**"MVP NON-GROUP INDEMNITY SUBSCRIBER CONTRACT"**

Issued by

**MVP Health Insurance Company**
**P.O. Box 1076, Schenectady, NY 12301-1076**
**518/370-4793**
**(800) 777-4793**

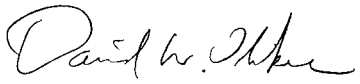
This Subscriber Contract ("Contract") with MVP Health Insurance Company ("MVP") is evidence of the health insurance coverage available to you and your eligible dependents under the Contract. Amendments, riders or endorsements may be delivered with this Contract or added thereafter. This Contract becomes effective on the date listed on your identification card (your "Effective Date") and continues for twelve (12) months. The Contract will automatically renew on the anniversary of your Effective Date unless it is terminated for any of the reasons described herein.

Read this entire Contract carefully. It describes: (1) the health care services for which MVP provides Benefits, (2) the limitations and exclusions regarding such Benefits, (3) other terms and conditions of coverage, (4) the rights and responsibilities of MVP, and (5) your rights and responsibilities. It is your responsibility to understand and comply with all terms and conditions of this contract. You should keep this Contract with other important papers so that it is available for reference.

**PLEASE READ THE COPY OF YOUR APPLICATION. IF ANYTHING IN IT IS NOT CORRECT, YOU MUST TELL US. YOUR CONTRACT IS ISSUED ON THE BASIS THAT ALL INFORMATION IN THE APPLICATION IS CORRECT AND COMPLETE. IF NOT, YOUR CONTRACT MAY NOT BE VALID.**

**IF YOU ARE NOT SATISFIED WITH THIS CONTRACT, YOU MAY RETURN IT AND ASK US TO CANCEL IT. THIS REQUEST MUST BE MADE, IN WRITING, WITHIN TEN (10) DAYS FROM THE DATE YOU RECEIVE THIS CONTRACT. IF YOU RETURN THIS CONTRACT IN THIS MANNER, WE WILL NOT PROVIDE ANY BENEFITS AND WILL REFUND ANY PREMIUM YOU HAVE PAID.**

MVP Health Insurance Company

By: 

David W. Oliker
President and Chief Executive Officer

## TABLE OF CONTENTS

## SECTION ONE – INTRODUCTION

This Contract explains your coverage with MVP Health Insurance Company. In this Contract, "MVP", "we," "us," "our" and "the Plan" mean MVP Health Insurance Company. "You," "your" and "yours" refer to you, the Subscriber who buys this Contract. Your eligible Dependents are referred to as "Members." Use of the word "he" in this Contract refers to he or she.

1. Understanding Your Benefits

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

B. Pre-Existing Conditions. This Contract has a Pre-Existing Condition Exclusion. Read Section Four to understand if and to what extent this exclusion applies to you.

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

Some Covered Services are listed in more than one Section. These services are listed this way to make clear that they may be received in different settings. It does not mean that you get Benefits for additional services, such as additional days or visits. Also, if Benefits for a Covered Service are payable under more than one provision of this Contract, Benefits will only be paid under the provision providing greater benefit, unless otherwise provided.

D. Health Care Providers. Except as described in paragraph E below, this Contract has no network of participating Providers and you may receive Covered Services from any Provider, as defined herein, that you choose. However, if you receive Medically Necessary Covered Services from a Provider who has a fee agreement with MVP, such Provider will, in most cases, bill MVP directly and accept MVP's payment of the Allowable Charge, together with any applicable Coinsurance and Deductible that you must pay, as payment in full. You can find out which providers have a fee agreement with MVP by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277); or check our web site at www.mvphealthcare.com. If you receive Medically Necessary Covered Services from a Provider who does *not* have a fee agreement with MVP, such Provider may bill MVP or may bill you. If he bills you, you must submit a claim to MVP for reimbursement. These Providers may NOT accept MVP's payment of the Allowable Charge, together with any applicable Coinsurance and Deductible, as payment in full. This means that, in addition to any applicable Coinsurance and Deductible, you must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

E. Preferred Provider Services. There are some Covered Services, including Mental Health Services, Substance Abuse Services, Transplant Services and Pharmacy Services, which must be provided by Preferred Providers. These services are marked "**Preferred Providers Only**" in bold and explained in more detail below. You may ask if a Provider is a Preferred Provider by calling MVP's Member Services Department. Call 1-888-MVP-MBRS (1-888-687-6277) or check MVP's web site at www.mvphealthcare.com. For more information about Preferred Mental Health and Substance Abuse Providers, call [PrimariLink] at [1-800-320-5895]. It is your responsibility to make sure that a Provider is a Preferred at the time you get services.

