This is Your

**HIGH DEDUCTIBLE HEALTH PLAN
EXCLUSIVE PROVIDER ORGANIZATION
CERTIFICATE OF COVERAGE**

Issued by

MVP Health Insurance Company

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

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

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

This Certificate is governed by the laws of Vermont.

MVP Health Insurance Company
Schenectady, NY

President
Denise Gonick

If You need foreign language assistance to understand this Certificate, You may call Us at the number on Your ID card.

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SECTION I

Definitions

Defined terms will appear capitalized throughout this Certificate.

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

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

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

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

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

Certificate: This Certificate issued by MVP Health Insurance Company, including the Schedule of Benefits and any attached riders.

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material

deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta). Emergency Services are not subject to prior authorization requirements.

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

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

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

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

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

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

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

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

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

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

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

Member: The Subscriber or a covered Dependent for whom required Premiums have

been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, “Member” also means the Member’s designee.

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

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

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

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

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

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

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

Primary Care Physician (“PCP”): A participating nurse practitioner or Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: Provider means a properly licensed and/or certified**:**

Physician	Free standing ambulatory center, free standing radiology/imaging center, free standing dialysis center, and free standing laboratory facility

Hospital	Athletic trainer
Approved facility for the treatment of mental health conditions	Advanced practice registered nurse who is certified as a nurse midwife
Approved institution for the treatment of alcohol or substance dependency	Naturopath
Skilled nursing facility	DME provider
Home care agency	Chiropractor
Health care professional	Podiatrist
Licensed midwife	Mental health provider
DDS (dentist)	

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

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

Schedule of Member Payments: The document that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Maximums, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of Vermont, in which We provide coverage.

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

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

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

Subscriber: The person to whom this Certificate is issued.

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

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

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

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

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

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage Under this Certificate.

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

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only

when the Covered Service is:
- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Member Payments ; and
- Received while Your Certificate is in force.

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

C. Participating Providers.
To find out if a Provider is a Participating Provider:
- Check Your Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.mvphealthcare.com.

D. The Role of Primary Care Physicians.
This Certificate does not have a gatekeeper, usually known as a Primary Care Physician ("PCP").

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

You may need to request Preauthorization before You receive certain services.

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

E. Services Subject to Preauthorization.
Our Preauthorization is required before You receive certain Covered Services. Your Participating Provider is responsible for requesting Preauthorization for in-network services.

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

Your Provider must contact Us to request Preauthorization as follows:

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

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

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

- Mental Health/Substance Abuse Services. To request Preauthorization, 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.

- Chiropractic Treatment. To request Preauthorization, 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.

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

You must contact Us to provide notification as follows:

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

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

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

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

We may base Our decision on a review of:

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

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

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

I. Delivery of Covered Services Using Telehealth.
If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

J. Important Telephone Numbers and Addresses.

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

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  1-800-318-8575

- ASSIGNMENT OF BENEFITS FORM

625 State Street
Schenectady, NY 12305
(Submit assignment of benefits forms for surprise bills to this address.)

- MEMBER SERVICES
  1-800-318-8575
  (Member Services Representatives are available Monday - Friday, 8:00 a.m. – 8:88 p.m.)

- PREAUTHORIZATION
  1-800-318-7575

- OUR WEBSITE
  www.mvphealthcare.com

SECTION III

Access to Care and Transitional Care

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

B. When Your Provider Leaves the Network.
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 60 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

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

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

D. Travel Times.

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

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

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

- Prescription drugs
- Labs
- X-rays
- MRIs

- Eye Exams
- Intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services
- Inpatient medical rehab
- outpatient physician specialty care

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

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

SECTION IV

Cost-Sharing Expenses and Allowed Amount

Your Payments.

Deductibles. Please see Your Schedule of Member Payments to see if You have an embedded or aggregate Deductible. These Deductibles are explained below.

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

Aggregate Deductible.
Except where stated otherwise, You must pay the amount in the Schedule of Member Payments during each Plan Year before We provide coverage. If You have other than individual coverage, You must pay the family Deductible in the Schedule of Member Payments for Covered Services under this Certificate during each Plan Year before We provide coverage for any person covered under this Certificate. However, after Deductible payments for persons covered under this Certificate collectively total the

family Deductible amount in the Schedule of Member Payments in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

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

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

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

Coinsurance. This COC has Coinsurance. Required Coinsurance payments are listed on your Schedule of Member Payments. Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network benefit as shown on the Schedule of Member Payments. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**

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

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

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

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

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

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

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

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

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

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

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for an Emergency Condition.

SECTION V

Who is Covered

A. Who is Covered Under this Certificate.

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

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

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

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

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

C. Children Covered Under this Certificate.

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

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to

request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

D. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed 90 days.
2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage within 30 days thereafter, coverage for Your Spouse and Child starts on the first day of the month following such marriage. If We do not receive notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.
4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth for 60 days. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

5. 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 60 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 60 days, You must comply with paragraph (ii) below. If You do not follow this procedure, We will not provide coverage beyond 60 days.

6. To continue the child's coverage beyond 60 days, You must complete and return an enrollment form, any requested documentation, and the required premium. If You do so within 60 days of the date of birth, adoption, placement for adoption, legal guardianship, legal custody, or within 60 days of the date the child became Your 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 60 days of the events described, You will not be able to add Your child to Your coverage until the first day of the month following the next premium due date after the next open enrollment period when We get the completed form, requested documents, and premium. Remember, a newborn child is always covered for the first 60 days. 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 60 days.

E. Special Enrollment Periods.

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

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

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

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

begin on the first day of the second month.

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

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

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

SECTION VI

Preventive Care

Please refer to the Schedule of Member Payments for Cost-Sharing requirements and visit Our website at www.mvphealthcare.com for services that may require Preauthorization or have Referral requirements.

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

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

(a) for Enrollees under age 40, we will provide benefits for mammography screening when recommended by a participating physician; and

(b) for Enrollees age 40 and older, we will provide benefits for an annual mammography screening.

Diagnostic Screening for Prostate Cancer. This is an Adult Preventive Care Service. You will not be required to make a payment for this service.

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

(a) Standard diagnostic testing, including a digital rectal examination and a prostate specific antigen test; and

(b) 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.

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

(a) For Enrollees age fifty (50) and older we will provide benefits for an annual fecal occult blood test plus one flexible sigmoidoscopy every five (5) years; or, one colonoscopy every ten (10) years or more often as Medically Necessary.

