895] phone, [(802) 258-3749] fax, or [PO Box 803, Brattleboro, Vermont 05302] address. The Outpatient Treatment Report must be submitted to [PrimariLink] at least 15 days before the additional proposed services are to be provided.

E. MVP's Response to Concurrent Review.

1. Urgent Matters

(a) If all necessary information is received at the time of the concurrent review, we will notify you and your Provider, in writing and your provider by telephone, of our decision within 24 hours after the review. If we deny Benefits as a result of our review, we will not provide any Benefits after the date that you get notice of our decision. You must then pay all Charges.

(b) If all necessary information is not received when MVP tries to conduct concurrent review, we will deny Benefits. If we deny Benefits, we will not provide Benefits after the date that you get notice of our decision. You must then pay all Charges.

2. Non-Urgent Matters

A. Pre-service.

(i) If all necessary information is received at the time of the concurrent review and services have not yet been provided to you, we will notify you of our decision within three (3) working days (two (2) working days for Mental Health and Substance Abuse Services). We will send written notice of our decision to you and your provider within twenty-four (24) hours of the telephone notice. If we deny Benefits, you must pay all Charges.

(ii) If all necessary information is not received at the time of the Concurrent Review, we will notify you and your Provider within fifteen (15) days after the review of any necessary information that is needed to complete the review. You and your Provider will have 45 days from the time you get notice to provide us with the missing information. In such cases, we will notify your Provider, by telephone, of our decision within three (3) working days (two (2) working days for Mental Health and Substance Abuse Services) after: (a) fifteen (15) days after we get the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner. We will send written notice of our decision to you and your provider within twenty-four (24) hours of the telephone notice. If we deny Benefits, you must pay all Charges.

B. Post Service.

(i) If all necessary information is received at the time of the review and services have already been provided to you, we will notify you of our decision within thirty (30) days. If we deny Benefits, you must pay all Charges.

(ii) If all necessary information is not received at the time of the Concurrent Review, we will notify you and your Provider within five (5) days after the review of any necessary information that is needed to complete the review. You and your Provider will have forty-five (45) days from the time you get notice to provide us with the missing information. In such cases, we will notify you and your Provider, in writing, of our decision within fifteen (15) days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner. If we deny Benefits, you must pay all Charges.

F. If we conduct Retrospective Review and determine that any admission or service was not Medically Necessary, we will not provide Benefits.

4. Retrospective Review. This means utilization review of medical necessity that is conducted after services have been provided to you, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

A. When Retrospective Review is Required. We reserve the right to conduct Retrospective Review on all claims.

B. How to get Retrospective Review. When you get Covered Services from a Preferred Provider, the Preferred Provider will submit your claim and bill MVP directly. MVP's timely receipt of a Preferred Provider's properly completed and submitted bill or electronic claim will be deemed a proper filing of Proof of Loss on your behalf. If you do receive a bill from a Provider, you must follow the claim submission instructions set forth in paragraph 4(C) below.

C. Claim Submission.

1. Submit your properly completed claims form to MVP. You may request claim forms by contacting MVP's Member Services Department at 1-800 318-8575. You may also request or download claim forms by visiting MVP's web site at www.mvphealthcare.com.

2. Mail your properly completed claim forms with any bills and receipts, and any final Primary Plan statements or Explanation of Medicare Benefits ("EOMB") statements by first class mail, postage prepaid, to MVP at:

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

3. You must mail your properly completed claim forms to MVP as soon as is reasonably possible after your receipt of the Provider's bill. If your claim is subject to Coordination of Benefits, as described in Section Sixteen, and MVP is the Secondary Plan, claims must be mailed to us as soon as is reasonably possible, after you get a final statement from your Primary Plan. If you have Medicare as your Primary Plan, as described in Section 16, claims must be mailed to us as soon as is reasonably possible after you get a final EOMB from Medicare.

D. MVP's Response to Retrospective Review. If all necessary information is received at the time of the claim submission, we will notify you of any adverse determination, in writing, within 30 days after we get the claim. If all necessary information is not received at the time of the claim, we will notify you and your Provider of the claim of any missing information that is needed to decide the claim and that MVP is taking a 15 day extension of time to decide. You and your Provider will have 45 days from receipt of our notice to provide us with the missing information. In such cases, we will notify you of any adverse determination, in writing, within fifteen (15) days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide us with the missing information, whichever is sooner.

5. Individual Case Benefit Management. If your Provider recommends an alternate setting or treatment as appropriate for your condition, at our discretion, we may provide Benefits for alternative settings or treatment even if we do not usually cover them under this COC. Our decision to cover alternate care in one case does not obligate us to provide the same benefits again. We will only provide Benefits for alternative settings or treatment:

   A. if the alternative services are Medically Necessary;
   B. if we did not cover the alternative services you would get Covered Services; and
   C. you agree in writing to a case management plan, to abide by MVP Protocols for case management and, if requested to waive specific Benefits for Covered Services in lieu of alternative services.

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

SECTION SIX - COVERED INPATIENT SERVICES

1. Inpatient Services. We will only provide Benefits if you get these services as described in Section One, paragraph 1(E). You must be a registered inpatient in the Hospital and be under the care of a licensed physician. We will provide benefits for up to 365 days per Single Confinement per Member per Contract Year for the following when provided to you in a Hospital.

   A. Semi-private room;

   B. Board and general nursing services;

   C. Use of operating, recovery, delivery, endoscopic and treatment rooms and equipment;

   D. Use of intensive care or special care units and equipment;

   E. Dressings and casts;

   F. Diagnostic X-ray and other Imaging Services:

      Benefits are available for standard diagnostic X-ray services and for high-tech imaging services performed in the outpatient department of a Hospital or other facility. Standard diagnostic services include X-rays, GI Series, and Ultrasounds.

      High-tech imaging services include:

      CT = Computerized Tomography;
      MRI = Magnetic Resonance Imaging;
      MRA = Magnetic Resonance Angiography;
      PET = Positron Emission Tomography; and
      MRCP = Magnetic Resonance Cholangiopancreatography.

   G. Therapeutic Services. This means:

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

      2. Chemotherapy. This means prevention of the development, growth, or multiplication of malignant diseases by chemical or biological agents, and includes growth cell stimulating factor injections taken as part of a chemotherapy regimen.

      3. Dialysis. This means removal of waste materials when a Member has acute kidney failure or chronic, irreversible kidney deficiency, and the use of equipment and disposable medical supplies. Benefits for Dialysis will

continue until you become eligible for Medicare or until your MVP coverage is terminated.

4. Infusion Therapy. This means treatment of disease by continuous injection of curative agents.

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

H. Therapeutic items used in and provided by the Preferred Hospital when performing Therapeutic Services, such as prescribed drugs, medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items;

I. Equipment, and supplies in connection with oxygen, anesthesia, and pathology services.

J. Laboratory services; and

K. Medical and surgical supplies.

You must pay the Copayment, Deductible and/or Coinsurance that applies.

2. Skilled Nursing Facility Care. Care that is most appropriately provided in a Skilled Nursing Facility, but at MVP's discretion is provided on an inpatient basis in a Preferred Hospital, may be covered under your Skilled Nursing Facility Benefits.

3. Maternity Care. We provide benefits for Inpatient Services to a covered mother for childbirth for at least 48 hours after a vaginal delivery or for at least 96 hours after a cesarean delivery in a Preferred Hospital or birthing center. The attending Preferred physician, with the mother or mother's designated representative, may decide to discharge the mother sooner. We will provide benefits for Inpatient Services for pregnancy and complications of pregnancy. You must pay the Copayment, Deductible and/or Coinsurance that applies.

4. Newborn Care. We will provide Benefits for Inpatient Services and routine inpatient nursery care and examinations for a covered newborn child for at least 48 hours after a vaginal delivery or for at least 96 hours after a caesarian delivery in a Preferred Hospital or birthing center. The attending Preferred physician, with the newborn's mother or the newborn's designated representative, may decide to discharge the newborn sooner. You must contact us within 48 hour or as soon as reasonably possible after the mother's discharge if the newborn stays in the Hospital or birthing center. Subject to the requirements set forth in Section Three, paragraph 5(B), we will provide Benefits for a covered newborn from the moment of birth through 31 days after birth for Covered Services for sickness, injury, and medically diagnosed congenital defects or birth abnormalities, or any combination of these, and Well Child Care. You must pay any Coinsurance that applies.

5. Breast Cancer Care. We will provide Benefits for Inpatient Services in connection with an inpatient Preferred Hospital stay following a mastectomy, lymph node dissection or lumpectomy for the treatment of breast cancer. We will provide Benefits for physical complications of mastectomy, including lymphedemas. We will provide Benefits for Inpatient Services in connection with an inpatient Preferred Hospital stay following reconstruction of the breast on which a mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. These surgical services will be performed in the manner that your Preferred attending physician, in consultation with you, determines is appropriate. You must pay the Copayment, Deductible and/or Coinsurance that applies.

   We will provide Benefits for breast prostheses you get from a Preferred Provider, which are required as a result of covered Breast Cancer Care. You must pay the Copayment, Deductible and/or Coinsurance that applies.

6. Physical Rehabilitation Care. **Prior Authorization is required except when such care is immediately preceded by an inpatient Hospital stay.** We will provide Benefits for up to 30 days per member per Contract Year for Inpatient Services only when such services are Acute Services provided by a Preferred facility licensed to provide inpatient physical rehabilitation services or by a unit of a Preferred Hospital designated as providing such services. You must pay the Copayment, Deductible and/or Coinsurance that applies.

7. Mental Health and Substance Abuse Services. MVP does not exclude from its network or list of authorized providers any licensed mental health or substance abuse provider located within the geographic coverage area of the health benefit plan if the provider is willing to meet the terms and conditions for participation established by the health insurer.

   A. Mental Health Services. **Prior Authorization is required.** We will provide Benefits for Inpatient Services and Mental Health Services for Mental Health Conditions only when such services are provided in a mental health facility The facility must be a MVP Preferred Provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

   B. Substance Abuse Services. **Prior Authorization is required for all Inpatient Substance Abuse Services.** We will provide Benefits for Inpatient Services and Substance Abuse Services only when such services are provided in an institution that provides a program for the treatment of alcohol or substance dependency. The institution must be a Preferred Provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

8. Clinical Trials for Cancer Patients. We will provide coverage for routine costs for patients who participate in approved cancer clinical trials.