2. Your Payments under this Contract.

A. Premium Payments. This Contract requires you to make premium payments in advance. This is described in Section Thirteen.

B. Coinsurance. This Contract requires you to pay a Coinsurance for prescription drugs and for certain outpatient services. These amounts are listed on your Schedule.

C. Deductibles. This Contract requires you to pay an Individual Deductible for Covered Services and a separate Individual Deductible for prescription drugs. Payments for prescription drugs count only toward the Deductible for prescription drugs, and not toward the Deductible for any other Covered Services. Payments for other Covered Services do not count toward the Deductible for Prescription Drugs. The Deductible amounts are listed on your Schedule. The Individual Deductibles apply to each Member each Calendar Year. You must pay the Individual Deductibles before MVP will pay any Benefits under this Contract. If you have met your Individual Deductibles, you do not have to pay any Individual Deductibles for the rest of that Calendar Year. You must still pay any applicable Coinsurance. If you have family coverage, you must pay the Individual Deductibles for two family members each Calendar Year.

i. Calculating the Deductible. You must provide MVP with copies of Providers' bills for Covered Services and your receipts for payment of such bills if such payments are to be counted toward your Deductibles. Expenses for non-Covered Services will not be counted toward your Deductibles. MVP will use the following procedure to determine which Expenses will be used to satisfy each Calendar Year Deductibles:

a. For all bills received by MVP at the same time, MVP will use the date the Expense was incurred and apply those Expenses first incurred to satisfy the Deductibles.

b. For all bills received by MVP at different times, MVP will use the date the bill was received by MVP and apply those Expenses in that order to satisfy the Deductibles.

ii. The following **DO NOT** Count Toward your Deductibles.

a. The difference, if any, between a Provider's Charge and the Allowable Charge.

b. Any penalties you must pay under this Contract.

c. Any Coinsurance.

d. Any excess Charges you incur if you have exhausted any Benefit maximums.

D. Charges in Excess of Allowable Charges. This Contract requires you to pay the difference, if any, between a Provider's Charge and the Allowable Charge.

E. Coordination of Benefits Savings. If you are covered under more than one health plan and coordination of benefits applies and MVP is the secondary plan, as described in Section Sixteen, then the amounts paid for Covered Services by your primary plan will count toward your Deductibles under this Contract.

3. MVP's Payments under this Contract.

A. Benefits. When a Member receives Medically Necessary Covered Services, MVP will pay the Allowable Amount for the Covered Service minus any applicable Coinsurance and Deductibles. Benefits are further limited to each Member's Annual Benefit Maximum. Calendar Year Benefit Maximums, and Lifetime Benefit Maximums, described below. Benefits may also be reduced by any Penalties if you do not comply with the Utilization Management requirements listed in Section Five.

i. Fee Agreement Providers. MVP will pay the Allowable Charge directly to the Provider. These Providers, in most cases, will accept MVP's payment, plus any applicable Deductibles and Coinsurance paid by you, as payment in full.

ii. Non-Fee Agreement Providers. MVP will pay the Allowable Charge. MVP may reimburse you or pay the Provider. These Providers may not accept MVP's payment, plus any applicable Deductibles and Coinsurance paid by you, as payment in full. You will also be responsible for the difference, if any, between the Allowable Charge and the Provider's Charge.