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

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

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

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

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

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

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

Tobacco Cessation Services. We will cover the cost of starting a tobacco cessation program per Enrollee per Benefit Year. We will also cover up to two 3-month supplies per year of tobacco cessation products including over-the-counter drugs when prescribed by a Participating Provider.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Member Payments for Cost-Sharing requirements and visit Our website at www.mvphealthcare.com for any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

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

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

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

- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

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

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

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

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

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

C. Limitations/Terms of Coverage.

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

SECTION VIII

Emergency Services and Urgent Care

Please refer to the Schedule of Member Payments for Cost-Sharing requirements and visit Our website at www.mvphealthcare.com for any Preauthorization or Referral requirements that apply to these benefits.

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

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

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

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

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest

Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**.

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

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

3. **Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be the Non-Participating Provider's charge.

   You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance.

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

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

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

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

SECTION IX

Outpatient and Professional Services

Please refer to the Schedule of Member Payments section for Cost-Sharing requirements and visit Our website at www.mvphealthcare.com for any Preauthorization or Referral requirements that apply to these benefits.

A. Advanced Imaging Services.
We Cover PET scans, MRI, nuclear medicine, and CAT scans.

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

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

D. Chemotherapy.
We Cover chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Certificate

E. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Certificate. Preauthorization is required if you use more than eight Chiropractic Treatment visits in any one Contract Year.

F. Clinical Trials.
We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

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

All other clinical trials, including when You do not have cancer or other life-threatening

disease or condition, may be subject to the Utilization Review and Appeal sections of this Certificate.

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

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

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

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

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

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

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

I. Infertility Treatment.
We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Such Coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services.

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultra sound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

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

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

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultra sound;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. Exclusions and Limitations. We do not Cover:

- In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs for an ovum donor or donor sperm;
- Sperm storage costs;
- Artificial insemination
- Cryopreservation and storage of embryos;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

J. Infusion Therapy.
We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office.

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

L. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for Coverage of inpatient maternity care.

We Cover the cost of renting or the purchase of one (1) breast pump per pregnancy or, if greater, one (1) per calendar year for the duration of breast feeding from a

Participating Provider or designated vendor.

M. Medications for Use in the Office and Outpatient Facilities.
We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

N. Office Visits.
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

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

P. 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. You must pay the Copayment, Deductible and/or Coinsurance that applies. Voluntary sterilization procedures for females are covered with no cost share. Voluntary sterilization procedures for males are subject to the deductible for members in plans that are title "MVP High Deductible" (an IRS HSA Qualified High Deductible Health Plan).

Q. **Office Surgery**. **Prior Authorization is not required when Surgery is performed in a Participating Provider's office**. We will provide benefits for Surgery and surgical care rendered in a Participating Provider's office. This includes surgery and surgical care for abortion and sterilization. You must pay the Copayment, Deductible and/or Coinsurance. Voluntary sterilization procedures for females are covered with no Cost Share. Voluntary sterilization procedures for males are subject to the deductible for members in plans that are titled "MVP High Deductible" (an IRS HSA Qualified High Deductible Health Plan).

R. Preadmission Testing.
We Cover preadmission testing ordered by Your Physician and performed in Hospital

outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

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

S. Rehabilitation Services.

We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to 30 visits per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:

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

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

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

T. Second Opinions.

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

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

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    - The second opinion must be given by a board certified Specialist who personally examines You.

- If the first and second opinions do not agree, You may obtain a third opinion.
- The second and third surgical opinion consultants may not perform the surgery on You.

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

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

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

If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:
- For the procedure with the highest Allowed Amount; and
- 50% of the amount We would otherwise pay for the other procedures.

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

- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

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

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

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

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

The telemedicine program is provided pursuant to a contract with American Well, and is a service that provides Participants with access to a national network of Providers for medical care in connection with a wide range of common, uncomplicated conditions and cases, including some mental health disorders. A member can access these services through online video and/or phone, using either desktop or mobile devices. More information can be found at myvisitnow.com.

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

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

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

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

SECTION X

Additional Benefits, Equipment and Devices

Please refer to the Schedule of Member Payments for Cost-Sharing requirements and visit Our website at www.mvphealthcare.com for any Preauthorization or Referral requirements that apply to these benefits.

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

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

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

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

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

        a. necessary to develop skills and abilities for the maximum reduction of physical or mental disability and for restoration of an individual to his or her best functional level, or to ensure that an individual under the age of 21 achieves proper growth and development;

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

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

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

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

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

2. **Benefits**.

- We will provide coverage for the evidence-based diagnosis and treatment of early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at birth and continuing until the child reaches age 21.
- The amount, frequency, and duration of treatment described in this section shall be based on medical necessity and is subject to prior authorization.
- We will provide coverage for applied behavior analysis when the services are provided or supervised by a licensed provider who is working within the scope of his or her license or who is a nationally board-certified behavior analyst.

- We will provide coverage for services under this section delivered in the natural environment (home or child care setting) when the services are furnished by a provider working within the scope of his or her license or under the direct supervision of a licensed provider or, for applied behavior analysis, by or under the supervision of a nationally board-certified behavior analyst.
- Except for inpatient services, if you are receiving treatment for an early developmental delay, we may require treatment plan reviews based on your needs, consistent with reviews for other diagnostic areas and with rules established by the department of financial regulation. We may review the treatment plan for children under the age of eight once every six months.
- Diagnosis and Treatment of Early Childhood Developmental Disorders are subject to the same Cost Share that is required for the diagnosis and treatment of other mental health conditions.
- You must pay the applicable Cost Share listed on your Schedule of Member Payments.
- We will not provide Benefits to an individual for services provided under an individualized family service plan, individualized education program, or individualized service program.

B. Diabetic Equipment, Supplies and Self-Management Education.
We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe:

1. **Equipment and Supplies.**
   We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:
   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - Insulin preparations
   - Automatic blood lance kit
   - Blood glucose kit
   - Blood glucose strips (test or reagent)
   - Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump

- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose reagent strips
- Glucose reagent tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, shall designate by regulation as appropriate for the treatment of diabetes.

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

2. **Self-Management Education.**
Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:
    - By a Physician, or other health care Provider authorized to prescribe under Vermont law, or their staff during an office visit;
    - Upon the Referral of Your Physician or other health care Provider authorized to prescribe Vermont law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
    - Education will also be provided in Your home when Medically Necessary.

