MVP HEALTHY NEW YORK

MVP Health Plan Inc.
625 State Street, P.O. Box 2207, Schenectady, NY 12301
518-370-4793

INDIVIDUAL SUBSCRIBER CONTRACT

This is your Healthy New York Contract with MVP Health Plan, Inc., (hereinafter "MVP"). It entitles you and your covered dependents, if any, to the benefits set forth in the Contract. Coverage begins on the effective date stated on your identification card. This Contract will continue unless it is terminated for any of the reasons described in the Contract.

Notice of 10-Day Right to Examine Contract

You have the right to return this Contract. Examine it carefully. You may return it and ask us to cancel it. Your request must be made in writing within ten (10) days of the date you receive this Contract. We will refund any premium you paid. If you return this contract, we will not provide you with any benefits.

IMPORTANT NOTICE:

Except as stated in this Contract, all services must be provided, arranged or authorized by your Primary Care Physician (“PCP”). You must contact your PCP in advance in order to receive benefits, except for emergency care and for certain obstetric and gynecological care.

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SECTION ONE - INTRODUCTION

1. **Healthy New York Program.** This Contract is being issued pursuant to a special New York State program designed to make health insurance available to uninsured employees whose employers do not provide group health insurance coverage. We will enroll you in the Healthy New York Program if you meet the eligibility requirements established by New York State and you will be entitled to the health care services described in this Contract. Each year, you must submit to us a certification of continued eligibility and necessary supporting documentation at least ninety (90) days prior to your annual renewal date. At least forty-five (45) days prior to the date that you must submit your certification of continued eligibility, we will send you a notice of your obligation to re-certify.

2. **Health Care Through an HMO.** This contract provides coverage through an HMO. In an HMO, all care must be Medically Necessary and provided and/or arranged by your PCP or authorized by the Health Plan (MVP). Except for emergency care and for certain obstetric and gynecological services, there is no coverage for care you receive without the approval of your PCP or MVP. In addition, coverage is only provided for care rendered by a Participating Provider, except in an emergency or when MVP refers you to a Non-Participating Provider. A Participating Provider is a professional provider or facility that has an agreement with us to provide health services to members.

   It is your responsibility to select a PCP from the list of PCPs when you enroll for this coverage. You may change your PCP by contacting an MVP Member Services Representative at (888) MVP MBRS. You may also submit the change to MVP via the Internet at www.mvphealthplan.com. The PCP you have chosen is referred to as "your PCP" throughout this Contract.

   In addition, each female member should select a Participating Provider of obstetric and gynecological services. You may access primary and preventive gynecological services, care related to a pregnancy or care for an acute gynecological condition directly from this selected Participating Provider.

3. **Words We Use.** Throughout this Contract, MVP will be referred to as "we", "us" or "our". The words "you", "your" or "yours" refer to you, the person to whom this Contract is issued and who is named on the identification card.

SECTION TWO - WHO IS COVERED

1. **Who is Covered Under this Contract.** You, the Subscriber to whom this Contract is issued, are covered under this Contract. If you selected other than individual coverage, the following members of your family may also be covered:

   a. Your spouse, unless you are divorced or the marriage has been annulled.

b. Your unmarried children who are under nineteen [19] years of age.

c. Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness or developmental disability, as defined in the New York Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which coverage under the Contract would otherwise have terminated. A physician must certify to the child's disability.

d. Your unmarried children who are under twenty-three [23] years of age and who are enrolled as full-time students at an accredited institution of learning. If a child covered under this provision is required to take a medical leave of absence from school due to illness, coverage for the child under this Contract will continue for up to one year beyond the last day of attendance in school or until the child's coverage would otherwise terminate under this Contract, whichever occurs first. For coverage under this Contract to continue for a full-time student while on a medical leave of absence, a physician licensed in the State of New York must certify to us in writing that the medical leave of absence from school is medically necessary.

2. **Other Children Covered Under this Contract.** In addition to your natural children, the following other children may also be covered under this Contract:

a. A legally adopted child;

b. A stepchild who is dependent upon you for support;

c. A child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final.

3. **Newborn Child.** If you have a type of coverage that would cover a newborn, your newborn child will be covered at birth, provided that you notify us within thirty (30) days of the birth by completing an enrollment form to add your child to your coverage. If you are changing the type of coverage in order to cover a newborn child, then you must complete an enrollment form within thirty [30] days of the birth to include your child and pay any additional premium that might be required. If your child gives birth, your newborn grandchild will not be covered.

4. **Adopted Newborns.** If you have a type of coverage that would cover a newborn, or switch to a type of coverage that will cover a newborn, we will cover a proposed adoptive newborn from the moment of birth if you, the adoptive parent, take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to Section 115-C of the New York State Domestic Relations Law within thirty [30] days of the infant's birth. However, we will not provide coverage for the initial hospital stay of the adopted newborn if one of the child's natural parents has coverage available to cover the newborn's initial hospital stay. We will also not provide coverage for the newborn if a notice of revocation of the adoption has been filed or one of the natural parents' revokes consent to the adoption.