B. Annual Benefit Maximums. These are the maximum amounts of days, visits or dollar amounts payable by MVP for a Covered Service for each Member during any one Calendar Year under the Contract. Covered Services that are subject to an Annual Benefit Maximum are marked in **bold**. **After we have paid the Annual Benefit Maximum for a Covered Service in any Calendar Year, you must pay all Charges for that Covered Service. Such Charges in excess of the Annual Benefit Maximum will not count toward your Deductibles.**

C. Calendar Year Benefit Maximums. This is the maximum amount of dollars payable by MVP for all Covered Services (including Covered Services subject to a separate Annual Benefit Maximum) for each Member during any one Calendar Year under the Contract. The amount of the Calendar Year Benefit Maximum is listed on your Schedule. **After we have paid the Calendar Year Benefit Maximum, you must pay all Charges for Covered Services. Such Charges in excess of the Calendar Year Benefit Maximum will not count toward your Deductibles and will not count toward your Lifetime Maximum Benefit.**

D. Lifetime Benefit Maximums. These are the maximum dollar amounts payable by MVP for Covered Services available during each Member's lifetime under the Contract. There are two different Lifetime Benefit Maximums, described below. The amount of each Lifetime Benefit Maximum is listed on your Schedule. **After you have reached the Lifetime Benefit Maximum, you must pay all Charges.**

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

ii. Lifetime Benefit Maximum for Durable Medical Equipment, and External Prosthetic Devices. This includes any Benefits paid by MVP for Durable Medical Equipment and External Prosthetic Devices.

E. **Penalties. Your Benefits will be reduced if you do not give a required Prior Notice or Concurrent Notice or if you do not get a required Precertification from MVP. Also, if MVP does not get the information required to conduct Concurrent Review, your benefits will be reduced unless the information was not reasonably available to you. Read Section Five. If your Benefits are reduced, you must pay the Provider the amount of the reduction PLUS any applicable Deductibles and Coinsurance, AND the difference, if any, between the Allowable Charge and the Provider's Charge.**

## SECTION TWO – DEFINITIONS

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

A. Allowable Charge. This means the maximum Benefit available under this Certificate. The Allowable Charge is established by MVP in accordance with a Fee Agreement; Usual, Customary and Reasonable Charges; or by law.

B. Benefits. This means payments made by MVP to you or a Provider for Covered Services.

C. Calendar Year. This means the twelve (12) month period beginning at 12:01 a.m. on January 1 and ending at 12:00 midnight on December 31. However, if you were not covered under this Contract for this entire period, Calendar Year means the period from your effective date until 12:00 midnight on December 31.

D. Charge. This means the total amount billed by a provider for a service. A charge is incurred on the date the service was provided to you.

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

F. Covered Services. This means the services specified in this Contract as eligible for benefits. There are no Benefits for preventive care or well care services, including immunizations, unless otherwise specifically stated. MVP maintains protocols to assist in determining whether a service is a Covered Service.

G. Custodial Services. This means services primarily for maintenance or designed to help you in your daily living activities. Custodial Services include, but are not limited to:

i. assistance in walking, bathing and other personal hygiene, toileting, getting in and out of bed
ii. dressing
iii. feeding
iv. preparation of special diets
v. administration of oral medications
vi. routine changing of dressings
vii. child care
viii. adult day care
ix. residential care
x. care not requiring skilled professionals

Custodial Services also means services that, according to generally accepted professional standards, are not expected to provide significant, measurable clinical improvement within a reasonable and medically predictable period of time, not to exceed two (2) months.

H. Deductible. This means a dollar amount, listed on your Schedule, that you must pay, in addition to the premium, before we provide Benefits under this Contract. There is a separate Deductible for prescription drugs. Coinsurance payments do not count toward the Deductibles. You must pay any Deductible directly to the provider or pharmacy, as applicable. If coordination of benefits applies and MVP is the secondary plan, amounts paid by your primary plan will count towards your Deductible under this Contract.

I. Dependent. This means a person other than the Subscriber, listed on the Subscriber's enrollment application who meets all eligibility requirements, and for whom the required premium has been received by MVP.

J. Diagnostic Services, Supplies and Equipment. This means supplies and equipment used in and provided by the Hospital when performing Diagnostic Services ordered by a physician to determine a definite condition or disease. Diagnostic Services includes radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scans, electroencephalograms (EEG), electrocardiograms (ECG), organ scans, allergy testing (percutaneous, intracutaneous, patch and RAST testing) and other medical and surgical diagnostic services.