   A. In-Network. Coverage is considered In-Network only if conducted under the auspices of the following cancer care providers ("Cancer Care Providers"): Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer

Center at Dartmouth-Hitchcock Medical Center, and approved clinical trials administered by a hospital and its affiliated, qualified cancer care providers.

B. Out-of-Network. Coverage is available only if:

(i) The Member provides Notification to MVP prior to participation in the clinical trial;
(ii) No clinical trial is available at the Vermont or New Hampshire Cancer Care Providers listed in paragraph A above;
(iii) The Member has completed a clinical trial at one of the Vermont or New Hampshire Cancer Care Providers listed in paragraph A above and that provider determines that a subsequent clinical trial related to the original diagnosis is available outside of the health benefit plan's network and determines participation in that clinical trial would be in the best interest of the patient, even if a comparable clinical trial is available at that time under; or
(iv) MVP has already approved a referral of the patient to an out-of-network cancer care provider and an out-of-network clinical trial becomes available and the patient's Cancer Care Provider determines participation in that clinical trial would be in the best interest of the patient, even if a comparable clinical trial is available at the Vermont or New Hampshire Cancer Care Providers listed in paragraph A above

If you participate in an Out-of-Network clinical trial, you will be required to get routine follow-up care In-Network, unless the cancer care provider determines this would not be in your best interest.

SECTION SEVEN – COVERED OUTPATIENT SERVICES

1. Outpatient Services. We will provide Benefits for the following Outpatient Services. Such services must be provided to you in the outpatient department of a Preferred Hospital or in a Preferred free standing facility. We will only provide benefits if a Covered Service is Medically Necessary. We will also only provide Benefits if you get these services as described in Section One, paragraph 1(E).

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

1. Your Preferred physician has ordered the tests; and
2. An operating room and inpatient bed at the Preferred Hospital have been reserved.
3. Surgery occurs within seven (7) days of the tests.
4. You are physically present at the Preferred Hospital for the tests.

You must pay the Copayment, Deductible and/or Coinsurance that applies.

B. Outpatient Surgery. **Prior Authorization is required.** Surgery means generally accepted invasive, operative, and cutting procedures. This includes, but is not limited to specialized instrumentation, endoscopic examinations, and correction of fractures and dislocations, and the pre- and post-operative care usually rendered in connection with such procedures. Sterilization is included. You must pay the Copayment, Deductible and/or Coinsurance that applies.

C. Therapeutic Services. This means the following when ordered by your Preferred Physician:

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

2. Chemotherapy. This means prevention of the development, growth, or multiplication of malignant diseases by chemical or biological agents, and includes growth cell stimulating factor injections taken as part of a chemotherapy regimen;

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

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

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

6. Items used in and provided by the Preferred Hospital or facility when performing Therapeutic Services, such as prescribed drugs, medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items.

You must pay Copayment, Deductible and/or Coinsurance that applies.

D. Diagnostic X-ray and other Imaging Services.

Benefits are available for standard diagnostic X-ray services and for high-tech imaging services performed in the outpatient department of a Hospital or other facility. Standard diagnostic services include X-rays, GI Series, and Ultrasounds.

High-tech imaging services include:

CT = Computerized Tomography
MRI = Magnetic Resonance Imaging
MRA = Magnetic Resonance Angiography
PET = Positron Emission Tomography
MRCP = Magnetic Resonance Cholangiopancreatography

You must pay the Copayment, Deductible and/or Coinsurance listed on your Schedule.

E. Mental Health and Substance Abuse Services. MVP does not exclude from its network or list of authorized providers any licensed mental health or substance abuse provider located within the geographic coverage area of the health benefit plan if the provider is willing to meet the terms and conditions for participation established by the health insurer.

1. Mental Health Services. **Prior Authorization is required.** Services must be provided by a Preferred Hospital or a Preferred facility that is a licensed or certified mental health provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

2. Substance Abuse Services. **Prior Authorization is required.** Services must be provided by a Preferred Hospital or a Preferred facility that is a licensed or certified substance abuse provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

F. Mammography Screenings. This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule.

We will provide the following Benefits:

1. For Members under age 40, we will provide Benefits for mammography screening when recommended by a Preferred physician; and

2. For Members age 40 and older, we will provide Benefits for an annual mammography screening.

G. Diagnostic Screening for Prostate Cancer. This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule.

We will provide Benefits for diagnostic screening for prostate cancer subject to the following limits.

1. Standard diagnostic testing, including a digital rectal examination and a prostate specific antigen test; and

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

H. Laboratory Services. We will provide Benefits for all laboratory services ordered by a Preferred Provider.

I. Cervical Cancer Screening. This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule.

This Contract covers an annual cervical cytology screening in the outpatient department of a Hospital or facility. This includes an annual pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

J. Therapy Services. We will provide Benefits for Physical, Occupational and/or Speech Therapy up to 30 visits combined per member per Contract Year when such services are Acute Services and are provided by a Preferred Hospital or a Preferred facility or at a Preferred Provider's office as described in Section Twelve. You must pay the Copayment, Deductible and/or Coinsurance that applies.

K. Cardiac Rehabilitation Care. We will provide Benefits for up to 36 visits per member per Contract Year only when such services are Acute Services and are provided by a Preferred Hospital or Preferred Facility. **Subject to Annual Benefit Maximum**. You must pay the Copayment, Deductible and/or Coinsurance that applies.

L. Reproductive Health Equity. **Prior Authorization is required.** We will provide coverage for outpatient contraceptive services including sterilizations. You must pay the Copayment, Deductible and/or Coinsurance that applies to outpatient surgery.

SECTION EIGHT – COVERED SKILLED NURSING FACILITY SERVICES

1. **Prior Authorization is required**. We will only provide Benefits if a Covered Service is Medically Necessary. We will also only provide Benefits if you get these services as described in Section One, paragraph 1(E).

2. What is a Skilled Nursing Facility (SNF)? – A Skilled Nursing Facility (a) is a facility operating pursuant to law; (b) is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of duly licensed physicians; (c) provides continuous 24 hour a day inpatient skilled nursing care by or under the supervision of a registered graduate professional nurse (R.N.);(d) maintains a daily medical record of each patient; and(e) is approved for payment of Medicare benefits or qualified to receive such approvals if so requested.. A SNF is *not*, other than occasionally, a place that provides minimal, custodial, ambulatory or part-time care services. The SNF must be a Preferred Provider.

3. Conditions For Skilled Nursing Facility Services. We will provide Benefits for Skilled Nursing Facility Care if:

   A. You are under the care of a licensed Preferred physician;

   B. You had a minimum 3-day in-patient stay at a Hospital within thirty (30) days immediately preceding admittance to the Skilled Nursing Facility; and

   C. You would need further Inpatient Services.

4. Skilled Nursing Facility Services. We will provide Benefits for the inpatient Skilled Nursing Facility Services listed below for up to 60 days per member per Contract Year. The days shall be consecutive. You may not select the day or days for which we will provide benefits. We will provide benefits for the day you are admitted. We will not provide benefits for the day you are discharged. If you are admitted and discharged on the same day, we will provide benefits for that day.

   A. Room and board in a semiprivate room.

   B. Skilled nursing care.

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

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

   You must pay the Copayment, Deductible and/or Coinsurance that applies.

SECTION NINE – SPECIAL COVERED SERVICES

1. Home Health Agency Services. **Prior Authorization is required**. We will only provide benefits if a Covered Service is Medically Necessary. We will also only provide Benefits if you get these services as described in Section One, paragraph 1(E).

A. What is a Home Health Agency? A Home Health Agency is an organization licensed or certified by Medicare to operate as a home health agency. The Home Health Agency must be a Preferred Provider.

B. Conditions for Home Health Agency Services. We will provide Benefits for Home Health Agency services if:

1. The services are supervised by a Preferred physician under a written treatment plan.

2. The services are provided by a Preferred home health agency.

3. Without these services you would need to be admitted to a Hospital or Skilled Nursing Facility.

4. You or your designated representative consent in writing to the treatment plan.

C. Home Health Agency Services. We will provide Benefits for up to 60 visits per member per Contract Year for the services listed below.

1. Part time or intermittent skilled nursing care by or under the supervision of a registered nurse.
2. Part time intermittent home health aide services, provided that such services consist primarily of caring for the patient and do not include Custodial Care.
3. Therapy Services if provided by Home Health Agency personnel. This means Acute Services, limited to physical therapy, occupational therapy, and speech therapy.
4. Medical supplies, equipment and drugs prescribed by a Preferred Physician and laboratory services, to the same extent that laboratory services would have been covered if you were an inpatient at a Hospital or Skilled Nursing Facility.

You must pay the Copayment, Deductible and/or Coinsurance that applies.

2. Non-Emergency Ambulance Services. **Prior Authorization is required.** We will provide Benefits for Hospital, municipal, professional, or licensed voluntary Ambulance Services when used locally to transport a Member to and from a Hospital, between Hospitals, and between a Hospital and a Skilled Nursing Facility. We will only provide benefits if a Covered Service is Medically Necessary. You must pay the Copayment, Deductible and/or Coinsurance that applies.

3. Hospice Services. **Prior Authorization is required.** We will only provide Benefits if a Covered Service is Medically Necessary. We will also only provide Benefits if you get these services as described in Section One, paragraph 1(E).

A. What is a Hospice? Hospice is an organization engaged in providing services to terminally ill persons. It must be federally certified to provide hospice services or accredited as a hospice by the Joint Commission. The Hospice must be a Preferred Provider.

B. Conditions for Hospice Services.

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

1. A Preferred physician certifies and MVP agrees that your terminal illness has a prognosis of 6 month life expectancy or less; and

2. The Hospice Services are supervised by a Preferred physician under a written Hospice Care plan; and

3. You consent to the written Hospice care plan.

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

1. Up to 210 days of inpatient Hospice Services in a Preferred Hospice or Preferred Hospital.

2. Skilled nursing visits - up to 2 visits per day.

3. Home health aide visits - up to 100 hours per month for personal care services only.

4. Continuous care - up to 5 days or 120 hours for the Member's continuous care in his or her home.

5. Social service visits - up to 6 visits before the Member's death and up to 2 visits following the Member's death. Social service visits include counseling and emotional support, assessment of social and emotional factors related to the Member's condition, assistance in resolving problems, assessment of financial resources and use of available community resources.