SECTION THREE – HOSPITAL BENEFITS

The following benefits are subject to copayments, coinsurance and/or deductibles, as indicated in the attached Schedule of Benefits.

1. **Hospital Defined.** A Hospital means a facility which is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured 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; if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of the United States Public Law 89-97 (42 USC 1395x**[**k**]**); 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, education or rehabilitory care.

2. **Care In a Hospital.** You are covered for Medically Necessary care as an inpatient in a Hospital if all the following conditions are met:

a. Except if you are admitted to the Hospital in an Emergency or MVP has arranged for your admission to a Non-Participating Hospital, the Hospital must be a Participating Provider.

b. Except in an emergency, your admission is authorized in advance by your PCP or another Participating MVP Physician. . When you are admitted as an inpatient through the emergency room of a hospital, you should call us within 48 hours of admission, or as soon as is reasonably possible so that we can coordinate your care.

3. **Covered Inpatient Services.** Covered inpatient services include the following:

a. Daily room and board, including special diets;

b. General nursing care;

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

d. Diagnostic and therapeutic items, such as drugs and medication, sera, biologicals, vaccines, intravenous preparations;

e. Dressings and casts;

f. Blood and blood products furnished in connection with surgery or inpatient hospital services;

g. Services, supplies and equipment in connection with oxygen, anesthesia, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;

h. Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this Contract.

4. **Maternity Care.** Other than for perinatal complications, we will provide coverage for inpatient maternity care in a hospital for the mother and inpatient newborn care in a hospital for the infant, if covered under this contract, for at least forty-eight (48) hours following a delivery and at least ninety-six (96) hours following a Caesarean Section. If the mother chooses to be discharged earlier than forty-eight (48) hours after delivery (ninety-six (96) hours in the case of Caesarean Section) and requests a home care visit before the end of those time frames, then coverage will include a home care visit. The home care visit shall not be subject to deductibles, coinsurance or copayments.

Maternity care shall include the services of a midwife licensed pursuant to and practicing consistent with New York Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to New York Public Health Law. However, we will not pay for duplicative routine services actually provided by both a licensed midwife and physician. Maternity care shall also include parent education, assistance and training in breast and bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

5. **Mastectomy Care.** Inpatient hospital care includes coverage of an inpatient hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. After consulting with you, your attending physician will determine the length of your stay. We also provide coverage for breast prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

6. **Limitations and Exclusions.**

a. We will not provide any benefits for any day that you are out of the Hospital, even for a portion of the day. We will not provide benefits for any day when inpatient care was not Medically Necessary.

b. Benefits are paid in full for a semi-private room. If you are in a private room at a Hospital, you must pay the difference between the cost of a private room and a semi-private room unless the private room is Medically Necessary and ordered by your physician.

c. We will not pay for non-medical items such as television rental or telephone charges.

d. We will not pay for medications, supplies and equipment that you take home from the facility.

SECTION FOUR -- MEDICAL BENEFITS

The following benefits are subject to copayment, coinsurance and/or deductibles, as indicated in the attached Schedule of Benefits.

1. **Your PCP Must Provide and/or Arrange all In-Plan Medical Services.** Except in an emergency or for certain obstetric and gynecological services, you are covered for the medical services listed below only if your PCP provides and/or arranges for the services. You are entitled to medical services provided at one of the following locations:

   a. Your PCP's office.

   b. Another Participating Provider's office or a facility if your PCP determines that care from that provider or facility is appropriate for the treatment of your condition, and provides you with the requisite referral or Plan authorization.

   c. The outpatient department of a Participating Hospital.

   d. As an inpatient in a Participating Hospital.

2. **Covered Medical Services.** We will pay for the following medical services:

   a. General medical and specialist care, including consultations and referrals.

   b. Preventive health services and physical examinations. We will pay for preventive health services including:

      i. Periodic routine physical examinations for adults aged nineteen (19) and older no more than once every three (3) years.

      ii. Adult immunizations.

      iii. Well child visits for covered children under age nineteen (19) in accordance with the prevailing clinical standards of the American Academy of Pediatrics, including an initial hospital checkup and necessary immunizations as determined by the Superintendent of Insurance in consultation with the Commissioner of Health consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenza type b and hepatitis b and varicella.

      We will cover services typically provided in conjunction with a well child visit. Such services include at least: complete medical histories; a

complete physical examination; developmental assessments; anticipatory guidance; laboratory tests performed in the practitioner's office or in a clinical laboratory and/or other services ordered at the time of the well child visit; nutrition education and counseling; hearing testing; medical social services; eye screening; tuberculin testing; dental and developmental screening; clinical laboratory and radiological testing; and lead screening.