K. Effective Date. This means the date your coverage under this Contract begins. Coverage begins at 12:01 a.m., Eastern Time, on that date.

L. Eligible Individual. This is defined by federal law to mean a person on his or her Effective Date under this Contract:

i. who has eighteen (18) or more months of Creditable Coverage, and
ii. whose most recent prior Creditable Coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with such plans; and
iii. who is not eligible for coverage under a group health plan, Medicare, Medicaid or any successor program, and does not have other health insurance coverage; and
iv. whose most recent prior Creditable Coverage was not terminated based upon nonpayment of premiums or fraud; and
v. who has elected and exhausted any COBRA or state continuation coverage, if available.

M. Emergency Medical Condition. This means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

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

N. Emergency Services. This are Covered Services provided to diagnose and treat an Emergency Medical Condition.

O. Expenses. This means expenses incurred by you for Medically Necessary Services and prescription drugs, including Deductible payments. Expenses do not include any Coinsurance for Prescription Drugs. Expenses also do not include premium payments, out of pocket costs for Non-Covered Services, expenses incurred by you prior to your Effective Date and/or after the termination of your coverage under this Contract, penalties, and any expenses you incur in excess of the Allowable Charge.

P. Experimental or Investigational Services. This means services that are either generally not accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

Q. Fee Agreement. This means an arrangement between MVP and Preferred Providers to provide Covered Services to Members.

R. Medical or Scientific Evidence. This means the following sources:

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

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

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

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

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

vi. peer-reviewed abstracts accepted for presentation at major medical association meetings.

S. Medically Necessary or Medical Necessity means that a Covered Service is:

i. Appropriate, in terms of type, amount, frequency, level, setting and duration, for the diagnosis or treatment of your condition;

ii. Consistent with generally accepted practice parameters as recognized by health care providers in the same or similar specialty as typically treat or manage the diagnosis or condition;

iii. A Covered Service which:

a. helps restore or maintain your health;
b. prevents deterioration of or palliate your condition; or
c. prevents the reasonably likely onset of a health problem or detect an incipient problem.

MVP maintains protocols to assist in determining whether a service is Medically Necessary. You may ask for a copy of such protocols by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). Even though a Provider prescribes, performs, orders, recommends, or approves a service, that does not mean that the service is Medically Necessary or that we must provide benefits for the service.

T. Member. This means the Subscriber or his or her Dependents.

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

i. Personal history of mental disorder (ICD-9-CM codes V11.00 through V11.99);

ii. Psychological trauma (ICD-9-CM code V15.40);

iii. Psychiatric condition (ICD-9-CM code V17.00);

iv. Other family circumstances and other psychosocial circumstances (ICD-9-CM codes V61.00 through V62.99, except V61.10 (marital counseling)); and

v. Observation for suspected mental condition (ICD-9-CM code V71.00).

Mental Health Condition does ***not*** include:

i. Substance Abuse Conditions;

ii. 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;

iii. Specific Delays in Development (ICD-9-CM codes 315.00 through 315.99);

iv. Psychic Factors associated with diseases classified elsewhere in the ICD-9-CM (ICD-9-CM code 316.00); and

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

V. Mental Health Services. This means services to diagnose or treat a Mental Health Condition.

W. Provider. This means properly licensed or certified physicians and health care professionals performing services within their licensure or certification. It also means Hospitals, ambulatory surgery centers, birth centers, Skilled Nursing Facilities, federally qualified mental health or substance abuse treatment facilities, Home Health Agencies, Hospices, Durable Medical Equipment and External Prosthetic Device suppliers, and Ambulance services. Some Providers must be Preferred Providers for their services to be covered. The provider must provide health care services within the scope of his or her practice, and must charge and bill patients for such services.

X. Resident. This means a person who is domiciled in Vermont, as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent.

Y. Schedule. This means the document attached to this Contract that describes the applicable Deductible, Coinsurance, Annual Benefit Maximums, Calendar Year Benefit Maximums, Lifetime Benefit Maximums and similar information.

Z. Spouse. This means the Subscriber's spouse under a legally valid marriage or civil union as defined by Vermont law.

AA. Subscriber. This means the person to whom this Contract is issued, who meets and continues to meet all eligibility requirements, and for whom the required premium has been received by MVP.