6. Respite Care - up to 72 hours per month. Respite care relieves the Member's family or caregivers by providing temporary relief from the duties of caring for the Member's illness.

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

You must pay the Copayment, Deductible and/or Coinsurance that applies.

SECTION TEN - COVERED EMERGENCY SERVICES AND URGENTLY NEED CARE

1. Emergency Services.

   A. **Prior Authorization is NOT required for Emergency Services. If your condition is not an Emergency Medical Condition, you must pay all Charges.**

   B. Emergency Services. We will provide Benefits for Emergency Services only if your condition is an Emergency Medical Condition. We will only provide benefits if a Covered Service is Medically Necessary.

   C. You, your Provider, or a member of your family must call MVP at 1-800 318-8575 within 48 hours, or as soon as reasonably possible, after receiving Emergency Services.

   You must pay the Copayment, Deductible and/or Coinsurance that applies. You will not have to pay this Copayment, Deductible and/or Coinsurance if you are admitted to a Hospital right away after receiving emergency room services. You must pay the Copayment, Deductible and/or Coinsurance for Hospital inpatient services.

2. Emergency Ambulance Services. We will provide Benefits for Ambulance Services, when used for an Emergency Medical Condition. We will only provide Benefits for transportation to the nearest appropriate facility. We will not provide Benefits for Ambulance Services if you could have safely ridden in a private car, whether or not one was available. We will only provide benefits if a Covered Service is Medically Necessary. You must pay the Copayment, Deductible and/or Coinsurance that applies.

3. Urgently-Needed Care. We will provide benefits for this service provided by a Preferred or a Non-Preferred Provider, whether in or out of the service area.

   A. Urgently-Needed Care provided by a Preferred Provider means Medically Necessary Covered Services to treat an illness or condition that, applying the judgment of a prudent layperson with an average knowledge of health and medicine, if not treated within 24 hours presents a serious risk of harm.

   B. Urgently-Needed Care provided by a Non-Preferred Provider means Medically Necessary Covered Services to screen and stabilize a condition that, applying the judgment of a prudent layperson with an average knowledge of health and medicine, if not treated within 24 hours presents a serious risk of harm, so that you can be safely transported to a Preferred Provider; provided that such services were received because you were unable to get services from a Preferred Provider.

   C. You, your Provider, or a member of your family must call MVP at 1-800 318-8575 within 48 hours, or as soon as reasonably possible, after receiving Urgently-Needed Care.

D. You must pay the Copayment, Deductible and/or Coinsurance that applies. You will not have to pay such Copayment, Deductible and/or Coinsurance if you are admitted to a Hospital right away. You must pay the Copayment, Deductible and/or Coinsurance for Hospital inpatient services.

SECTION ELEVEN – COVERED PREVENTIVE CARE

1. Covered Services. We will provide Benefits for the following Preventive Care. These services must be provided at the office of a Preferred Provider. We will also only provide Benefits if you get these services as described in Section One, paragraph 1(E).

A. Well Child Care. We will provide Benefits for Well Child Care for Dependent children from the date of birth to attainment of age 19. Well Child Care means an initial newborn check-up in the hospital and well child visits. Well child visits include a medical history, a complete physical examination, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit. Such laboratory tests must be performed in the office or in a clinical laboratory.

Well Child Care also includes immunizations against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type B, and hepatitis B, and other necessary immunizations. **These services are covered in full.** Services not described above and services which exceed the frequency levels described above are not covered under Well Child Care. You must pay the Copayment, Deductible and/or Coinsurance that applies.

All well child visits must be provided in accordance with the standards and frequency schedule of the Advisory Committee of Immunization Practices (ACIP). Any amendment to the ACIP standards and frequency schedule during the term of this Contract shall be incorporated herein.

B. Annual Adult Health Evaluations. This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule.

We will provide Benefits for one visit per Contract Year for periodic routine physical examinations for covered persons age 19 and older.

C. Adult Immunizations. This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule. We will provide benefits for adult immunizations, including flu shots, and flu mist received at any time.

D. Mammography Screenings. This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule.

We will provide the following Benefits for this service:

1. for Members under age 40, we will provide Benefits for mammography screening when recommended by a Preferred physician; and
2. for Members age 40 and older, we will provide Benefits for an annual mammography screening.

E. Gynecological Health Care Services – This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule.

We will provide Benefits for 2 visits per member per Contract Year for this service. Gynecological health care services means preventive and routine gynecological care. Such services include annual screening, cervical cytology screening, contraceptive services, counseling and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists.

F. Diagnostic Screening for Prostate Cancer. This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule.

We will provide Benefits for this service subject to the following limits:

1. Standard diagnostic testing, including a digital rectal examination and a prostate specific antigen test; and

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

G. Bone Mineral Density Measurements or Tests. This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule. 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.

H. Screening Colonoscopies and Sigmoidoscopies. This is an Adult Preventive Care Service. You will not be required to make a payment for this service, unless noted on your Schedule. We will provide Benefits for screening colonoscopies and sigmoidoscopies associated with Adult Annual Health Evaluations.

SECTION TWELVE – COVERED PROFESSIONAL SERVICES & SUPPLIES

1. Covered Services. We will provide Benefits for the following services. The Provider must be a Preferred Provider. We will only provide Benefits if a Covered Service is Medically Necessary. We will also only provide Benefits if you get these services as described in Section One, paragraph 1(E).

   A. Provider Office Visits. We will provide benefits for the examination, diagnosis, and treatment of an injury, illness or condition and laboratory services provided at the time of such visit. Coverage includes injections given during a covered office visit, including desensitization treatments to alleviate allergies. You must pay the Copayment, Deductible and/or Coinsurance that applies.

   B. Maternity Care.

      1. We will provide Benefits for the initial visit to confirm a pregnancy. The visit must be to a Preferred Provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

      2. We will provide Benefits for prenatal and postnatal office visits to a Preferred Provider and for delivery. You must pay the Copayment, Deductible and/or Coinsurance that applies.

      3. You must pay the Copayment, Deductible and/or Coinsurance for all other Covered Services related to Maternity Care. This includes diagnostic testing performed during prenatal and postnatal care.

   C. Consultations. We will provide Benefits for inpatient or office consultations by Preferred Providers when requested by your attending physician for the evaluation of your condition. A written report must be given to the requesting Preferred Provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

   D. Second Surgical Opinions. We will provide Benefits for a second surgical opinion when your Provider has made a recommendation on the need for covered elective Surgery. Except as provided in Paragraph 2(P) below, you do not have to have a second surgical opinion. The second opinion must be given by a Preferred board-certified specialist who examines you and who, by reason of his or her specialty, is competent to consider the proposed Surgery. If you get services in a Preferred Provider's office, you must pay the Copayment, Deductible and/or Coinsurance listed on your Schedule. The specialist who gives the second opinion must not perform the Surgery. If services are provided at a hospital or other facility, you must pay the Deductible and Coinsurance listed on your Schedule.

E. Mental Health/Substance Abuse Services.

1. Mental Health Services **Prior Authorization is required.** We will provide Benefits for Mental Health Services only when such services are provided by a licensed or certified mental health professional who is a Preferred Provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

2. Substance Abuse Services. **Prior Authorization is required.** We will provide Benefits for Substance Abuse Services only when such services are provided by a substance abuse counselor or other person approved by the secretary of human services who is a Preferred Provider. . You must pay the Copayment, Deductible and/or Coinsurance that applies.

F. Chiropractic Treatment. **Prior Authorization is required if you use more than eight Chiropractic Treatment visits in any one Contract Year.** We will provide Benefits for clinically necessary chiropractic services. The services must be provided by a Preferred licensed chiropractic physician. Services are for treatment of conditions related to subluxations, joint dysfunctions, and neuromuscular and skeletal disorders. We will not provide Benefits for:

1. Adjunctive therapies, except physiotherapy modalities and rehabilitative exercises when used in conjunction with other, covered, chiropractic treatment; and

2. Treatment of any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs.

You must pay the Copayment, Deductible and/or Coinsurance listed on your Schedule.

G. Diabetes Equipment, Supplies and Treatment. We will provide Benefits for equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if such equipment, supplies and training are prescribed by a Preferred licensed, health care professional legally authorized to prescribe such items. We will provide Benefits for self-management training and education. This includes medical nutrition therapy, described above only if provided by a Preferred certified, registered, or licensed health care professional with specialized training in the education and management of diabetes.

1. Diabetes Equipment and Supplies. You must pay the Copayment Deductible and/or Coinsurance per each 30-day supply.

2. Diabetes Treatment. You must pay the Copayment, Deductible and/or Coinsurance.

H. Inpatient Professional Care. We will provide Benefits for physician services rendered when you are receiving Covered Inpatient Services in: (1) a Preferred Hospital or Preferred Skilled Nursing Facility; (2) a Preferred mental health care facility or a Preferred institution for the treatment of alcohol or substance dependency; or (3) a Preferred physical rehabilitation facility. We will only provide Benefits for one visit per day per Preferred Provider. You must pay the Copayment, Deductible and/or Coinsurance.

I. Office Surgery. **Prior Authorization is not required when Surgery is performed in a Preferred Provider's office**. We will provide benefits for Surgery and surgical care rendered in a Preferred Provider's office. This includes surgery and surgical care for abortion and sterilization. You must pay the Copayment, Deductible and/or Coinsurance.

J. Breast Cancer Care. We will provide Benefits for mastectomy and treatment of physical complications of mastectomy such as lymphedema, lymph node dissection, or lumpectomy for the treatment of breast cancer. Following a covered mastectomy, we will provide Benefits for all stages of reconstruction of the breast on which the mastectomy was performed. We will provide benefits for surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined appropriate by your Preferred Provider, in consultation with you. Benefits shall include coverage of routine costs for patients who participate in approved cancer clinical trials as required by Vermont law. You must pay the Copayment, Deductible and/or Coinsurance.

We will provide Benefits for breast prostheses you get from a Preferred Provider which are required as a result of covered Breast Cancer Care. You must pay the Copayment, Deductible and/or Coinsurance.