3. **Diagnosis and treatment of illness, injury or other conditions.** We will pay for the diagnosis and treatment of illness or injury, including:

   a. **Pre-Admission Testing.** We will provide coverage for tests ordered by your physician which are given to you as a preliminary to your admission to the Hospital as a registered bed-patient for surgery if all of the following are met:

      i. The tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;

      ii. You have made a reservation for a Hospital bed and/or the operating room before the tests are given;

      iii. You are physically present at the Hospital where the tests are given;

      iv. Surgery actually takes place within seven (7) days after the tests are given.

   b. **Surgical Services.** We will provide coverage for care in connection with surgery, including any pre- and post-operative care. Surgical care also includes endoscopic procedures and the care of fractures and dislocations of bones.

   c. **Anesthesia Services.** This includes the administration of necessary anesthesia and related procedures in connection with a covered surgical service. A Participating Provider other than the Participating Provider performing the surgery or an assistant must provide the services.

   d. **Diagnostic X-ray and Laboratory Services.** We will provide coverage for laboratory tests, x-rays and other diagnostic procedures, including ultrasound, CAT scan, and magnetic resonance imaging procedures.

   e. **Second Surgical Opinion.** We will provide coverage for a second surgical opinion under the following conditions:

      i. You seek the second surgical opinion after your physician determines your need for surgery;

      ii. The second surgical opinion is rendered by a Participating Provider who is a board certified specialist, and who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure;

iii. The second surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Contract if such surgery was performed;

iv. You are examined in person by the Participating Provider rendering the second surgical opinion;

v. The specialist who renders the second surgical opinion does not perform the surgery.

f. **Second Medical Opinion.** We will cover a second medical opinion provided by an appropriate specialist, including one affiliated with a specialty care center, where there has been a positive or negative diagnosis of cancer, or a recommendation of a course of treatment of cancer. The specialist rendering the second medical opinion must be a Participating Provider to whom you have received a referral by your attending physician, unless you have received a referral from your attending physician to a Non-Participating Provider.

4. **Radiologic Services, Chemotherapy and Hemodialysis.** We will pay for radiologic services and chemotherapy, including injections and medications provided at the time of therapy. We will pay for hemodialysis services in your home or at a facility, whichever we deem appropriate.

5. **Obstetrical and Gynecological Services.** You may receive the following services from a qualified Participating Provider of obstetric and gynecologic services without your PCP's authorization:

a. Up to two (2) annual examinations for primary and preventive obstetric and gynecologic care; and

b. Care required as a result of the annual examinations or as a result of an acute gynecological condition.

6. **Maternity Care.** Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes subsequent prenatal and postpartum care. You do not need an approved referral from your PCP for maternity care; however, the care received must be received from a Participating Provider.

7. **Cervical Cancer Screening.** If you are a female who is aged eighteen (18) or older, we will provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states. Cervical cytology screening shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

8. **Mammography Screening.** We will provide coverage for mammography screening for occult breast cancer, subject to the following schedule:

a. Upon the recommendation of a physician, a mammogram at any age if you have a prior history of breast cancer or if your mother or sister has a prior history of breast cancer;

b. A single baseline mammogram for women aged thirty-five (35) through thirty-nine (39), inclusive;

c. A mammogram every two (2) years, or more frequently upon the recommendation of a physician, for women aged forty (40) through forty-nine (49), inclusive;

d. An annual mammogram for women aged fifty (50) and older.

9. **Post-Mastectomy Breast Reconstruction Surgery.** We will provide coverage for all stages of reconstruction of the breast on which the mastectomy has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined by the attending physician and the patient to be appropriate.

SECTION FIVE -- EMERGENCY CARE

The emergency care benefits described apply both when you are within or without the Service Area.

1. **Emergency Condition.** We will provide coverage for care at an emergency room of a Participating Provider or Non-Participating Provider if your illness or condition is considered an Emergency Condition.

   An Emergency Condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or, in the case of a behavioral condition placing the health of such person or others in serious jeopardy; or (B) serious impairment to such person's bodily functions; or (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

2. **Authorization.** If your condition is an Emergency Condition as set forth above, you do not need to obtain authorization from MVP or your PCP prior to receiving care at an emergency room. When you have received emergency room care for an emergency condition, you or a member of your family should notify us within 48 hours so that your follow-up care can be coordinated by a Participating Provider. If it was not reasonably possible to give notice within that time, notice should be given as soon thereafter as is reasonably possible.

3. **Non-Participating Providers.** We will provide coverage with a Non-Participating Provider only for as long as MVP determines that the emergency room care was

Medically Necessary and that your medical condition prevented your transfer to a Participating Provider.

SECTION SIX -- OTHER COVERED SERVICES

1. **Diabetic Equipment and Supplies.** We will pay for the following equipment and supplies for the treatment of diabetes which are Medically Necessary and prescribed or recommended by your PCP or other Participating Provider legally authorized to prescribe under Title VIII of the New York State Education Law:

   a. Blood glucose monitors;

   b. Blood glucose monitors for legally blind;

   c. Data management systems;

   d. Test strips for monitors and visual reading;

   e. Urine test strips;

   f. Injection aids;

   g. Cartridges for legally blind;

   h. Insulin;

   i. Syringes;

   j. Insulin pumps and appurtenances thereto;

   k. Insulin infusion devices;

   l. Oral agents; and

   m. Additional equipment and supplies designated by the Commissioner of Health as appropriate for the treatment of diabetes.