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

C. Durable Medical Equipment.
We Cover the rental or purchase of durable medical equipment.

1. **Durable Medical Equipment.**
   Durable Medical Equipment is equipment which is:
   - Designed and intended for repeated use;
   - Primarily and customarily used to serve a medical purpose;
   - Generally not useful to a person in the absence of disease or injury; and
   - Appropriate for use in the home.

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

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

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

- Skilled nursing visits - up to 2 visits per day.
- Up to 210 days of inpatient Hospice Services in a Participating Hospice or Participating Hospital.
- Home health aide visits - up to 100 hours per month for personal care services only.
- Continuous care - up to 5 days or 120 hours for the Member's continuous care in his or her home.
- 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.
- Respite Care - up to 72 hours per month. Respite care relieves the Member's family or caregiver by providing temporary relief from the duties of caring for the Member's illness.

- Durable Medical Equipment
- Prescription drugs.

Hospice Services are available only once per each Member's lifetime. You must pay the Copayment, Deductible and/or Coinsurance that applies.

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

F. Inherited metabolic disease.
We Cover the diagnosis and medically necessary treatment of inherited metabolic disease. Preauthorization is required.

G. Ostomy Equipment and Supplies.
We Cover ostomy equipment and supplies prescribed or recommended by a Health Care Professional.

H. Prosthetics.

1. **External Prosthetic Devices.**
   We Cover prosthetic devices that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease.
   We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

   Eyeglasses and contact lenses are not Covered.

   We do not Cover shoe inserts.

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

   Coverage is for standard equipment only.

   We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if

the repair or replacement is the result of misuse or abuse by You.

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

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

   Coverage is for standard equipment only.

I. Craniofacial disorders.
We Cover the diagnosis and medically necessary treatment of Craniofacial disorders. Preauthorization is required.

SECTION XI

Inpatient Services

Please refer to the Schedule of Member Payments for Cost-Sharing and visit Our website at www.mvphealthcare.com for any Preauthorization or Referral requirements that apply to these benefits.

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

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;

- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

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

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

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

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

E. Inpatient Stay for Mastectomy Care.
We Cover inpatient services for Members undergoing a lymph node dissection,

lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

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

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

We Cover speech and physical therapy only when:

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

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

H. Skilled Nursing Facility.
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in “Hospital Services” above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 60 days per Plan Year for non-custodial care.

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

Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:
1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

J. Limitations/Terms of Coverage.

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

SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Member Payments for Cost-Sharing requirements and day or visit limits, and visit Our website at www.mvphealthcare.com for any Preauthorization or Referral requirements that apply to these benefits.

Mental Health Care and Substance Use Services can be obtained from both in network and out of network Providers, to the extent out-of-network benefits are available under the Plan. Out of network services may incur a higher out of pocket cost than in network services. For more information about Mental Health and Substance Use Providers, please call PrimariLink at 1-800-320-5895. You will be responsible for a primary care provider (PCP) Cost Share when You receive benefits for the treatment of mental health conditions or benefits for the treatment of alcohol or substance dependency that are identified in the "Primary Care Mental Health and Substance Abuse Procedure Codes" and rendered by a participating mental health provider, an approved facility for the treatment of mental health conditions, a participating licensed or certified substance

abuse provider, or an approved institution for the treatment of alcohol or substance dependency.

Mental Health Condition. Any condition or disorder involving mental illness or alcohol or substance use 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. The list of "Primary Care Mental Health and Substance Abuse Procedure Codes" is developed and maintained by the Vermont Department of Financial Regulation. You may obtain the list of codes upon request by calling the MVP's Customer Care Center at 1-888-687-6277:

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.

A. Inpatient 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 qualified pursuant to rules adopted by the secretary of human services or in an institution approved by the secretary of human services, that provides a mental health treatment program pursuant to a written plan and that is a licensed or certified substance abuse provider or an approved institution for the treatment of alcohol or substance dependency. The facility

must be a MVP Participating Provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

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

C. Outpatient Mental Health/Substance Use Services.

1. **Mental Health Services.** 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 Participating Provider. You must pay the Copayment, Deductible and/or Coinsurance that applies.

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

We will not provide benefits for the following services: adventure-based activities and wilderness programs that focus on education, socialization or delinquency.

SECTION XIII

Prescription Drug Coverage

Definitions. In this Section, the following terms shall have the meanings set forth below.

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

- The American Hospital Formulary Service Drug Information); or

- Thomson Micromedex DrugDex with a strength of recommendation at least Class IIa, Strength of evidence at least Category B and Efficacy at least Class IIa.

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

B. **A Participating Pharmacy** (this includes Retail, Mail or Specialty Pharmacies) is a pharmacy within MVP's Provider Network. You may get a list of Participating Pharmacies by calling CVS/caremark at 1-866-284-7134 or by viewing the list online at www.mvphealthcare.com.

C. **Allowable Charge** or **Allowable Amount** in this Section is the maximum amount or benefit that MVP will pay for a Covered Drug. The Allowable Amount shall be equivalent to the negotiated rate charged to MVP or at the pharmacy's usual and customary cost, whichever is less. Any Cost Share requirements shall be deducted from MVP's Allowable Charge in determining your benefit.

D. **Tier Structure**. MVP divides prescription drugs into 3 tiers to make it easier for you and your doctor to choose the most appropriate, lowest cost drug to treat your condition. Medications are placed into tiers based on their overall value to treat conditions. Each tier has a payment level for covered prescription drugs within that tier.

- Tier 1 is the lowest payment choice. It includes drugs selected for their effectiveness and utilization. Many generic drugs have a Tier-1 cost share.

- Tier 2 is a mid-range payment choice. It includes drugs selected for their effectiveness and utilization. Select brand drugs have a Tier-2 cost share.

- Tier 3 is the highest payment choice. It includes all other covered prescription drugs. It also includes those drugs that are not on the prescription drug formulary and new drugs that are being reviewed for inclusion on the formulary. This tier also includes all covered compounded prescriptions.

E. **Brand/Generic Difference**. If you have a covered prescription filled with a brand name drug, as defined by MediSpan® and there is a generic equivalent drug for that brand name drug, and you have not obtained an exemption based on the medical necessity for the brand name drug, you

must pay the Tier 1 Cost Share, plus the difference in cost between the generic and the brand name drug, not to exceed the cost of the drug, for each 30 day supply. The amount you pay for the difference between generic and brand will not apply to any maximum benefit, out of pocket maximum or deductible.