K. Anesthesia Services. We will provide Benefits for consultation before anesthesia is given, administration of anesthesia during covered surgery or maternity care, and the Preferred Provider's services during and after such covered surgery or maternity care. We will not provide anesthesia for services not covered under this COC. You must pay the Copayment, Deductible and/or Coinsurance.

L. Laboratory Services. We will provide Benefits for Laboratory Services provided in a Preferred Provider's office, or laboratory facility. You must pay the Copayment, Deductible and/or Coinsurance.

M. Diagnostic Services. Diagnostic Services means services ordered by a Preferred physician to determine a definite condition or disease. Standard Diagnostic Services include X-rays, GI Series, and Ultrasounds. High-tech imaging services include:

CT = Computerized Tomography

MRI = Magnetic Resonance Imaging
MRA = Magnetic Resonance Angiography
PET = Positron Emission Tomography
MRC P= Magnetic Resonance Cholangiopancreatography

We will provide Benefits for Diagnostic Services provided in a Preferred Provider's office, including allergy testing, or in a Preferred Hospital or facility. You must pay the Copayment, Deductible and/or Coinsurance.

N. Medical Foods. We will provide Benefits for low protein modified food products and medical foods prescribed by a Preferred Provider that you get from a Preferred pharmacy or a Preferred supplier for use under the direction of a Preferred physician for the medically necessary dietary treatment of an inherited metabolic disease. A low protein modified food product must be formulated to have less than one gram of protein per serving. A medical food means an amino acid modified preparation. You must pay the Copayment, Deductible and/or Coinsurance. Benefits are limited to $2,500 per member per Contract Year.

O. Craniofacial Disorders. We will provide Benefits for Preferred Provider services for diagnosis and treatment. This includes surgical and non-surgical procedures of a musculoskeletal disorder that affects any bone or joint in the face, neck or head. Such disorder must be the result of accident, trauma, congenital defect, developmental defect, or pathology. Surgical procedures require a second opinion as set forth in paragraph 2(D) above. **Prior Authorization is required for surgical procedures**. We will not provide Benefits for the diagnosis and treatment of dental conditions or disorders. We will not provide Benefits for dental pathology primarily affecting the gums, teeth, or alveolar ridge. We will also not provide Benefits for prescription or non-prescription drugs prescribed or recommended by a dentist. You must pay the Copayment, Deductible and/or Coinsurance amounts that apply to the particular services you get.

P. Therapy Services. We will provide Benefits for up to a combined total of 30 visits per member per Contract Year when provided by a Preferred Provider or by the outpatient department of a Preferred Hospital or a Preferred facility as described in Section Seven. You must pay the Copayment, Deductible and/or Coinsurance.

Q. Transplant Services/Donor Costs. **Prior Authorization is required.** We will provide Benefits for organ and bone marrow Transplant Services only when you get such services through MVP's Transplant Network. You may get a description of this Network by calling MVP at 1-800 318-8575. The cost of outpatient drugs for these services will not be covered. **MVP Transplant Network Only.**

We will provide Benefits for live donor medical expenses, up to your coverage limits and after payment of your Benefits as follows:

1. If we cover both the recipient and the donor, each receives benefits under his or her own COC;

2. If we cover the recipient, but not the donor, both get Benefits under the recipient's COC (Benefits available to the recipient will be paid first);

3. Benefits are available if we cover the donor, but not the recipient.

You must pay the Copayment, Deductible and/or Coinsurance amounts that apply to the services received.

R. Durable Medical Equipment. **Prior Authorization is required.** Durable Medical Equipment means equipment which is primarily and customarily used only for a medical purpose. Such equipment is appropriate for use in the home, and is designed for prolonged and repeated use. It is generally not useful to a person in the absence of an illness, injury or condition. Durable medical equipment includes, but is not limited to wheelchairs, hospital beds, walkers, traction equipment, and respirators.

We will provide Benefits for the purchase or rental, repair or replacement of Durable Medical Equipment prescribed by and obtained from a Preferred Provider. The option of whether to rent or purchase Durable Medical Equipment is at the sole discretion of MVP. The total rental benefits may not exceed our Allowable Charge for the purchase of the equipment. You must pay the Coinsurance and/or Deductible.

S. External Prosthetic Devices. **Prior Authorization is required.** External Prosthetic Devices are devices 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 external body part.

We will provide Benefits for the purchase, repair and replacement of covered External Prosthetic Devices. Custom prosthetics will not be covered if a standard device exists, unless a custom device is Medically Necessary. You must pay the Copayment, Deductible and/or Coinsurance.

T. Artificial Limb Devices. **Prior Authorization is required.** Artificial Limb Devices are external prosthetics that replace all or part of an arm or a leg.

We will provide Benefits for the purchase, repair and replacement of covered Artificial Limb Device prescribed by and obtained from a Preferred Provider. Custom devices will not be covered if a standard device exists, unless a custom device is Medically Necessary. You must pay the Copayment, Deductible and/or Coinsurance.

U. Breast Prostheses. **Prior Authorization is required.**

We will provide Benefits for the purchase, repair and replacement of covered external breast prostheses prescribed by and obtained from a Preferred Provider for Members who received covered Breast Cancer Care. Replacement of external breast prostheses are covered once every two Contract Years, if replacement is Medically Necessary. Custom prosthetics will not be covered if a standard device exists, unless a custom device is Medically Necessary. You must pay the Copayment, Deductible and/or Coinsurance.

SECTION THIRTEEN – EXCLUSIONS

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

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

   A. A private room, unless it is Medically Necessary. If you stay in a private room when it is not Medically Necessary, you must pay the difference between the charge for the private room and the charge for a semi-private room;

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

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

   D. An inpatient stay while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, when such care is available to you;

   E. Any inpatient services for dental services, except as provided in Section Twelve, paragraph 1(P) (Craniofacial Disorders);

   F. Any charges because you did not leave your room at the discharge time;

   G. Any services provided by a private duty nurse..

   H. Any non-medical items including, but not limited to, telephone, television, beauty and barber services, guest trays, guest services and accommodations; and

   I. Any items that you take home from the Hospital.

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

   A. Services Starting Before Coverage Begins. We will not provide Benefits for any services you get:

1. prior to your Effective Date; or

2. on or after your Effective Date if the service is covered or required to be covered under any other health benefits contract, certificate, program or plan.

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

B. Non-Covered Services. We will not provide Benefits for any services not listed in this COC as a Covered Service. We will not provide Benefits for any service that is related to services not covered under this COC. We will not provide Benefits for services in excess of any limits or maximums described in this COC.

C. Non-Medically Necessary Services. We will not provide Benefits for any services that are not Medically Necessary.

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

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

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

G. Alternative Services. We will not provide Benefits for alternative or complementary health services, products, remedies, treatments and therapies. This includes, but is not limited to, acupuncture, biofeedback (except for treatment of urinary incontinence), massage therapy, hypnosis and hypnotherapy, naturopathy, homeopathy, primal therapy, chelation therapy, carbon dioxide therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, aroma therapy, hair analysis, thermograms and thermography, yoga, meditation, and recreational therapy and any related diagnostic testing; unless listed as a Covered Service on your Schedule.

H. Aviation. We will not provide Benefits for any illness, injury, or condition that is a direct result of air travel, except when you are a fare paying passenger on a commercial airline scheduled flight.

I. Blood Products. We will not provide Benefits for charges for whole blood, blood plasma, packed blood cells, or other blood products or derivatives if a volunteer

blood replacement program is available. If a program is not available, we will provide benefits if billed by a Preferred Provider. We will provide Benefits for autologous blood donations when they are Medically Necessary. We will provide Benefits for administration and processing charges.

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

K. Chiropractic Treatment. We will not provide Benefits for services performed by a provider other than a licensed chiropractic physician. This includes but is not limited to doctors of osteopathy.

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

M. Consultations. We will not provide Benefits for consultations except when they are between Preferred Providers. Such Providers must attach a written report to your medical record.

N. Cosmetic Services and Surgery. We will not provide Benefits for any services or surgery that are mostly meant to improve your appearance. This includes but is not limited to, plastic surgery and scar repair or revision. We will provide Benefits for services for reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part. This includes breast reconstruction and symmetry surgery as described in Section Six, paragraph 6 and Section Twelve, paragraph 1(K) (Breast Cancer Care). We will provide Benefits for reconstructive surgery because of congenital disease or anomaly of a covered dependent child, which has resulted in a functional defect. Please see Section 3 paragraphs 2(C)(6) and 5(B) for more information about covered newborn children.

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

P. Criminal Behavior. We will not provide Benefits for any services related to an illness, injury or condition arising out of your participation in a felony, riot insurrection or illegal occupation. The felony, riot, insurrection or illegal occupation will be determined by the law of the state where the criminal behavior occurred.

Q. Custodial Services. We will not provide Benefits for this service, for bed rest for convenience reasons.

R. Dental Services. Except as provided in Section Twelve, paragraph 1(P) (Craniofacial Disorders), we will not provide Benefits for dental services. This includes, but is not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, bony impacted teeth, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, dental implants, and prosthetic restoration of dental implants. We will not provide Benefits for temporomandibular joint disease or dysfunction where it is dental in nature. We will not provide Benefits for inpatient or outpatient services for dental services unless such services are Medically Necessary and precertified by MVP. We will provide Benefits for the removal of diseased teeth prior to radiation therapy if such services are Medically Necessary and precertified by MVP.

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

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

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

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

W. Experimental or Investigational Services. Except as provided in this paragraph, we will not provide Benefits for services which we determine are Experimental or

Investigational Services. We will provide Benefits for Experimental or Investigational Services if we determine: (a) that the proposed service has demonstrated promise in treating the underlying condition through a Phase III or Phase IV clinical trial sanctioned by the United States Food and Drug Administration; and (b) that an expert panel with quality assurance and technology assessment expertise has reviewed the proposed service and deemed it appropriate. Phase I and II clinical trials, whether or not sanctioned by the United States Food and Drug Administration, are excluded. In addition, we will provide Benefits for routine costs for patients who participate in a cancer clinical trial as follows:

1 Cancer clinical trials conducted under the auspices of the following cancer care providers ("Cancer Care Providers"): Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, and approved clinical trials administered by a hospital and its affiliated, qualified cancer care providers.