   Repair, replacement and adjustment of the above diabetic equipment and supplies are covered when made necessary by normal wear and tear. Repair and replacement of diabetic equipment and supplies made necessary because of loss or damage caused by misuse or mistreatment are not covered.

2. **Diabetes Self Management Education.** We will pay for diabetes self management education provided by your PCP or another Participating Provider. Education will be provided upon the diagnosis of diabetes, a significant change in your condition, the onset of a condition which makes changes in self-management necessary or where re-education

is Medically Necessary as determined by us. We will also pay for home visits if Medically Necessary.

3. **Prescription Drugs.**

a. **Scope of Coverage.** We will pay for those FDA approved drugs, which require a prescription, including contraceptive drugs, which are listed in our formulary. Our formulary is based on sound clinical evidence and the advice of participating physicians and pharmacists. The formulary is reviewed and updated on an ongoing basis through MVP's Pharmacy and Therapeutics Committee and the Quality Improvement Committee. At least two drugs in each therapeutic class will be made available unless there are clinically equivalent over the counter products readily available. MVP reserves the right to limit restrict or exclude coverage of certain prescription drugs in accordance with its policies governing medical necessity and quality of treatment. Such restrictions may involve a decision by MVP not to cover a particular drug or to impose a limit on the quantity of such drug covered within a given time frame. A copy of the list of excluded drugs is available for inspection. Your physician may request an excluded drug through MVP's Medical Formulary Appeals Procedure. Such appeals will be addressed by the Office of the Vice President of Medical Affairs on an expedited basis. New drugs will be reviewed by MVP's Pharmacy and Therapeutics Committee prior to being included in the Formulary. We will also pay for Medically Necessary enteral formulas prescribed by your PCP or other Participating Provider legally authorized to prescribe under Title VIII of the Education Law. Such written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death. We will also provide coverage for modified solid food products that are low protein, or which contain modified protein which are Medically Necessary for the treatment of certain inherited diseases of amino acid and organic acid metabolism.

b. **Participating Pharmacy.** We will only pay for prescription drugs for use outside of a Hospital. The prescription must be issued by a Participating Provider and filled at a Participating Pharmacy, except in an emergency or where otherwise authorized by Us.

c. **Exclusions and Limitations.** Under this Section we will not pay for the following:

i. Any prescription drug that we determine is not Medically Necessary, unless coverage is recommended by an External Appeal Agent.

ii. Experimental or investigational drugs, unless recommended by an External Appeal Agent.

iii. Nutritional supplements taken electively.

iv. Non-FDA approved drugs except that we will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type for which FDA approval was obtained. However the drug must be recognized for treatment of the type of cancer for which it has been prescribed by one of these publications: AMA Drug Evaluations; American Hospital Formulary Service; U.S. Pharmacopoeia Drug Information; or a review article or editorial comment in a major peer-reviewed professional journal.

v. Devices and supplies of any kind.

SECTION SEVEN - ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

1. **When a Specialist Can Be Your PCP.** If you have a life threatening or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may receive a referral to a network specialist with expertise in treating such disease or condition who shall be responsible for and capable of providing and coordinating your primary and specialty care. In such case, the designated specialist is permitted to treat you without a referral from your PCP and may arrange such referrals, procedures, tests and other medical services as your PCP would otherwise be permitted to provide and/or arrange, subject to the terms of a treatment plan approved by us, in consultation with your PCP, the specialist and you or your designee.

2. **Standing Referral To a Network Specialist.** If we, or your PCP in consultation with us and a participating specialist, if any, determine that you need ongoing specialty care, you may receive a "standing referral" to a specialist who is a Participating Provider. This means that you will not need to obtain a new referral from your PCP every time you need to see that specialist. Such a referral shall be pursuant to a treatment plan approved by us in consultation with your PCP, the specialist and you or your designee, and may limit the number of visits or the period during which such visits are authorized.

3. **Standing Referral To a Specialty Care Center.** If you have a life-threatening or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may receive a standing referral to a network specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If we, or your PCP or specialist in consultation with our Medical Director, determine that your care would most appropriately be provided by a specialty care center, we will refer you to such center. Any such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by us, in consultation with your PCP and specialist, when applicable.

   For purposes of this provision, a specialty care center is one that is accredited or designated by an agency of the state or federal government or by a voluntary national

health organization as having special expertise in treating your life-threatening or disabling condition or disease.

4. **When Your Provider Leaves the Network.** If you are undergoing a course of treatment when your provider leaves our network, then you may be able to continue to receive care from the former Participating Provider, in certain instances, for up to ninety (90) days after you are notified by us of the provider's leaving. If you are pregnant and in your second trimester, you may be able to continue care with the former provider through delivery and postpartum care directly related to the delivery.

   However, in order for you to continue care with a former Participating Provider, the provider must agree to accept our payment and to adhere to our procedures and policies, including those for assuring quality of care.