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

Conditions of Coverage. MVP will cover Covered Drugs, subject to the terms, conditions, and limits set forth in your Contract, that are:

A. Prescribed by a Provider who is authorized to write prescriptions; AND

B. Obtained from an MVP Participating Retail Pharmacy except that:

(i) You may use MVP's mail order pharmacy program to get prescription drugs by mail. To determine which drugs can be filled at mail order, refer to MVP's Formulary and look for the symbol that indicates they can be filled at mail order.

(ii) You must get prescription drugs listed on MVP's Specialty Pharmacy List at MVP's Specialty Pharmacy Vendor, upon prior authorization from MVP. You or your prescribing Provider may ask if a drug is listed on MVP's Specialty Pharmacy List by calling CVS/caremark at 1-866-284-7134. You can also view the list online. Go to www.mvphealthcare.com and follow the instructions.

Benefits Available. Prescription drugs other than contraceptives are covered up to a thirty (30) day supply ("Standard Supply"). You may get two vacation supplies per Benefit Year. This means that you may get up to an additional 30 day supply for vacation periods two times per Benefit Year. You must pay the applicable multiple payments for a vacation supply. Prescription contraceptive drugs and devices approved by the FDA are covered subject to any applicable Cost Share as per HRSA guidelines, and may be covered up to a 12 month supply. Vacation overrides are not allowed on specialty medications.

MVP will permit prescriptions to be filled by such retail pharmacy in the same manner and at the same level of reimbursement as they are filled by mail order pharmacies with respect to the quantity of drugs or days' supply of drugs dispensed under each prescription.

Retail Pharmacy Benefit. For covered prescription drugs that you get at an MVP Participating Retail Pharmacy, MVP will provide coverage subject to our Allowable Charge for up to a thirty (30) day supply per dispensing (Standard Supply) and subject to

the Cost Share requirements set forth on your Schedule of Member Payments. For any prescription drugs that you get at an MVP Participating Retail Pharmacy identified on the MVP Formulary as available through mail, MVP will provide coverage for up to a 90-day supply per dispensing by the Participating Retail Pharmacy, subject to the same Allowable Charge and Cost Share requirements as detailed in the Mail Order Pharmacy Benefit below. Note that mail order prescriptions may not be available at all MVP Participating Retail Pharmacies.

Mail Order Pharmacy Benefit. For covered prescription drugs listed on MVP's MVP Formulary as available through mail and that you get through MVP's Mail Order Pharmacy. MVP will provide coverage subject to our Allowable Charge for up to a ninety (90) day supply per dispensing (Standard Mail Order Supply) and subject to the Cost Share requirements set forth on your Schedule. You or Your prescribing Provider may get a copy of MVP's Formulary or ask if a prescription drug is available through MVP's mail order pharmacy program by calling CVS/caremark at 1-866-284-7134 or by contacting us online at www.mvphealthcare.com and following the instructions.

How to Use the Mail Order Program Through CVS/caremark Mail.

1. New Prescriptions. Ask your doctor to send Your prescription electronically when he/she prescribes a drug eligible for the mail order program, for up to a 90-day supply, to CVS/caremark mail order pharmacy. If You need the prescription immediately, have Your doctor also send in a 30-day prescription to Your local retail pharmacy. If you have questions, You may call CVS/caremark at 1-866-284-7134 or go online to www.caremark.com.

   Information on a Mail Order Pharmacy Form must be provided to the mail order pharmacy. You may ask for a copy of the Form by calling CVS/caremark at 1-866-284-7134. You may also visit MVP's web site at www.mvphealthcare.com to download the Form or ask for a copy. Complete and sign the Form and mail it to the address listed on the Form.

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

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

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

   (iii) Refills On line. You can order refills online at www.mvphealthcare.com.

Getting the MVP Formulary. You may only get drugs approved by MVP for mail order through the mail order pharmacy program or at approved retail pharmacies. You may get a copy of MVP's Formulary which designates drugs approved for mail order or ask whether a drug is an approved maintenance drug by calling CVS/caremark at 1-866-284-7134. You may also visit MVP's web site at **www.mvphealthcare.com** and enter the name of a drug to find out if it is approved for mail order or to ask for a copy of the list of drugs approved for mail order.

Changes to the MVP Formulary. MVP notifies Providers, in writing, when we add new drugs to the list of drugs approved for mail order or delete previously approved drugs from the list of drugs approved for mail order. MVP gives at least 90 days prior written notice to Enrollees who use a drug on the list when we delete the drug they use from the list. MVP also gives notice of new drugs added to the list in MVP's member newsletter or other communication. You may also file a claim for Mail Order benefits by following the instructions in Paragraph 8 of this Section.

Specialty Pharmacy Benefit. This is not the same as the mail order benefit. For covered prescription drugs listed on MVP's Formulary to be obtained through CVS Specialty Pharmacy, MVP will provide coverage subject to our Allowable Charge for up to a thirty (30) day supply per dispensing (Standard Supply) and subject to the Cost Share by tier as set forth in the Formulary.

How to Use the Specialty Pharmacy Vendor Program.

1. **New Prescriptions**. If your prescription is designated as obtained through CVS Specialty Pharmacy on MVP's Formulary, your doctor should send the prescription electronically to the Specialty Pharmacy Vendor. Once the vendor gets your prescription, an account will be set up. The vendor may call you for shipping and billing information or you may also contact the vendor.

2. **Refills**. When you need to refill a prescription, you may call the Specialty Vendor to arrange for a refill and provide updated shipping and billing information. For details on how to refill by phone go to www.mvphealthcare.com. The Specialty Pharmacy Vendor may also proactively contact you with refill reminders.

3. **Getting the MVP Formulary**. You may only get specialty drugs through the MVP's Specialty Pharmacy Vendor or at approved retail pharmacies. You may get a copy of MVP's Formulary which lists drugs to be obtained through MVP's Specialty Pharmacy Vendor by calling CVS/caremark at 1-866-284-7134. You may also visit MVP's web site at www.mvphealthcare.comand enter the name of a drug to find out if you must get it through MVP's Specialty Pharmacy Vendor.

4. **Changes to the MVP Formulary**. MVP lets Providers know when we add new

drugs to the MVP Formulary that you must get through MVP's Specialty Pharmacy Vendor and when we delete drugs from the list. MVP gives at least 90 days prior written notice to Enrollees who use a drug on the list when we are going to delete the drug they use from the list. MVP also gives notice of new drugs added to the list in MVP's member newsletter or similar communication.