2. For participation in clinical trials located outside Vermont, coverage under this section shall be required only if the patient provides notice to the health benefit plan prior to participation in the clinical trial, and:

(a) no clinical trial is available at the Cancer Care Providers;

(b) the Member already has completed a clinical trial under subparagraph (A) and the Member's cancer care provider determines that a subsequent clinical trial related to the original diagnosis is available outside of MVP's preferred provider network and determines participation in that clinical trial would be in the best interest of the Member, even if a comparable clinical trial is available at that time at the Cancer Care Providers; or

(c) MVP already has approved a referral of the Member to a Non-preferred cancer care provider and an out-of-network clinical trial becomes available and the Member's cancer care provider determines participation in that clinical trial would be in the best interest of the Member, even if a comparable clinical trial is available at one of the Cancer Care Providers.

3. If a Member participates in a clinical trial administered by a cancer care provider that is not in our preferred provider network, we may require that routine follow-up care be provided within our preferred provider network, unless the cancer care provider determines this would not be in the best interest of the patient.

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

Y. Family Services. We will not provide Benefits for services provided by your immediate family.

Z. Foot Care. We will not provide Benefits for routine or palliative foot care. This includes but is not limited to any services in connection with corns, callouses, flat feet, fallen arches, weak feet, toenails, chronic foot strain, or symptomatic complaints of the feet. We will provide Benefits for Medically Necessary foot care.

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

BB. Government Benefits. We will not provide Benefits for any services for which benefits are available to you under any federal, state, or local government program, except Medicaid, but including Medicare to the extent it is your primary payor. This exclusion applies even if you fail to enroll, do not make a proper or timely claim, fail to pay the charges for the program, fail to appear at any hearing, or do not claim the benefits available to you.

CC. Government Hospital. We will not provide Benefits for services you get in any hospital or other facility or institution which is owned, operated or maintained by the Veteran's Administration, the federal government, or any state or local government, or the United States Armed Forces. We will provide Benefits for covered services in such hospital, facility or institution if the conditions of coverage described in Section Ten (Covered Emergency Services) are satisfied or for covered services provided for non-military service related conditions.

DD. Home Modifications and Fixtures. We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of home modifications and fixtures. For example: installation of electrical power, water supply or sanitary waste disposal, elevators, escalators, ramps, seat lift chairs, stair glides, handrails, swimming pools, whirlpool baths, home tracking systems, exercise or physical fitness equipment, home appliances, air or water purifiers, central or unit air conditioners, humidifiers, dehumidifiers, and emergency alert systems and equipment, and business or vehicle modifications, or for services for evaluation, fitting or modification of such modifications and fixtures.

EE. Late Submitted Charges. We will not provide Benefits for charges for services rendered by Preferred Providers which are submitted to MVP more than one hundred eighty (180) days after the date of service, except when coordination of benefits applies and MVP is the secondary payor. We will not provide Benefits for charges for services rendered by Non-Preferred Providers which are not submitted to MVP as soon as is reasonably possible after the date of service, except when coordination of benefits applies and MVP is the secondary payor.

FF. Ophthalmic Services. We will not provide Benefits for vision correction or accommodations or for the expense of purchasing corrective lenses.

GG. Prescription Drugs. We will not provide Benefits for prescription drugs except for: (i) those that are administered to you in the course of covered outpatient or inpatient services in a Preferred Hospital, through covered Preferred Home Care or Hospice Services, or for covered immunizations; (ii) medical foods prescribed for the Medically Necessary treatment for an inherited metabolic disease in accordance with Section Twelve, paragraph 1(O); and (iii) drugs prescribed for the Medically Necessary treatment of diabetes in accordance with Section Twelve, paragraph 1(H).

HH. Military Service-Connected Illnesses, Injuries and Conditions. We will not provide Benefits for any services in connection with any military service-connected illness, injury, or condition if the Veteran's Administration is responsible for providing such services. MVP will also not provide Benefits for any services related to an illness, injury, or condition that results from an act of declared or undeclared war.

II. No-Fault Automobile Insurance and MedPay. We will not provide Benefits for any service that is covered by mandatory automobile no-fault benefits or applied to any no-fault deductible, for any service that is covered by MedPay or for any service that is covered by similar policies or programs. This exclusion applies if you fail to maintain the mandatory required insurance, if you do not make a proper or timely claim for benefits available to you under such policy or program, or if you fail to appear at any hearing. We will also not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you get money from that lawsuit and have repaid the medical expenses you received payment for under such policy or program.

JJ. Orthotic Devices for Feet. We will not provide Benefits for orthotic devices. This includes, but is not limited to, custom made shoes, orthopedic shoes, arch supports, elastic support stockings and shoe inserts, or for services for evaluation, fitting, or modification of such devices.

KK. Personal Hygiene and Comfort and Convenience Items and Services. We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of personal hygiene or comfort and convenience items or provider services. This includes, but is not limited to, massage services, spa services, and other provider services, central or unit air conditioners, air or water purifiers, waterbeds, furniture such as reclining chairs, massage equipment, radio, telephone, television, beauty and barber services, commodes, hypoallergenic bedding, mattresses, waterbeds, dehumidifiers, humidifiers, hygiene equipment, saunas, whirlpool baths, exercise or physical fitness equipment, emergency alert systems and equipment, handrails, heat appliances, and business or vehicle modifications, or for services for evaluation, fitting or modification of such items.

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

MM. Reproductive Procedures. We will not provide Benefits for any services for or related to artificial means to induce pregnancy. This includes, but is not limited to, artificial insemination, in vitro fertilization and embryo transplantation, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and drugs used in connection with such procedures, cryopreservation and storage of sperm, eggs, or embryos, intracytoplasmic sperm injection (ICSI), sperm storage, sperm banking, donor costs, surrogate parenting, acrobeads sperm assay, hamster egg penetration test, hypo-osmotic swelling test, retrieval of sperm through electrostimulation, preimplantation genetic diagnosis and gender selection, and drugs used in connection with such services. However, we will provide coverage for outpatient contraceptive services including sterilizations

NN. Residential Care. We will not provide benefits for this service.

OO. Reversal of Elective Sterilization. We will not provide Benefits for this service.

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

QQ. Smoking and Caffeine Cessation Services. We will not provide Benefits for programs and services to help you stop smoking or alleviate caffeine dependence.

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

SS. Support Therapies. Except as provided in Section Nine, paragraph 3 (Hospice Services), we will not provide Benefits for support therapies. This includes, but is not limited to, marriage counseling, pastoral or religious counseling, sex counseling, or other social counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy and play therapy.

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

UU. Transsexual Surgery and Related Services. We will not provide Benefits for any services related to or leading up to transsexual surgery. This includes but is not limited to, hospital services, hormone therapies, procedures, treatments or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender.

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

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

XX. Vision and Hearing Examinations, Therapies and Supplies. We will not provide Benefits for any services related to eye or hearing examinations for prescribing, fitting, determining the need for, or provision of eyeglasses, lenses, frames, contact lenses, or hearing aids. We will not provide Benefits for vision or hearing therapy or training, vision perception training or orthoptics. We will not provide Benefits for the correction of refractive errors by means of any surgical or other procedures, including radial keratotomy. We will not provide Benefits for services for disorder of vision correction or accommodations. We will provide Benefits for Medically Necessary eye and ear care.

YY. Weight Loss Services. We will not provide Benefits for any services or programs in connection with weight reduction, dietary control, dietary supplements and replacements, and exercise classes We will provide Benefits for Medically Necessary Covered Services for the treatment of morbid obesity. Morbid obesity is defined as having a body mass index greater than 40 or a body mass index greater than 35 with at least 2 severe comorbidities such as diabetes and heart disease.

ZZ Wigs. We will not provide Benefits for wigs. This includes toupees, hair pieces, hair transplants, hair extensions or similar hair items. We will not provide Benefits for any products or services to promote hair growth.

AAA. Workers' Compensation. Except for sole proprietors and partners who are not voluntarily covered under a workers' compensation insurance policy, we will not provide Benefits for any service for which you have received or are eligible to get benefits under a workers' compensation act or similar law or for services which are the subject of a controverted Workers' Compensation claim or case. This exclusion applies even if you do not get such benefits because you did not submit a proper or timely claim for benefits or because you fail to appear at a hearing. We will also not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you get money from that lawsuit and you have repaid the medical expenses you received payment for under the workers' compensation act or similar law.

SECTION FOURTEEN - TERMINATION OF YOUR COVERAGE

This Section describes how your coverage may terminate. When your coverage terminates, it stops at 12:00 midnight on the termination date. You may be eligible for Benefits after termination as described below.

1. Automatic Termination. Your coverage will automatically terminate in the event of any of the following:

A. Discontinuance of Your Group Membership. If you are covered under this COC as a member of a group, your coverage will automatically terminate on the date of discontinuance of your group membership, or the date to which your premium is paid, whichever is sooner. See Section Fifteen as to how you may get continuation and conversion coverage.

B. Termination of Group Contract. If the group contract under which this COC was issued is terminated, your coverage will automatically terminate as of the date the group contract terminates. Your group must give you prior written notice if the group contract is terminated.

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

D. Dissolution of Marriage or Civil Union. If you become divorced, or your marriage or civil union is annulled or legally dissolved, your Spouse's coverage will automatically terminate on the date of dissolution, or the date to which your premium is paid, whichever is sooner. You must immediately notify us of any such dissolution. See Section Fifteen as to how your Spouse may get continuation and conversion coverage.

E. Termination of Coverage of a Child. Your child's coverage under this COC will automatically terminate on the last day of the month following the earliest of the following dates, or the date to which your premium is paid, whichever is sooner: (a) the child reaches age 19; (b) marries; (c) is no longer chiefly dependent upon you for support and maintenance; or (d) upon termination of your civil union, in which case coverage for the child of such civil union spouse will be terminated.. If your child is covered pursuant to Section Three, paragraph 2(B), the child's coverage will automatically terminate on the earliest of the date the child is no longer incapable of self-sustaining employment, is no longer disabled, or is no longer chiefly dependent upon you for support and maintenance. You must immediately notify us when your child is no longer eligible for coverage. See Section Fifteen as to how your child may get continuation and conversion coverage.

Special Rule for Children Covered Pursuant to Qualified Medical Support Orders. We will not terminate the coverage of a child required to be covered pursuant to a qualified medical support order until we are provided satisfactory written proof that:

a. The order is no longer in effect, or

b. The child is or will be enrolled in comparable coverage through another insurer which will take effect not later than the date coverage under this COC would terminate.