5. **When New Members are in a Course of Treatment.** If you are in a course of treatment with a Non-Participating Provider when you enroll with us, you may be able to receive care from the Non-Participating Provider for up to sixty (60) days from the effective date of enrollment under this Contract. The course of treatment must be for a life threatening or degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if you are in the second trimester of a pregnancy when you become covered under this Contract. You may continue care through delivery and any post-partum services directly related to the delivery.

   However, in order for you to continue care, the Non-Participating Provider must agree to accept our payment and to adhere to our policies and procedures including those for assuring quality of care.

SECTION EIGHT -– PRE-EXISTING CONDITIONS

In addition to the exclusions and limitations described in other sections of this Contract, we will not provide coverage for Pre-Existing Conditions.

1. **Pre-Existing Conditions.** We will not provide coverage for any services related to a Pre-Existing Condition until you have been continuously covered under this Contract or by other Creditable Coverage for at least twelve (12) consecutive months (ten (10) months for pregnancy). A Pre-Existing Condition is any physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received by a licensed health care provider within the six (6) month period preceding the Enrollment Date. The Enrollment Date is the earlier of your effective date under this Contract or the date that you file a substantially complete application for coverage with us.

   You may receive credit toward the waiting period for any time that you were covered under Creditable Coverage if there was no break in coverage greater than sixty- three (63) days between the termination of the previous coverage and your Enrollment Date under this Contract. In the case of previous HMO coverage any affiliation period before

coverage became effective shall be considered as time covered for purposes of providing credit for previous coverage. Creditable Coverage includes a group health plan, health insurance coverage, Medicaid, Medicare, government-sponsored health benefit programs such as CHAMPUS, Peace Corps or Indian Health Service; Federal Employees Health Benefits Program, state health benefits risk pool or coverage under any health insurance plan sponsored by a state, county or other political subdivision.

Genetic information in the absence of a diagnosis of the condition related to such genetic information is not a Pre-Existing Condition under this Contract. In addition, no Pre-Existing Condition waiting period shall apply to an individual who is covered under Creditable Coverage on the thirtieth (30^{th}) day after birth, and no Pre-Existing Condition waiting period shall apply to a child under age eighteen (18) who is adopted or placed for adoption and who is covered under Creditable Coverage on the thirtieth (30^{th}) day after adoption or placement, so long as there is no break in coverage of more than sixty-three (63) days between the end of such Creditable Coverage and the Enrollment Date under this Contract.

Additionally, a Pre-Existing Condition exclusion shall not apply to an Eligible Person. An Eligible Person is a person who had at least eighteen (18) months of Creditable Coverage, who has taken and exhausted his/her COBRA or other continuation coverage not more than sixty-three (63) days prior to his/her enrollment date. An Eligible Person's most recent prior Creditable Coverage must have been under a group health plan, governmental plan, or church plan and must not have been terminated for fraud, intentional misrepresentation, or nonpayment of premiums. In addition, an Eligible Person must not have any other health insurance coverage and must not be eligible for coverage under a group health plan, Medicare or Medicaid.

SECTION NINE -– LIMITATIONS AND EXCLUSIONS

1. **Experimental or Investigational Services.** In general, we do not cover experimental or investigational treatments. However, we shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with Section Fourteen of this Contract. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or other costs which would not be covered under this Contract for non-experimental or non-investigational treatments provided in such clinical trial.

2. **Non- Medically Necessary Care.** In general, we will not cover any health care service that we, in our sole judgment, determine is not Medically Necessary. Medically Necessary means those covered services that MVP determines are necessary to prevent, diagnose, correct or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with a persons capacity for normal activity or threaten

significant medical handicap. If an External Appeal Agent certified by the State overturns our denial, however, we shall cover the procedure, treatment, service or pharmaceutical product, for which coverage has been denied, to the extent that such procedure, treatment, service or pharmaceutical product is otherwise covered under the terms of this Contract. See Section Fourteen of this Contract for further information on External Appeal.

3. **Cosmetic Surgery.** We will not provide coverage for cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

4. **Routine Foot Care.** We will not provide coverage for foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

5. **Subluxation.** We will not provide coverage for care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

6. **Government Programs.** We will not provide coverage for treatment provided in a government hospital; benefits provided under a governmental program, any state or federal workers' compensation, employer's liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made.

7. **Dental Care.** We will not provide coverage for dental care or treatment, except for dental care or treatment due to accidental injury to sound natural teeth within twelve (12) months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.

8. **Vision and Hearing Care.** We will not provide coverage for eyeglass, hearing aids and examination for the prescription and fitting thereof.

9. **Medicare.** We will not provide coverage for any service or care for which benefits are payable under Medicare.

10. **Non-Covered Services.** Covered Services for the Healthy New York Program are set by law. We will not provide coverage for any service or care that is not specifically described as a covered service herein even when a Participating Provider considers the service or care to be Medically Necessary and appropriate. Examples of services not

covered include mental health care, substance abuse treatment services, physical therapy and home health care.