Prescriptions cannot be refilled until at least seventy-five percent (75%) of the original prescription (or a subsequent refill) has been used. Drugs with quantity limits are not subject to this rule.

If your prescribed dosage is not commercially available, you may have to make more than one payment. For example, if your prescription drug is available only in 20 milligram and 30 milligram doses and your Provider prescribes 50 milligrams, you may have to make one payment for the 20 milligram dose and a second payment for the 30 milligram dose.

5. MVP Prescription Drug Formulary.

MVP's Pharmacy and Therapeutics Committee, which includes physicians, pharmacists, and other health care professionals, evaluates FDA approved drugs and devices and determines which drugs MVP will approve for coverage, their Tier status and any utilization management requirements. The list of approved drugs is called the Formulary. Drugs that MVP has not approved for coverage are called Non-Formulary Drugs or Excluded Drugs. MVP's Pharmacy and Therapeutics Committee reviews and must approve new drugs prior to such new drugs being added to the Formulary.

Getting Formulary Information. At any time, you may get a copy of the Formulary, ask whether a drug is listed on the Formulary, or ask if a drug requires Prior Authorization by calling CVS/caremark at 1-866-284-7134. You may also visit MVP's web site at www.mvphealthcare.com and enter the name of a drug to find out if it is listed on MVP's Formulary or to ask for a copy of the Formulary.

A. **Changes to the Formulary**. MVP lets Providers know, in writing, when we add new drugs to the Formulary, or make changes to the tier status of a drug on the MVP Formulary. MVP gives at least 90 days prior written notice to Enrollees who use a drug on the Formulary when we are going to change the tier status of the drug they use on the Formulary. MVP also gives notice of new drugs added to the Formulary in MVP's member newsletter or similar communication.

6. Prior Authorization Requirements. In some cases, MVP may require that your prescribing Provider satisfy MVP Prior Authorization Requirements before a prescription is filled at the pharmacy. Drugs that must be Prior Authorized before

they are filled are identified on the Formulary. They are also listed by therapeutic categories on our Formulary. MVP notifies Providers, in writing, when we change these requirements. New FDA approved prescription medications are subject to Prior Authorization for a minimum of six (6) months. All compounded prescriptions over $100 require Prior Authorization. Compounds containing non-FDA approved drugs may also require Prior Authorization.

Changes to Prior Authorization Requirements or Quantity Limits.

A. MVP lets Providers know, in writing, when we change Prior Authorization or quantity limit requirements for a Formulary Drug. MVP gives at least 90 days prior written notice to Enrollees who use a drug that requires Prior Authorization or has quantity limits when we are going to change the requirements or limits to such Formulary Drug. MVP also provides such notice in MVP's member newsletter or similar communication.

B. When prior authorization is required, your Provider must submit a request for coverage to MVP that includes what is being requested, the intended use, and clinical information relating to your treatment of the requested use. Forms for this are available to your Provider on the MVP website. Prior authorization and prescription drug override requests can be submitted via fax to 1-800-280-7346, or submitted online at www.mvphealthcare.com.

C. If MVP does not provide the required 90-day prior written notice, the prescription remains valid; and if it is not possible to timely obtain a prescription consistent with the changed requirement, coverage will be provided for an interim supply of the drug and, if relevant, any additional supply for the number of days that is medically necessary to safely discontinue the drug for no more than ninety (90) days or until the prescribing Provider can order a new prescription; or, if necessary, until the grievance and independent review process can be initiated and completed. A managed care organization shall not be required to cover an interim supply if:

(i) Enrollee's prescribing Provider explicitly consents to the change; or

(ii) the drug has been determined to be unsafe for the treatment of the Enrollee's disease or medical condition, has been discontinued from coverage for safety reasons or cannot be supplied by or has been withdrawn from the market by the drug's manufacturer.

You may also file a claim for benefits by following the instructions in Paragraph 7 of this section.

D. As long as a drug continues to be prescribed for an Enrollee and is considered safe for the treatment of the Enrollee's condition, an Enrollee who has previously been prescribed an otherwise covered drug that is the subject of prior authorization, other review and/or denial shall be entitled to coverage for a supply of the drug sufficient to continue treatment through the following time periods, as well as any additional supply that is medically necessary to safely discontinue the drug if the denial is ultimately upheld:

(i) until the prior authorization or other review process has been completed;

(ii) if applicable, until all required internal expedited grievances have been exhausted; and

(iii) until the independent external review decision is issued, if expedited independent external review is requested within twenty-four (24) hours of the receipt of the final grievance decision and notice of appeal rights by the Enrollee, and expedited independent external review is conducted in accordance with the time frames specified by law.

E. MVP will grant an exception to a pharmacy requirement and will provide coverage on the same terms as if the pharmacy requirement was not in place if your prescribing health care Provider certifies, based on relevant clinical information about you and sound medical or scientific evidence or the known characteristics of the drug, that the alternative treatment:

(i) has been ineffective or is reasonably expected to be ineffective or significantly less effective in treating your condition such that an exception is medically necessary; or

(ii) has caused or is reasonably expected to cause adverse or harmful reactions to you.

F. If MVP denies the request related to a prescribed drug you will be notified in writing with a detailed explanation of:

(i) the information required to meet MVP policy criteria and, if necessary, to file an appeal of the decision by you or your Provider;

(ii) how to request an appeal and provide clinical or other required information to MVP;

(iii) where information must be submitted, including telephone, fax and other contact information for MVP;

(iv) under what circumstances and how an interim supply of medication may be obtained; and

(v) the fact that a denial of a request for coverage is a determination subject to independent external review under Vermont law, and any applicable notice required by the state of Vermont with a reference to descriptions of the independent external review process.

G. **Exception to a Pharmacy Requirement**. If a Prescription Drug is not on our Formulary, you, your designee or your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug. The request should include a statement from your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under our standard or expedited Formulary exception process, you are entitled to an external appeal as outlined in the External Appeal section of this Contract. Visit our website at www.mvphealthcare.com or call the number on your ID card to find out more about this process. Please see your Schedule of Benefits for any limits and cost-sharing that applies to this benefit.