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

2. MVP's Termination of Your Coverage. MVP may terminate your coverage for the following reasons. We will give you 30 days prior written notice:

A. Fraud or Misrepresentation. MVP will immediately void your coverage for any fraud or material misrepresentation made by you when you enrolled or when you filed any claim under this COC. MVP is entitled to all remedies provided for in law and equity. This includes but is not limited to, recovery from you for the charges for benefits provided.

B. Discontinuance of Class of COC. We discontinue the entire class of COCs to which this COC belongs. We will offer you coverage under a replacement plan. We will give you 90 days prior written notice.

C. Withdrawal from the Applicable Market. We withdraw from the market as permitted by Vermont law and regulation. We will give you 180 days prior written notice.

D. Regulatory. Any reason found to be acceptable to the Vermont Department of Banking, Insurance, Securities and Health Care Administration, authorized by the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations thereunder.

3. Your Option to Terminate Coverage. You may terminate your coverage at any time by giving us 30 days prior written notice.

4. Obligations on Termination. Except as provided in paragraph 5 below, once your coverage ends, MVP will not provide any more Benefits except for Covered Services received before termination.

5. Benefits After Termination. If you are Totally Disabled on the date your coverage terminates, and such Total Disability occurred before your coverage terminated, we will continue to provide Benefits for covered services which are directly related to the illness, injury or condition causing the Total Disability. This extension of Benefits will continue until the earliest of: (1) the date you are no longer Totally Disabled; or (2) twelve months from the date your coverage would have terminated. We will not provide more Benefits than would have been provided if your coverage under this COC had not been terminated

and we will not provide Benefits for any services covered or required to be covered under any other insurance plan, certificate or contract.

If you have coverage other than individual coverage under this COC, this extension of Benefits covers only the member with the Total Disability. MVP will terminate the coverage of other family members who were covered under this COC as of the termination date.

6. MVP's Right to Recover. If we incorrectly provide Benefits after your coverage or this COC has been terminated, MVP may recover from you the charges for Benefits provided.

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

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

1. Continuation Coverage:

   A. Under Federal Law. Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act 1985 (COBRA), most employer sponsored group health plans must offer: (1) employees and (2) their spouses and dependents, as those terms are defined by federal law, the opportunity for continuation of health insurance coverage when their coverage would end. This means that: (1) civil union spouses and dependents and (2) domestic partners and their dependents are not eligible for COBRA coverage unless such spouses/partners and dependents meet the federal law definition of spouse or dependent or unless your Group has elected, by purchasing a Rider to this COC, to extend COBRA coverage beyond that required by law. Members should call or write your Group or us to find out if your employer offers COBRA and, if so, whether you are eligible for COBRA coverage.

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

1. The deceased or terminated Subscriber was not covered under this COC during the entire 3 month period preceding the death or termination;

2. The Member seeking continuation coverage is or could be covered by Medicare;

3. The Member is or could be covered as an employee, member or dependent by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group under which the member was not covered immediately prior to termination; or

4. The Subscriber's termination of employment was due to misconduct as defined by Vermont law.

2. Requesting Continuation Coverage:

A. COBRA. If you wish to elect COBRA, you must request the coverage, in writing, to your Group, within sixty (60) days of the later of: (i) the date that coverage under this COC would terminate; or (ii) the date you are given notice of the right to COBRA. Your premium payment must be included with this election.

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

C. Termination of COBRA Coverage. COBRA Coverage shall terminate upon the occurrence of any of the following:

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

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

3. 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; eligibility for Medicare; or your failure to meet the federal definition of a dependent child.

4. The date twenty-nine (29) months after your coverage would have terminated because of termination 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. 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.

5. The date your Group no longer provides coverage under this COC to any of its employees or members.

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

1. Six (6) months after the date the Member's benefits under this COC would have terminated because of the death of the Subscriber or the Subscriber's termination of employment or group membership, or the Subscriber's divorce or legal separation, or a dependent child ceasing to be a covered dependent child under this COC.

2. The end of the period for which premium payments were made, if the Group or the Member fails to make timely payment of a required premium payment.

3. The member is or could be covered by Medicare.

4. The date on which the group's contract with MVP is terminated. In such event, if coverage is replaced by similar coverage under another Group Contract:

a. The Member shall have the right to become covered under the replacement Group Contract for the balance of the period that he would have remained covered under the prior Group Contract;

b. The minimum level of benefits provided by the replacement Group Contract shall be the applicable level of benefits of the prior Group Contract, reduced by any benefits payable under that prior Group Contract; and

c. The prior Group Contract shall continue to provide benefits to the extent of its accrued liabilities and extension of benefits as if the replacement had not occurred.

3. Conversion to a Direct Contract: When Continuation Coverage under this COC terminates because of the death of the Subscriber or the Subscriber's termination of employment or

group membership, the Subscriber and/or the Subscriber's Dependents may purchase a direct contract with MVP in accordance with the following rules:

A. The following Members may purchase an individual, direct payment conversion contract from MVP, without proof of insurability, under which no Pre-Existing Condition exclusion period will be applied to him or her.

1. An Eligible Individual.

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

3. A child placed with the Subscriber of the direct payment contract for adoption, or an adopted child. When such child is adopted or placed after the effective date of the direct payment contract.

4. A Subscriber's newborn natural child or a newborn child placed with the Subscriber for adoption, provided that the child is enrolled within 94 days of the date of birth.

5. If a Member does not qualify under one of the above categories, the Member may still be eligible to purchase a direct payment contract from MVP, without proof of insurability. A pre-existing condition exclusion period may be imposed.

B. Creditable Coverage. If a Pre-Existing Condition exclusion applies to you, the exclusion period can be reduced. The time you were covered under Creditable Coverage before you become covered under a direct payment contract will be counted to reduce the excluded period. This only applies if there was not a break in coverage greater than 63 days between termination of the previous Creditable Coverage and your Effective Date under this COC.

C. Notice and Application Requirements. You must apply for Conversion Coverage not later than 30 days prior to the date of termination of your Continuation Coverage. To apply, you must submit a written application and the first premium payment to MVP within this timeframe.

D. Circumstances Under Which Conversion is Not Available. MVP does not have to provide Conversion Coverage if:

1. the Member was not entitled to or did not properly elect Continuation Coverage;
2. the person is or could be covered by Medicare;
3. the person is covered for similar benefits by another individual contract or policy;

4. the person is or could be covered for similar benefits under any insured or self insured group arrangement, or by reason of any state or federal law, and together with this Conversion Coverage, would result in overinsurance according to MVP's standards; or
5. your Group cancels coverage with us and gets coverage with another health insurer or you are eligible for group coverage, we cannot continue your Group or direct-pay coverage.

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

A. This paragraph applies only to the extent required by law and only if you are a member of a reserve component of the Armed Forces of the United States, including the National Guard, you serve no more than five (5) years of active duty, and you either:

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

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

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

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

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

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

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

SECTION SIXTEEN – EFFECT OF MEDICARE

1. When you become eligible for Medicare, you must enroll in Part B and notify MVP in writing. Except as described below, Medicare then becomes your Primary Plan. We will not provide Benefits for any service or care for which benefits are payable under Medicare and your MVP Benefits will run concurrent with your Medicare Benefits. When you are eligible for Medicare, we will reduce our Benefits by the amount Medicare would have paid for the services or care. This reduction is made even if: you fail to enroll in Medicare or if you do not pay the premiums or other charges for Medicare.

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

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

1. the Subscriber is in "current employment status" (working actively in a group with 20 or more employees and not retired) with the Group; and

2. the Subscriber's employer maintains or participates in an employer group health plan that is required by law to have this COC pay benefits before Medicare pays.

In this case, Medicare is the Secondary Plan.

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

1. the Subscriber is in "current employment status" (working actively in a group with 100 or more employees and not retired) with the Group; and

2. the Subscriber's employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this COC pay its benefits before Medicare pays.

In this case, Medicare is the Secondary Plan.

C. Eligibility for Medicare By Reason of End-Stage Renal Disease. You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. We will not reduce this COC's benefits, and we will provide benefits before Medicare pays, during the waiting period (this means that Medicare is the Secondary Plan during this waiting period). We will provide benefits before Medicare pays during the coordination period with Medicare. After the waiting period, Medicare will pay its benefits before we provide benefits under this COC (this means that Medicare is the Primary Plan after this waiting period).

3. MVP as Primary Plan.

A. If this exclusion does not apply and MVP is the Primary Plan, MVP will provide Benefits under the terms of this COC.

B. The benefits provided by Medicare will be reduced to provide benefits only to the extent not provided by MVP.

4. MVP as Secondary Plan. If this exclusion applies and MVP is the Secondary Plan, you must follow Medicare's rules, the terms of this COC, and pay all Deductible, Copayments and Coinsurance before MVP will provide Benefits. The Benefits provided by MVP will be reduced to provide Benefits only to the extent not provided by Medicare. This means, generally, that if your Provider accepts Medicare assignment, MVP will pay the amount of your Medicare Coinsurance, minus the amount of your MVP Copayment, Coinsurance and Deductible, up to Medicare's Allowable Charge. If your Provider does not accept Medicare assignment, this means, generally, that MVP will pay the amount of your Medicare Coinsurance plus any balance due to your Provider, minus the amount of your MVP Copayment, Coinsurance and Deductible, up to MVP's Allowable Charge.

5. Claims Submission when MVP is the Secondary Plan. You must follow the instructions in Section Five, paragraph 5(C).

6. Recovery of Overpayment. If we provide more Benefits than we should have, MVP, or our agents, have the right to recover the overpayment from you or from any other person, insurance company, agency or organization. You must cooperate with us to recover the overpayment.

SECTION SEVENTEEN - COORDINATION OF BENEFITS

This Section applies only if you have other health benefits.

1. When You Have Other Health Benefits. You may be covered by two or more health plans which provide similar benefits. If you get a service which is covered at least in part by any of the plans involved, we will coordinate our benefits with the benefits under the other plan. This prevents overpayment or duplicate payments for the same service. One plan (called the Primary Plan) will pay benefits (up to the limits of its policy). The other plan (called the Secondary Plan) will pay benefits (up to the limits of its policy) if the benefits of the Primary Plan do not fully cover your expenses. The benefits of the Secondary Plan will be reduced to cover only those expenses which were not covered by the Primary Plan.