11. **Unauthorized Services.** Except for emergency care and certain obstetric and gynecological care, we will not provide coverage for any service or care unless the treatment is performed and/or arranged in advance by your PCP or authorized by MVP.

SECTION TEN - PREMIUMS FOR THIS CONTRACT

1. **Amount of Premiums.** The amount of premium for this Contract is determined by us and approved by the Superintendent of Insurance of the State of New York.

2. **Grace Period.** All premiums for this Contract are due on the first of the month. However, we will allow a thirty (30) day grace period for the payment of all premiums, except the first month's premium. This means that, except for the first month's premium, if we receive payment within thirty (30) days of the date the payment was due, we will continue coverage under this Contract for the entire period covered by the payment. If we do not receive payment within the thirty (30) day grace period, the coverage under this Contract will terminate as of the last day of the month when payment is due.

3. **Agreement to Pay For Services if Premium is Not Paid.** You are not entitled to any services for periods for which the premium has not been paid. If services are received during such period, you agree to pay for the services received.

4. **Change in Premiums.** If there is to be an increase or decrease in the premium for this Contract, we will give you at least thirty (30) days written notice of the change.

SECTION ELEVEN - TERMINATION OF COVERAGE

1. **For Non-Payment of Premium.** This Contract will terminate at the end of the thirty (30) day grace period if we do not receive your payment. For example, if your premium is due on July 1, and it is not paid by July 31, the end of the thirty (30) day grace period, no payment will be made under this Contract for any service given to your after June 30.

2. **When You Move Outside the Service Area.** This Contract shall terminate when you cease to reside permanently in the service area.

3. **When You No Longer Meet Eligibility Requirements.** This Contract shall terminate on its renewal date if you fail to provide us with timely written certification, along with any supporting documentation that we require, demonstrating your continued eligibility and compliance with the applicable terms of the Healthy New York Program.

4. **Change in Family Status.** If you are covered under this Contract as a dependent or spouse of the subscriber, coverage will end when you no longer meet the eligibility requirements of a dependent or spouse.

5. **Termination of the Healthy New York Program.** This Contract shall automatically terminate on the date when the New York State law that establishes the Healthy New York Program is terminated.

6. **Our Option To Terminate This Contract.** We may terminate this Contract at any time for one or more of the following reasons:

   a. Fraud in applying for enrollment under this Contract or in receiving any services.

   b. Such other reasons on file with the Superintendent of Insurance at the time of such termination and approved by him. A copy of such other reasons shall be forwarded to you. We shall give you no less than thirty (30) days prior written notice of such termination.

   c. Discontinuance of the class of Contracts to which this Contract belongs upon not less than five (5) months prior written notice of such termination.

7. **Your Option to Terminate This Contract.** You may terminate this Contract at any time by giving us at least one (1) month's prior notice. We will refund any portion of the premium for this Contract that has been prepaid by you.

8. **On Your Death.** This Contract will automatically terminate on the date of your death.

9. **Benefits After Termination.** If you are totally disabled on the date this Contract terminates and you have received medical services for the illness, injury or condition which caused the total disability while covered under this Contract we will continue to pay for the illness, injury or condition related to the total disability during an uninterrupted period of total disability until the first of the following dates:

   a. A date on which you are in our sole judgment, no longer totally disabled; or

   b. A date twelve (12) months from the date this Contract terminates.

   We will not pay for more care than you would have received if your coverage under this Contract had not terminated.

SECTION TWELVE- RIGHT TO A NEW CONTRACT AFTER TERMINATION

You have a right to convert to a new contract if your coverage under this Contract terminates under the circumstances described below:

1. **Termination on the Death of the Subscriber.** If your coverage under this Contract terminates because of the death of the Subscriber, then you may be entitled to purchase a contract with us as a direct payment subscriber.

2. **Termination of your Marriage.** If your coverage under this Contract terminates because you are divorced or your marriage is annulled, then you may be entitled to purchase a contract with us as a direct payment subscriber.

3. **Termination of Coverage of a Child.** If your coverage under this Contract terminates because you no longer qualify as a dependent, then you may be entitled to purchase a contract with us as a direct payment subscriber.

4. **Termination of the Healthy New York Program.** If the Healthy New York Program is terminated or you no longer meet the eligibility requirements for the Healthy New York Program, then you may be entitled to purchase a contract with us as a direct payment subscriber.

5. **When to Apply for the New Contract.** If you are entitled to purchase a new contract as described above, then you must apply to us for the new contract within thirty-one (31) days after termination of your coverage under this contract. You must also pay the first premium of the new contract within the same thirty-one (31) period.

6. **The New Contract.** If you meet the eligibility requirements, then you may purchase a Healthy New York individual health insurance contract with us as a Subscriber. Otherwise, the new contract(s) that we will offer on conversion will be our standardized direct payment HMO or HMO Point of Service contracts.