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

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

Exclusions. In addition to all other terms, conditions, and limits in this Contract, MVP will not provide benefits for the following items:

A. Non-Medically Necessary drugs.

B. Experimental or Investigational Drugs (unless directed to be covered pursuant to Independent External Appeal). This term means drugs that are either not generally accepted by informed health care Providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by medical or scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed. However, we will provide benefits, to the extent required by law, to cover routine costs for off-label drugs used in connection with approved cancer clinical trials. See paragraph 1.A within this Section Thirteen.

C. Compounded prescriptions (prescriptions that require the mixing of two or more ingredients but do not contain at least one legend ingredient with a valid NDC number) or other drug formulations compounded, for which compounding is not Medically Necessary or for which commercially available products are available.

D. Drugs that require a prescription but have an exact equivalent that is available over the counter, unless the prescription is Medically Necessary.

E. Drugs used in connection with a medical service that is not covered under your Contract.

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

G. Nutritional Supplements (prescription or over the counter).

H. Medications which are primarily intended to improve your appearance or lifestyle, subject to Medical Necessity review, including but not limited to:

(1) Rogaine and other products for hair growth and/or restoration;
(2) Retinoic acid and similar products for the prevention of the wrinkling of the skin; and
(3) Agents affecting the color, tone, pigmentation or texture of the skin.
(4) Caffeine cessation products.

I. Vaccines, immunizations, and medications received by injection that are not self- administered, except as determined otherwise by MVP (see Your Contract for covered vaccines and immunizations).

J. Prescription drugs not approved by the FDA of the United States for the indication prescribed and/or the duration, frequency or dosage prescribed and/or not recommended in the below established reference compendia. MVP, however, will not exclude coverage of drugs approved by the FDA for the treatment of certain types of cancer on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. Provided, however, that such drug has been recognized for treatment of the specific type of cancer for which the drug has now been prescribed in the below established reference compendia. MVP will also evaluate coverage for medications for Non-FDA approved indications if the drug has been recognized as safe and effective in the below established reference compendia:

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

K. Immunizations, vaccinations, oral drugs or other services taken solely as a precaution prior to travel within or outside the United States.

L. Any prescription that is illegally obtained.

M. FDA approved prescription products that are only approved for relief of symptoms related to the common cold.

N. Over the Counter medications except in cases in which a prescription is obtained pursuant to Federal Health Care Reform coverage under the Contract.

How to file a Claim for Retail Pharmacy Benefits, Mail Order Pharmacy Benefits or Specialty Pharmacy Benefits.

STEP ONE: Have your Provider complete any required Prior Authorization requirements and send a prescription electronically to the appropriate pharmacy (retail, mail order or specialty).

STEP TWO: Provide Your MVP ID card to the MVP Participating Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy. If the pharmacist fills Your prescription and charges You in accordance with Your prescription drug benefit, then You will have completed the claim filing process. If the pharmacist does not fill Your prescription or in Your opinion has not properly applied Your benefit, then You must process to **STEP THREE** to complete the claim filing process.

STEP THREE: If the pharmacist does not fill your prescription or in your opinion has not properly applied your benefit, then you may do the following:

(1) You may decline to have the pharmacist fill your prescription and submit a Prior Authorization request directly to MVP, or

(2) You may elect to have the prescription filled (pay the full pharmacy charges) and submit a Claim for benefits. In this case, if the claim is approved, you will be reimbursed up to the allowed amount under your pharmacy benefit minus any cost share requirements. Claims will be subject to all formulary utilization rules, including prior authorization, step therapy and quantity limits.

How to file a Claim for Mail Order Pharmacy Benefits. To file a Claim you, your designee or your prescribing Provider, must mail a completed claim form to the address listed on the form. To complete the form, you must fill in all required information; you must have the dispensing pharmacist sign the form; and, you must attach the original receipt for the prescription to the form. You may get claim forms by calling CVS/caremark at 1-866-284-7134 or by visiting MVP's website. Claims must be properly submitted within one (1) year from the date the prescription was filled, or as soon as reasonably possible thereafter. MVP will make a decision on your Claim within the timeframe set forth in your Contract.

How to file a Prior Authorization request for Pharmacy Benefits. Generally, Prior Authorization requests for Pharmacy Benefits will be considered urgent. To request Prior Authorization for a medication, you, your designee or the prescribing Provider must fax a request to MVP at 1-800-280-7346. MVP will make a decision on your Prior Authorization request within the timeframe set forth in your Contract.

How to file an Urgent Prior Authorization request for Pharmacy Benefits. To file an Urgent Prior Authorization request you, your designee or your prescribing Provider must mark the faxed request “Urgent”. MVP will make a decision on your Urgent Care Claim within the timeframe set forth in your Contract. See “Urgent Matters” in Section Six “Utilization Management” of the Contract.

Restricted Enrollees. If MVP determines that you have received contraindicated,

excessive or duplicative pharmacy services, MVP may impose one or more of the following restrictions on the provision of benefits to you under your Contract:

A. MVP will restrict benefits to Covered Drugs obtained from one or more designated Participating Pharmacies.

B. MVP will restrict benefits to Covered Drugs prescribed by one or more designated Providers.

Before MVP will impose any of the above restrictions, we will give you at least ninety (90) days prior written notice. The notice will specify the effective date and scope of the restrictions, explain the reasons for the restrictions, your right to file a complaint and/or appeal and the procedures for filing a complaint or appeal. You may request a copy of MVP's protocols regarding contraindicated, excessive or duplicative services by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). Nothing in this Subsection shall limit MVP's ability to terminate your coverage under your Contract for any of the reasons set forth in your Group Contract or Contract.

Other Provisions. All of the terms, conditions, and limits of your Certificate also apply to this Rider, except where changed by this Rider.

Your group has added this Rider to your Certificate. In addition to the paragraph 14 of this Rider, this Rider may be deleted, at your group's option, upon renewal of the group's contract with MVP.

SECTION XIV

Exclusions and Limitations

No coverage is available under this Certificate for the following:

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.

Blood Products. We will not provide Benefits for charges for whole blood, blood plasma, packed blood cells, or other blood products or derivatives if a volunteer blood replacement program is available. If a program is not available, we will provide benefits if billed by a Participating Provider. We will provide Benefits for autologous blood donations when they are Medically Necessary. We will provide Benefits for administration and processing charges.

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

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

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

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.

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.

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

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

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

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.

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.

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

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.

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.

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.

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

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

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

Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

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.

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

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

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

Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, We will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

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

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

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.