2. The following are considered to be health plans:

   A. Any group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g. Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;

   B. Any Blue Cross, Blue Shield, or other service type group plan;

   C. Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;

   D. Any coverage under governmental programs, or any coverage required or provided by any statute. Medicaid, CHAMPUS/TRICARE and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall be Secondary Plans; and

   E. If you have an accident and you are covered for accident-related expenses under any of the following types of coverage, the other payer is primary and we are secondary:

      (i) No-Fault auto insurance;
      (ii) Group auto insurance;
      (iii) traditional fault-type auto insurance;
      (iv) uninsured or underinsured motorists insurance;
      (v) automobile-medical payment insurance;
      (vi) Workers' Compensation coverage;
      (vii) homeowner's insurance;
      (viii) personal injury protection insurance;
      (ix) financial responsibility insurance;
      (x) medical reimbursement insurance coverage that you did not purchase; or

(xi) any other property and liability insurance providing medical payment benefits.

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

A. If your other plan does not have a provision like this one, which coordinates benefits, it will always be the Primary Plan.

B. If you are covered under one plan as a subscriber and under the other plan as a spouse or dependent, the plan which covers you as a subscriber is the Primary Plan. This is true even if you have coverage under two MVP Plans.

C. If you are covered as a child dependent under two plans, then the rules are as follows: (i) the coverage of the parent whose birthday is first in a year will be primary and the parent whose birthday is later in the year will be secondary; (ii) if both parents have the same birthday, the benefits of the plan in effect longer will be primary; (iii) if the other plan does not have this rule, but instead has a rule based upon the parents gender; and if as a result, the plans do not agree on the order of benefits, then the rule in the other plan will determine the order of benefits.

D. There are special rules for a child of separated or divorced parents.

1. If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.

2. If no such court decree exists or if the Plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:

a. First, the Plan of the parent with custody of the child;

b. Then, the Plan of the spouse of the parent with custody of the child;

c. Then, the Plan of the parent not having custody of the child;

d. Finally, the Plan of the spouse of the parent not having custody of the child.

3. If the terms of a court decree specify joint custody, then the birthday rule described in paragraph 3(C) above applies.

E. A plan which covers you as an active employee or as that employee's dependent is primary. A plan which covers you as a laid off or retired employee (or as that employee's dependent) or which provides for continued or extended coverage under federal or state law such as COBRA or an extension of benefits provision, or covers you as an inactive employee is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on which plan is primary, this subsection 3(E) is ignored.

F. If none of the above rules determines the order of benefits, the benefits of a plan which covered you longer is primary.

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

4. MVP as Secondary Plan. If MVP is considered the secondary payor, you are required to follow the rules and procedures of the primary plan before MVP will make payment. If MVP is to make payment on a secondary basis, the rules and procedures of MVP, as stated in this COC, must also be followed. When MVP is the Secondary Plan, benefits under this COC will be reduced so that the total benefits payable under the Primary Plan and MVP do not exceed your expenses for an item of service. We will not pay more than we would have paid if MVP was the Primary Plan. We count as actually paid by the Primary Plan any items of expense that would have been paid if you had made the proper claim.

5. Recovery of Overpayment. If we provide benefits greater than we should have, MVP or its agents have the right to recover the overpayment from you or from any other person, insurance company, or organization which may have gained from our overpayment. We may reduce or withhold future Benefits to recover any incorrect payments. When the overpayment includes services which you received under this COC, the amount of the overpayment will be based on prevailing rates for those services. You agree to do what is necessary to help us to recover our excess payment. This includes but is not limited to: (1) agreeing to complete and file claim forms with other organizations or insurance companies and endorsing checks over to us, and (2) authorizing MVP to complete and file claim forms with other organizations or insurance companies on your behalf. Whether MVP is the primary or secondary plan, you will be responsible for all Copayments that apply.

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

6. Copayments When You are Enrolled in Two MVP Plans. If you are covered under MVP as a Subscriber and also a Dependent of a separate MVP plan, you are responsible for the lesser of the two Copayments.

7. Payments to Others. We may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which we decide we should have paid. These payments are the same as benefits paid.

SECTION EIGHTEEN -- THIRD PARTY LIABILITY AND RIGHTS OF REPAYMENT

1. Introduction. If MVP provides benefits to a Member for an injury, illness, or condition for which a third party is or may be responsible, then MVP retains the right to be repaid the full cost of all benefits provided by MVP that are for or related to the injury, illness or condition. MVP may recover the full cost of all benefits provided by MVP without regard to any fault by the Member.

2. Right to Subrogation. When MVP has provided benefits as described above and the Member has not yet recovered such costs from the third party, MVP is subrogated to the Member's rights of recovery against any third party for the full cost of benefits. MVP or its agent may proceed against any third party without the consent of the Member.

3. Right to Reimbursement. When MVP has provided benefits as described above and the Member or Member's representative has recovered such costs from the third party, MVP is entitled to reimbursement from the Member for the full cost of benefits. MVP may engage an agent to pursue such rights. As a condition of coverage under this COC, each Member hereby grants to MVP: (1) an assignment of the proceeds of any settlement, judgment, benefits under any automobile policy or other coverage, or any other payment received by the Member, to the extent of the full cost of all benefits provided by MVP; and (2) a first priority lien against the proceeds of any settlement, verdict, judgment, benefits under any automobile policy or other coverage, insurance proceeds, or any other payment received by the Member, to the extent of the full cost of all benefits provided by MVP.

4. Sources of Payment. MVP's rights apply to any payments made to or on behalf of a Member from third-party sources. This includes, but is not limited to: (1) payments made by a tortfeasor or any insurance company on behalf of such third-party tortfeasor; (2) any payments or awards under Medpay or an uninsured or underinsured motorist automobile policy; (3) any worker's compensation or disability award or settlement; (4) medical payments coverage under any automobile policy; (5) premises or homeowners medical payments coverage or premises or homeowners insurance coverage; (6) any other payments from a source intended to compensate a Member for injuries resulting from alleged negligence of a third party. No court costs or attorneys fees may be deducted from MVP's recovery without MVP's prior written consent.

5. Cumulative Rights. MVP may choose to exercise either or both rights.

6. Member's Obligations.

A. Promptly notify MVP when notice is given to any third party to pursue a claim for injuries, illnesses or conditions that may be the legal responsibility of a third party.

B. Cooperate with MVP or MVP's agent to protect MVP's rights to reimbursement and subrogation, including:

1. signing and delivering, within 30 days of a reasonable request to do so, any documents needed to secure MVP's subrogation claim, to protect MVP's right to reimbursement, or to effect the assignment or lien described in paragraph 3 above;

2. providing any relevant information;

3. getting the consent of MVP before releasing any party from liability for payment of medical expenses;

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

5. not taking any action that prejudices MVP's rights to reimbursement or subrogation, including but not limited to making any settlement or recovery which attempts to reduce or exclude the full cost of benefits provided by MVP.

7. Consequence of Failure to Comply. If the Member fails to comply with the requirements of paragraph 6, a Member shall be responsible for all benefits provided by MVP in addition to costs, attorneys' fees, and interest incurred by MVP in getting repayment. Your future benefits may be reduced or withheld to recover monies owed to us.

SECTION NINETEEN – GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW

1. Grievances. A grievance means a written or verbal complaint submitted to MVP by or on behalf of a Member expressing dissatisfaction regarding the availability, delivery or quality of health care services, claims payment, handling or reimbursement for health care services, or expressing dissatisfaction regarding matters governed by or related to this COC. It includes requests that MVP change decisions that services are not Medically Necessary or are not Covered Services. You, your appointed representative (such as a family member, friend, or lawyer), or a Provider acting for you, may submit a grievance. You must call MVP at 1-800 318-8575 in order to appoint a representative. Your decision as to whether or not to submit a grievance has no effect on your rights to any other benefits under this COC. At your request and free of charge, MVP will provide you with reasonable access to and copies of documents, records, and other information relevant to your grievance. First Level Grievances are mandatory. This means that you must commence and complete a First Level Grievance before you may seek any other internal or external remedy, including Independent External Review or court action.

2. Grievance Reviewers.

A. First Level Grievances. Medical grievances are reviewed by one of MVP's medical directors. Non-medical grievances are reviewed by a member of MVP's administrative staff. This person has the necessary education and experience to resolve the matter. First level grievances are reviewed by persons who were not involved in making the initial decision and who are not subordinate to such persons.

B. Second Level Grievances. Second level grievances are reviewed by a panel comprised of MVP senior medical and administrative staff and/or board members. This panel has the necessary education, training and experience to resolve the matter. The medical staff participating in at least one level of grievance review will have appropriate training and experience in the field of medicine involved in the particular grievance. Such staff will be actively practicing in the same or similar specialty and typically treat the condition or provide the service that is the subject of the grievance. Alternatively, MVP may use independent organizations to provide medical specialists practicing in the same or similar specialty as consultants for a grievance. Second level grievances are reviewed by persons not involved in making the initial decision or the first level grievance decision and who are not subordinate to such persons. More information about the panel reviewing your grievance is included in MVP's written response to the grievance.

3. Information Reviewed. MVP will review all comments, documents, records and other information you provide, without regard to whether such information was submitted or considered when making the initial decision or any first level grievance decision. Grievances are reviewed without regard to the initial decision or any first level grievance decision.

4. Time Limit for Submitting a First Level Grievance. You must submit a grievance within 180 days of receiving our decision regarding the matter that is the subject of the grievance. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral grievance by calling MVP at 1-800 318-8575. You may submit a written grievance to MVP Health Insurance Company, 625 State Street, Schenectady, New York 12305.

5. MVP's Response to First Level Grievances. MVP will respond to grievances as follows:

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

1. application of the time periods described in subparagraph B below:

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

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

2. a physician with knowledge of your medical condition determines that a Prior Authorization, or concurrent review request is urgent.

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

B All other Grievances. MVP will notify you of our decision within 15 days after we get the grievance. In cases involving Mental Health or Substance Abuse Services, a licensed mental health review agent will make a decision within 10 days of the date the grievance is submitted. You will be notified of our decision in writing.