SECTION THIRTEEN - GRIEVANCE PROCEDURE AND UTILIZATION REVIEW

1. **Grievance-Procedure.** You may file a grievance regarding any dispute you may have with MVP, provided that such dispute does not involve a denial of benefits or services on the basis that such service is not medically necessary and/or denials based on the experimental or investigational nature of the service. (See, Section 13, Subsection 2). You or a representative appointed by you may file a grievance verbally or in writing by contacting MVP's Member Services Department. A Member Services Representative will be available to accept calls between the hours of 8:00 a.m. and midnight, Monday through Friday, at (888) MVP-MBRS.

a. MVP will review and respond to grievances within the following timeframes:

i. Forty-eight (48) hours after the receipt of all necessary information, when a delay would significantly increase the risk to your health.

ii. Thirty (30) days after receipt of all necessary information in all other cases.

iii. MVP will acknowledge receipt of all grievances within fifteen (15) days of their receipt.

b. MVP will send you a written notice of the grievance determination, which

shall include the following:

i. The reasons for the decision, including medical rationale where applicable;

ii. The procedures for appealing the decision.

c. You or a representative appointed by you may appeal an adverse grievance determination.

i. You have sixty (60) business days after receipt of the notice of grievance determination to file an appeal.

ii. You shall receive written acknowledgment of your appeal within fifteen(15) days from its receipt.

iii. An appeal of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination.

iv. Appeals shall be decided and notification provided to you within two (2) business days after receipt of all necessary information, when a delay would significantly increase the risk to your health and thirty (30) business days in all other instances.

v. The notice of an appeal determination shall include the detailed reasons for the determination and the clinical rationale for the determination, if applicable.

vi. At anytime during the appeal process you may request a review by the New York State Department of Health and/or Insurance.

(Additional information regarding MVP's grievance process is contained in MVP's Member Handbook).

2. **Utilization Management/Review:** is a process used to determine if services are or were medically necessary. As discussed above, MVP will only extend coverage for health services or treatments you have or will receive if that care, in our judgment, is medically necessary.

a. **Initial Review**. MVP's Utilization Management Department can be reached at (800) 568-0458 between the hours of 8:00 a.m. to midnight, if you call after hours, the MVP answering service will take a message, and an MVP representive

will contact you on the next business day. Once we have received all of the necessary information with regard to the your utilization review, a determination will be made according to the following time frames:

i. Procedures or treatment involving services which require pre-certification shall be decided and notice of a determination sent to you or your designee and/or the your health care provider by telephone and/or in writing, within three (3) business days of receipt of all necessary information;

ii. For situations involving continued or extended health care services, or additional services for a member undergoing a course of continued treatment prescribed by a health care provider, a decision shall be made and notice of such decision provided to the member, the member's designee or the member's health care provider, by telephone and/or in writing within one (1) business day of receipt of all the necessary information. This notice shall include the number of extended services authorized to begin and the date the next utilization review is scheduled to take place;

iii. A utilization review determination involving services, which have already been provided, will be made within thirty (30) days of receipt of all necessary information.

iv. If MVP fails to make a decision within the above-mentioned timeframes, then the healthcare service and/or treatment is considered denied and you or a representative appointed by you may appeal the decision.

b. **Denial Notices.** In the case of a denial for medical necessity, all decisions will be made by qualified clinical personnel. Notices of denials will include information about the basis of the decision and further appeal rights. All denial notices will also inform you that: you, or someone you choose as a representative, and/or your health care provider may request, in writing, the clinical review criteria used in making the decision on the service or treatment being denied.

c. **Right to Reconsideration.** In situations where there has been a denial of services as not medically necessary without attempting to discuss the matter with the provider who recommended the service, procedure or treatment under review, the provider shall have the opportunity to request a reconsideration of the denial. The reconsideration review shall occur within one (1) business day of receipt of the request, except in cases where reconsideration request is for services which have already been provided.

d. **Utilization Review Appeals (Standard).** All adverse determinations (as evidenced by a denial notification) based upon medical necessity may be appealed by you and, in more limited circumstances, the requesting physician. You also have the right to designate a representative for the purpose of initiating an appeal of denied services. Appeals must be submitted within forty-five (45) days of your

receipt of the denial notification. MVP will acknowledge the receipt of the request for appeal within fifteen (15) days. MVP will render a decision within sixty (60) days of the receipt of the appropriate information needed to conduct the appeal. Notification of MVP's decision on the appeal will be provided in writing to you, and your health care provider, if appropriate, within two (2) business days of the determinations. This notification will be deemed a final adverse determination for purposes of initiating an external appeal (see below, "External Appeal").

e. **Utilization Review Appeals (Expedited).** Expedited or immediate appeals are available to the member, if he wants to appeal an adverse determination based upon medical necessity that involves:

i. Continued or extended healthcare services;

ii. Procedures, treatments or additional services for a member who is undergoing a course of continued treatment prescribed by his or her healthcare provider; or

iii. A situation where the member's healthcare provider believes an immediate appeal is needed. However, this does not apply in situations where we originally paid the member's claim before we had all the information needed.

We will reach a decision with regard to the expedited appeal, within two (2) business days of the time we receive all the necessary information we need to conduct the appeal. We will notify you immediately of our decision by telephone. We'll send a written notice within two (2) business days of the decision. If you do not receive a satisfactory answer through our expedited appeals process, you may use the standard appeal process described above or apply to New York State for an external appeal.