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

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

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

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.

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

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.

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.

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

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.

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

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.

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.

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

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.

Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

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

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

Vision Services.

We do not Cover the examination or fitting of eyeglasses or contact lenses.

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

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

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

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

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

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

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

- Any services provided by a private duty nurse.

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

- Any items that you take home from the Hospital.

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.

SECTION XV

Claim Determinations

A. Claims.

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

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

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

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

SECTION XVI

Grievances and Independent External Review

1. **Grievances**. A grievance means a written or verbal complaint submitted to MVP by or on behalf of an Member expressing dissatisfaction regarding the availability, delivery or

quality of health care services, claims payment, handling or reimbursement for health care services, or expressing dissatisfaction regarding matters governed by or related to this Contract, including requests that MVP change decisions that services are not Medically Necessary or are not Covered Services. You, your designated representative (such as a family member, friend, or lawyer), or a Provider acting on your behalf, may submit a grievance. You must call MVP at 1-800-348-8515 in order to designate a representative. If English is not your primary language, you may call MVP's Customer Care Center for help 1-800-348-8515 or to get information in your primary language about how to file a grievance and how to participate in the grievance process. You may also call either the Vermont Department of Financial Regulation's Consumer Service at 1-800-964-1784 or the Vermont Office of Health Care Advocate at 800-919-7787 for assistance. If you are unable to file a written grievance, you may notify MVP of a grievance orally or through another alternative mechanism. MVP shall be responsible for documenting such grievances and providing copies to you for your use, or the use of your appointed' representative. If you have a disability, you shall be provided with reasonable accommodations for filing grievances and for participating in the grievance process. Your decision as to whether or not to submit a grievance has no effect on your rights to any other benefits under this Contract. At your request and free of charge, MVP will, within two (2) business days, provide you with reasonable access to and copies of documents, records, and other information relevant to your grievance. MVP shall identify to you any clinical expert(s) whose advice was obtained on behalf of the managed care organization in connection with a an adverse benefit determination without regard to whether the advice was relied upon in making the determination 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 who has the necessary education and experience to resolve the matter. First level grievances are reviewed by persons who were not involved in making the initial decision and who are not subordinate to such persons.

(b) Second Level Grievances. Second level grievances are reviewed by a panel comprised of MVP senior medical and administrative staff and/or board members with the necessary education, training and experience to resolve the matter. The medical staff participating in at least one level of grievance review will have appropriate training and experience in the field of medicine involved in the particular grievance, and will be actively practicing in the same or similar specialty who typically treats the condition or provides the services that is the subject of the grievance. Alternatively,

MVP may engage independent organizations to provide medical specialists practicing in the same or similar specialty as consultants for a particular grievance. Second level grievances are reviewed by persons not involved in making the initial decision or the first level grievance decision and who are not subordinate to such persons. Further information about the panel reviewing your grievance is included in MVP's written response to the grievance.

3. First Level Grievances - General Information.

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

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

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

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

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

f. Time Limit for Submitting a First Level Grievance. You must submit a grievance within 180 days of receiving our decision regarding the matter that is the subject of the grievance. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral grievance by calling MVP at 1-800-348-

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

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

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

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

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

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

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

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

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

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

ii. a physician with knowledge of your medical condition determines that a concurrent review or prior authorization request is urgent.

MVP shall notify you and your treating provider (if known) of our determination (whether adverse or not) as expeditiously as your medical condition requires, but not later than twenty-four (24) hours after receipt of the grievance.

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

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

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

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

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

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

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

3. any grievance designated as urgent by your health care provider or by you.

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

A. In the case of a grievance relating to a non-urgent, pre-service request, MVP shall notify you and the your treating provider (if known) of our determination (whether adverse or not) as expeditiously as your medical condition requires, but not later than fifteen (15) calendar days after receipt of the grievance.

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

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

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

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

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

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

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

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

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

B. Commence a Voluntary Second Level Grievance with MVP as described in paragraphs 11-16 below. If you do so, your time to commence court

action will not start until you receive MVP's response to the Voluntary Second Level Grievance.

9. Additional Provisions.

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

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

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

10. Voluntary Second Level Grievances - General Information.

A. 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.

B. MVP Shall:

(i) provide you the right to meet with one (1) or more of the reviewers, at your request, before a final determination is made on the voluntary second level grievance.
(ii) provide for either an in-person meeting or a telephone meeting; however, if it is inconvenient for you to participate in the manner offered by MVP, the other method of meeting must be made available to you.
(iii) ensure that your treating provider(s) and any other person(s) requested by you is (are) entitled but not required to participate in such a meeting or call.
(iv) ensure that the meeting date shall be arranged in consultation with you.
(v) not unreasonably deny a request for postponement of the review made by you.
(vi) ensure that the right to have a voluntary second level grievance considered shall not be made conditional on your appearance either in person or by telephone at such a meeting.
(vii) For any grievances relating to an adverse benefit determination, we shall promptly authorize and/or otherwise arrange for coverage for

any covered service that had been denied or restricted and as to which a reversal has been made by its reviewers under this section.

C. Submitting a Voluntary Second Level Grievance. You must submit this grievance within 90 days of receiving our decision issued in response to the first level grievance. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral grievance by calling MVP at 1-800-348-8515. You may submit a written grievance to MVP Health Plan, Inc., 625 State Street, Schenectady, New York 12305. Second level grievances are reviewed by a panel. You also have the right to appear before the panel to discuss your grievance. If you cannot appear before the panel in person, you may communicate with the panel by conference call or other appropriate technology.

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

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

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

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

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

A. In the case of a voluntary second-level grievance relating to an urgent, pre-service request, and in cases where:

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

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

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

(ii) a physician with knowledge of your medical condition determines that a concurrent review or prior authorization request is urgent. MVP shall notify you and your treating provider (if known) of our determination (whether adverse or not) as expeditiously as your medical condition requires, but not later than twenty-four (24) hours after receipt of the voluntary second-level grievance. You will be notified of our decision by telephone and in writing.

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

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

A. In the case of a voluntary second-level grievance relating to a non-urgent, pre-service request, MVP shall notify you and your treating provider (if known) of our determination (whether adverse or not) as expeditiously as your medical condition requires, but not later than fifteen (15) calendar days after receipt of the grievance.

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

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

A. In the case of a voluntary second-level post-service grievance, MVP shall notify you and your treating provider (if known) of our determination (whether adverse or not) within a reasonable period of time but not later

than fifteen (15) calendar days after receipt of the grievance.