6. A. If you are not satisfied with MVP's decision in response to your First Level Grievance, you may, in addition to any other legal remedy available to you:

(1) Proceed directly to Independent External Review, as described in paragraph 11 below; or

(2) Commence a Voluntary Second Level Grievance with MVP as described in paragraph 7 below. If you do so, your time to commence court action will not start until you receive MVP's response to the Voluntary Second Level Grievance.

B. Additional Provisions.

(1) MVP waives any right to assert that you failed to exhaust administrative remedies because you did not elect to make a Voluntary Second Level Grievance.

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

(3) No fees or costs are imposed on you as part of the Mandatory First Level or Voluntary Second Level Grievance.

7. Time Limit for Submitting a Voluntary Second Level Grievance. In cases not involving Mental Health or Substance Abuse Services, if you are not satisfied with MVP's decision in response to the first level grievance, you may submit a second level grievance. If you proceed, you are not required to make a Voluntary Second Level Grievance in order to pursue any external remedy that may be available to you. You must submit this grievance within 90 days of receiving our decision in response to the first level grievance. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral grievance by calling MVP at 1-800 318-8575. You may submit a written grievance to MVP Health Insurance Company, 625 State Street, Schenectady, New York 12305. As described in paragraph 2, second level grievances are reviewed by a panel. You also have the right to appear before the panel to discuss your grievance. If you cannot appear before the panel in person, you may communicate with the panel by conference call or other appropriate technology. For cases involving Mental Health or Substance Abuse Services, please see paragraph 9 below.

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

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

      1. application of the time periods described in subparagraph B below:

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

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

      2. a physician with knowledge of your medical condition determines that a Prior Authorization or concurrent review request is urgent.

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

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

9. If you are not satisfied with MVP's decision in response to your Second Level Grievance, you may, in addition to any other legal remedy available to you, proceed directly to Independent External Review as described in paragraph 11 below.

10. Review of First Level Grievance Decisions in Cases Involving Mental Health or Substance Abuse Services. If you are not satisfied with the decision in response to the first level grievance, you, your provider, or your authorized representative may submit an appeal to the Independent Panel of Mental Health Care Providers established by the Vermont Department of Banking, Insurance, Securities and Health Care Administration. You must contact the Vermont Department of Banking, Insurance, Securities and Health Care Administration at 1-800-631-7788 for assistance in submitting this appeal.

11. Independent External Review.

    A. You have the right to an "independent external review" of certain first or second level grievance decisions made by MVP. An independent external review is an independent review of our decision by a third party known as an independent review organization. Independent review organizations are selected by the Vermont Department of Banking, Insurance, Securities and Health Care Administration and must not have any conflict of interest associated with the review. You may have the right to an expedited external review if the subject of the review concerns an emergency medical condition, emergency services, or urgently needed care. The timeframes for expedited external reviews are shorter than the timeframes for standard external reviews.

    B. You must request this review within 90 days of receiving MVP's second level adverse decision. To request an independent external review, you must call the Vermont Department of Banking, Insurance, Securities and Health Care Administration at 1-800-631-7788.

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

    D. You may not request an independent external review unless we have issued a first level grievance decision. This means that you must complete MVP's first level grievance process before requesting an independent external review.

    E. To be eligible for independent external review, the first or second level grievance decision must be based on a decision that the requested service is not Medically Necessary, is Experimental or Investigational, is an off-label use of a drug, or is a service involving a medically-based decision that a condition is preexisting, or that we have limited your selection of a provider in a manner inconsistent with the terms of this COC or laws and regulations that apply. You do not have the right to external review of any other decisions, even if those other decisions affect your eligibility or benefits.

12. Effect of Review Organization's Decision; Coverage. The decision of the review organization is binding on MVP. If the organization decides in our favor, we will not change our decision or provide benefits for the service that is the subject of the review. If the organization decides in your favor, we will provide benefits subject to all other terms

and conditions of this COC. We will not provide benefits for any service that is not a Covered Service. In addition, this section does not change any Copayment, Coinsurance, or Deductible.

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

ERISA provides that all plan participants shall be entitled to:

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

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

C. Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called ''fiduciaries'' of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or discriminate against you in any

way to prevent you from getting a (pension, welfare) benefit or exercising your rights under ERISA.

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

E. Assistance with Your Questions. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in getting 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 get certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

F. Newborns and Mothers Health Protection Act. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider get authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

G. Women's Health and Cancer Rights Act of 1998. Federal law requires us to notify you of our benefits for reconstructive surgery following mastectomy. The Women's Health and Cancer Rights Act of 1998 requires that we provide benefits for reconstruction of the breast on which a mastectomy has been performed and/or the other breast (to produce a symmetrical appearance). We also cover prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as required by the Act. Benefits for the above services are subject to all terms and conditions of your COC. For example, they require the same Coinsurance, Copayments and Deductibles as the rest of your coverage. If you have any questions about your rights under this Act, please contact MVP's Member Services Department at 1-800 318-8575.

SECTION TWENTY -- GENERAL PROVISIONS

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

2. Notices. Any notice that we give you will be mailed to you at your address as it appears in our records. You must notify MVP of any change of address right away. All notices to MVP must be mailed, postage prepaid, registered or certified mail, return receipt requested, or personally delivered to us at 625 State Street, Schenectady, New York 12305.

3. Your Medical Records. To provide benefits, it may be necessary to get your medical records from providers who treated you. Providing Benefits includes determining your eligibility, conducting utilization management, processing your claims, reviewing grievances involving your care, and quality assurance and quality improvement reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this COC, you authorize each and every Provider to:

   A. disclose to MVP all facts about your care, treatment, and condition to assist us in providing Benefits;

   B. give MVP reports about your care, treatment and condition; and

   C. permit MVP to review and copy your records.

   At any time we request, you will give us a signed authorization to get your records for these purposes. We have the right to deny benefits under this COC if you refuse to give us such authorization. We will maintain your medical records in accordance with state and federal confidentiality laws. You authorize us to give your medical records to the Vermont

Department of Banking, Insurance, Securities and Health Care Administration or other quality oversight organizations. This disclosure excludes the release of any information about previously administered tests for HIV antibodies, T-Cell counts, AIDS or ARC.

4. Changes to this COC.

   A. We may change the terms of this COC and change or eliminate any of the benefits if approved by the Vermont Department of Banking, Insurance, Securities and Health Care Administration. Members have no vested rights to any benefits or other provisions of this COC. We will give you at least 30 days prior written notice of a change.

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

5. Time to File Claims. Claims for services rendered by Preferred Providers under this COC must be submitted to us for payment within 180 days, or as soon thereafter as is reasonably possible, after the date of service. Claims for services rendered by approved Non-Preferred Providers must be submitted to us for payment as soon as is reasonably possible, after the date of service.

6. Who Receives Payment Under this COC. Payments for Covered Services provided by a Preferred Provider will be made by us directly to the provider. When services are provided by a Prior Approved Non-Preferred Provider, you or the approved Non-Preferred Provider must submit a claim to MVP. Payments may be made to you or to the approved Non-Preferred Provider. See Section Five.

7. Legal Action. You may not commence any legal action against MVP prior to the expiration of sixty (60) days after written proof of loss was submitted to MVP in accordance with Section Five of this COC. You may not start a legal action against us prior to exhausting the first level grievance process outlined in Section Twenty. You must start any lawsuit against us within 3 years from the date we made a first level grievance decision. Service or process must be made upon an officer of MVP at 625 State Street, Schenectady, New York 12305 or in accordance with state or federal law.

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

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

8. Venue for Legal Action. You must start any lawsuit against us in a court in Vermont. You agree not to start a lawsuit against us in a court located anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the

proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action we bring against you.

9. MVP's Relationship with Providers. MVP and Providers have an independent contract relationship. Providers are not agents or employees of MVP and MVP is not an agent or employee of any Provider. This COC does not require any particular Provider to accept you as a patient and we do not guarantee such acceptance by any particular Provider. Providers are solely responsible for all services rendered or not rendered to Members.

   MVP does not control the treatment or other professional actions of providers. MVP's decisions relate only to whether we will provide benefits under this COC and are not a substitute for the professional judgment of your Provider. Further, the persons making these decisions for MVP do not get incentives to limit or deny benefits and are not paid based upon the quantity or type of such decisions.

10. Identification Cards. Possession of a card confers no automatic right to benefits. To be eligible for benefits, you must be listed on a completed enrollment form submitted to and accepted by us and your premiums must be paid in full. We may terminate your Coverage if you allow another person to wrongfully use an MVP identification card.

11. Construction and Interpretation of this COC. Subject to any rights you have to dispute a determination of coverage or benefits under this COC, MVP determines whether and to what extent Members are entitled to coverage and benefits and to construe disputed or unclear terms under this COC. This means that even if a Provider provides, prescribes or recommends a service, MVP still determines whether benefits for the service are available under this COC. In the event of any dispute or question concerning enrollment, eligibility, coverage, or other terms and conditions, this COC controls over other sources of general information issued by MVP.

12. Furnishing Information. Except as provide, you must, within 30 days of our request, provide us with all information and records that we may need to perform our obligations under this COC. In the event of a dispute concerning the provision or denial of benefits, MVP may require that a Member be examined, at MVP's expense, by a provider designated by MVP.

13. Inability to Provide Service. In the event of circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of our offices, a significant part of our network, or entities with whom MVP has arranged for services, and our ability to provide benefits under this COC is delayed or becomes impossible, we will not be liable for such delay or failure, except to refund unearned premiums. We are required only to make a good faith effort to provide or arrange for the provision of benefits.

14. Recovery of Overpayments. If we make a payment to you in error, we will tell you and you must return the amount of the overpayment to us within 60 days. If we owe you a payment

for other claims received, we have the right to subtract any amount you owe us from any payment we make to you.

15. Nonwaiver of Our Rights. We may choose not to enforce certain terms or conditions of your COC. This does not mean we give up the right to enforce these terms or conditions later.

16. Time Limit on Certain Defenses. After 3 years from the effective date of this COC, no misstatements, except fraudulent misstatements, made by the Subscriber or his or her Dependents in the enrollment application for this COC, shall be used to void this COC or used as a basis to deny a claim after the expiration of such 3 year period.

17. Choice of Law. Unless federal law applies, this COC is subject to the laws of Vermont.

18. Severability. If any provisions of your Contract are declared invalid or illegal for any reason, the remaining terms and provisions will remain in full force and effect.