SECTION FOURTEEN – EXTERNAL APPEAL

1. **Your Right to an External Appeal.** Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, you or your representative may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

2. **Your Right to Appeal Determination That Service is Not Medically Necessary.**

If we have denied coverage on the basis that the service is not Medically Necessary, you may appeal to an External Appeal Agent if you satisfy the following two (2) criteria:

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

- You must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial or we both must agree in writing to waive any internal appeal.

3. **Your Right to Appeal Determination That Service is Experimental or Investigational.** If you have been denied coverage on the basis that a service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

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

   - You must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial or we both must agree in writing to waive any internal appeal.

   In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one that, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen (18), a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

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

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

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

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

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

4. **The External Appeal Process.** If, through the first level of our internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, you have forty-five (45) days from receipt of such notice to file a written request for an external appeal. If we both have agreed in writing to waive any internal appeal, you have forty-five (45) days from receipt of such waiver to file a written request for an external appeal. We will provide an external appeal application with the final adverse determination issued through the first level of our internal appeal process or our written waiver of an internal appeal.

You may also request an external appeal application from New York State at 1-800-400-8882. Submit the completed application to the New York State Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

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

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

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

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

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

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

5. **Your Responsibilities. It is your responsibility to initiate the external appeal process.** You may initiate the external appeal process by filing a completed application with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

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

SECTION FIFTEEN- GENERAL PROVISIONS

1. **No Assignment.** You cannot assign the benefits of this Contract. Any assignment or attempt to do so is void. Assignment means the transfer to another person or organization of your right to the benefits provided by this Contract.

2. **Legal Action.** You must bring any legal action against us under this Contract within twelve (12) months from the date we refused to pay for a service under this Contract.

3. **Amendment of Contract.** We may change this Contract if the change is approved by the Superintendent of Insurance of the State of New York. We will give you at least forty-four (44) days written notice of any change.

4. **Medical Records.** We agree to preserve the confidentiality of your medical records. In order to administer this Contract, it may be necessary for us to obtain your medical records from hospitals, physicians or other providers who have treated you. When you become covered under this Contract, you give us permission to obtain and use such records.

5. **Who Receives Payment Under This Contract.** We will pay Participating Providers directly to provide services to you. If you receive covered services from any other provider, we reserve the right to pay either you or the provider.

6. **Notice.** Any notice under this Contract may be given by United States mail, postage prepaid, addressed as follows:

If to us: MVP Health Plan, 625 State Street, P.O. Box 2207, Schenectady, New York 12301

If to you: To the latest address provided by you on the member enrollment or official change-of-address form.

SCHEDULE OF BENEFITS

A. Inpatient Hospital Services (including inpatient maternity care) Daily room & board General nursing care Special Diets Miscellaneous hospital services & supplies	 $ 500 copayment per continuous confinement.
B. Outpatient Hospital Services Diagnostic and treatment services Outpatient surgery	 $ 20 copayment per visit $ 75 facility copayment
C. Physicians Services Diagnostic & treatment services Consultant & referral services Anesthesia services Second surgical opinion Second opinion for cancer Surgical services (including breast reconstruction following a mastectomy)	 $20 copayment per visit 20% or $ 200, whichever is less
D. Pre-admission Testing	$ 20 copayment
E. Maternity Care Prenatal care Postnatal care Delivery Home Visit	 $ 10 copayment per visit (prenatal) $ 10 copayment per visit (postnatal) 20% or $ 200, whichever is less No Copayment
F. Adult Preventive Health Care Mammography screening Cervical cytology screening Periodic physical examinations Adult immunizations	 $ 20 copayment per visit
G. Child Primary & Preventive Health Services Preventive & primary care Immunizations Scheduled Well-Child Visits	 $ 20 copayment per visit
H. Diabetic Equipment & Supplies and Self-Management Education	$ 20 copayment per visit for self-management education $ 20 copayment per each item of equipment $ 20 copayment per 34-day supply of insulin, hypoglycemics and supplies

I. Diagnostic X-Ray & Lab Services	$20 copayment per visit
J. Emergency Services	$ 50 copayment per visit (waived if hospital admission results from visit)
K. Therapeutic Services Radiological services Chemotherapy Hemodialysis	$ 20 copayment per visit
L. Blood and Blood Products	$ 20 copayment per visit
M. Prescription Drugs	Deductible: $ 100 per individual per calendar year Copayment: $ 10 per generic drug per 34-day supply $ 20 per brand name drug plus difference in cost between the brand name drug and its generic equivalent per 34 day supply Mail order program $ 20 per generic drug per 90-day supply) $ 40 per brand name drug per 90-day supply plus difference in cost between brand name and its generic equivalent Benefit Maximum $ 3000 per individual per calendar year

Final 12/12/2000 removed variables (street address) on 11/25/2003 when printing for Dan. Corrected page numbers in TOC on 4/28/04.