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

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

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

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

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

16. Independent External Review.

A. You have the right to an "independent external review" of an appealable decision 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 ("IRO") are selected by the DFR and must not have any conflict of interest associated with the review.

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

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

You may have the right to an expedited external review if the subject of the review concerns an emergency medical condition, emergency services, or urgently needed care. The timeframes for expedited external reviews are shorter than the timeframes for standard external reviews. You may request an expedited external appeal even if your internal appeal was non-expedited.

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

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

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

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

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

17. **Effect of Review Organization's Decision; Coverage**. The decision of the review organization is binding on MVP, the member, the provider, and the group. 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 Contract. We will not provide benefits for any service that is not a Covered Service. In addition, this section does not change any Cost Sharing responsibilities.

18. Assistance.

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

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

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

Office of Health Care Advocate
264 North Winooski Avenue
Burlington, CT 05402
800-884-1955 or 802-863-2316

SECTION XVII

Utilization Review

This Contract requires concurrent review and prior authorization by MVP before you receive certain Covered Services. All other services are subject to retrospective review. MVP's approval of services through concurrent review, or prior authorization are not a guarantee of benefits. MVP may deny benefits in cases where there is material misrepresentation or fraud by a Member, and as otherwise permitted by law.

1. **Urgent Matters**. Requests and claims for Retrospective Review are excluded from this paragraph 1.

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

   B. In cases where:

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

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

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

      (c) a physician with knowledge of your medical condition determines that a concurrent review or prior authorization request is urgent, if all necessary information is received at the time of the request, we will notify you and your Provider, by telephone and in writing, of our decision within 48 hours

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

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

A. When Prior Authorization is Required.

i. For In-Network Services. Check with your MVP Participating Provider. He or she will ask for Prior Authorization from MVP on your behalf when it is needed for In-Network services. MVP makes a list of these services available to Participating Providers. Go to MVP's website at www.mvphealthcare.com if you would like to see the list of In-Network services that need Prior Authorization. You may also call MVP's Customer Care Center at 1-800-348-8515 to ask if a service is on the list.

ii. For Out-of-Network Services. You must get Prior Authorization from MVP for yourself when the services are Out-of-Network. Go to MVP's website at www.mvphealthcare.com for a list of Out-of-Network services that require you to get Prior Authorization. You may also call MVP's Customer Care Center at 1-800-348-8515 to ask if a service is on the list.

B. If all necessary information is received at the time of the prior authorization request, we will notify you and your provider, by telephone and in writing, of our decision as soon as possible but no later than two (2) business days from receipt of the request. If all necessary information is not received at the time of the prior authorization request, we will notify you

and your Provider of any missing information that is needed to decide the request. You and your Provider will have 45 days from the receipt of our notice to provide us with the missing information. MVP will make our decision and notify you and your Provider, in writing, within two (2) business days of receipt of the information or the expiration of the time allowed to provide the missing information, whichever is earlier.

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

4. **Retrospective Review**. Retrospective review means our review, after services have been provided to you, to determine whether such services are Medically Necessary Covered Services. We will review information about your medical condition and the services provided to you. If all necessary information is received at the time of the request for retrospective review, we will notify you of any adverse determination, in writing, within 30 days after our receipt of the request. If all necessary information is not received at the time of the request for retrospective review, we will notify you and your Provider within 5 days after our receipt of the request of any missing information that is needed to decide the request. You and your Provider will have 45 days from receipt of our notice to provide us with the missing information. In such cases, we will notify you of any adverse determination, in writing, within 30 days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide us with the missing information, whichever is sooner. Except in cases of missing information, MVP's time to conduct retrospective review shall not exceed a total of thirty (30) days.

5. **Emergency or Urgent Care Services**. You, your Provider, or a family member or other representative must contact us at 1-800-348-8515 within 48 hours, or as soon as reasonably possible, after receiving Emergency Services or Urgent Care Services that result in an inpatient admission so that MVP can coordinate your follow up care.

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

7. Appeal Assistance.

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

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

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

Office of Health Care Advocate
264 North Winooski Avenue
Burlington, VT 85402
Toll free: 1-800-917-7787

SECTION XVIII

Coordination of Benefits

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

A. Definitions.

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

2. **"Plan"** is other group health coverage with which We will coordinate benefits. The term "plan" includes:

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

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

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

B. Rules to Determine Order of Payment.

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

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

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

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

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

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

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

C. Effects of Coordination.
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

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

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

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

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

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

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

SECTION XIX

Termination of Coverage

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

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

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

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

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the month in which the Child turns 26 years of age.

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

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

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

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

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

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

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

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

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

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

Termination section of this Certificate for Your right to conversion to an individual Contract.

SECTION XX

Extension of Benefits

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

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

A. When You May Continue Benefits.

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

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

B. Termination of Extension of Benefits.

Extended benefits will end on the earliest of the following:

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

C. Limits on Extended Benefits.

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends; or

- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

SECTION XXI

Continuation of Coverage

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

A. Qualifying Events.

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

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

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

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

- Death of the Subscriber.

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

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

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

Continued coverage under this section will terminate at the earliest of the following:

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

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

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group the

required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

SECTION XXII

Conversion Right to a New Contract after Termination

A. Circumstances Giving Rise to Right to Conversion.

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

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

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

3. **On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Certificate because of the death of the Subscriber,

the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

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

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

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

7. **Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under the Termination of Coverage section of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.

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

C. The New Contract.
We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four (4) Contracts offered by Us. The coverage may not be the same as Your current coverage. If You are age 65 or over and enrolled in Medicare, We will also offer You contracts issued to Medicare-enrolled individuals.

SECTION XXIII

General Provisions

1. Agreements Between Us and Participating Providers.

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

2. Assignment.
You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation. Any assignment of benefits or legal claims based on a denial of benefits by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

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

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

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

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

7. Continuation of Benefit Limitations.
Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Entire Agreement.

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

9. Furnishing Information and Audit.
The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

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

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

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

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

13. Notice.

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

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

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

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

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

18. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

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

20. Third Party Beneficiaries.

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

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

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

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

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

25. Who Receives Payment under this Certificate.
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either the Subscriber or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Certificate for more information about surprise bills.

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

27. Your Medical Records and Reports.
In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our

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

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

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

28. Your Rights.
You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

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

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

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

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