BB. Substance Abuse Condition. This means the following disorders involving alcohol or substance abuse that falls as listed in the Mental Disorders Section in the International Classification of Diseases Manual (ICD-9-CM):

i. Alcohol and drug psychoses (ICD-9-CM codes 291.00 through 292.99);

ii. Alcohol dependence syndromes (ICD-9-CM codes 303.00 through 303.99);

iii. Drug dependence (ICD-9-CM codes 304.00 through 304.99); and

iv. 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).

CC. Substance Abuse Services. This means services to diagnose or treat a Substance Abuse Condition.

DD. Surgery. This means generally accepted invasive, operative, and cutting procedures including, but not limited to specialized instrumentation, endoscopic examinations, and correction of fractures and dislocations, and the pre- and post-operative care usually rendered in connection with such procedures. Sterilization is included.

EE. Therapeutic Services. This means:

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

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

iii. Dialysis. This means removal of waste materials when a Member has acute kidney failure or chronic, irreversible kidney deficiency, and the use of equipment and disposable medical supplies. Alternatively, Dialysis may be provided at home. If provided at home, MVP will provide Benefits for the reasonable rental cost of equipment, as determined by us, plus Medically Necessary supplies for home dialysis treatment when ordered by your physician. MVP will not provide benefits for any furniture,

electrical or other fixtures or plumbing to perform the dialysis treatments at home. For outpatient or home-based Dialysis to be covered, the treatments must be provided, supervised or arranged by your physician, and you must be a registered patient of an MVP approved kidney diseases treatment center. Benefits for Dialysis will continue until you become eligible for Medicare due to end stage renal disease, or until your MVP coverage is otherwise terminated, whichever comes first.

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

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

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

FF. Totally Disabled or Total Disability. This means an illness, injury or condition for which you are receiving Covered Services and which causes you to be incapable of engaging in any employment or occupation for which you are qualified or become qualified by reason of education, training or experience. You must not, in fact, engage in any employment or occupation for wage or profit.

GG. Usual, Customary and Reasonable (UCR) Charges are established based on a percentile of national prevailing charge data compiled for a specific procedure and adjusted for geographic differences.

## SECTION THREE – ENROLLMENT AND COVERAGE

1. Initial Enrollment. MVP will send you an enrollment form to complete and sign. Your Spouse and your adult Dependents must also sign the form. By signing, you confirm your enrollment and provide written authorization for MVP to obtain your medical records and information so that we can administer your benefits, process your claims and conduct other health care operations as permitted by law.

2. Who Is Eligible To Be Covered Under This Contract.

A. The Subscriber.

B. The Subscriber's Spouse.

C. The Subscriber's children, as described below.

i. The Subscriber's unmarried children who are under age nineteen (19), live with the Subscriber, and are chiefly dependent upon the Subscriber for support and maintenance;

ii. The Subscriber's unmarried children who are under age twenty-five (25) if such children are full-time Students at an accredited college or university. A full-time Student is enrolled in at least twelve (12) credit hours per semester. MVP may require subsequent proof of such enrollment; and

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

3. Children Covered Under This Contract. To be covered, the Subscriber's children must meet the requirements of paragraph 2(C)(i), 2(C)(ii), or 2(C)(iii) above. The Subscriber's children must also be related to the Subscriber in one of the following ways:

A. The Subscriber's natural child;

B. The Subscriber's legally adopted child;

C. A child for whom the Subscriber is the legal guardian or has legal custody;

D. The Subscriber's stepchild;

E. A child under age eighteen (18) who has been placed with the Subscriber for adoption and for whom the Subscriber has assumed and retains a legal obligation to support;

F. A child of the Subscriber's Dependent, limited to coverage from the moment of birth for thirty-one (31) days, and further 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; or

G. A child for whom the Subscriber has been ordered to provide dependent health insurance coverage pursuant to a qualified medical support order, even if the child does not live with the Subscriber or in the State of Vermont.

4. Enrollment of Subscriber's New Family Members.

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

B. To add a child.

i. If the Subscriber plus a Spouse, or the Subscriber plus a child or children are already covered under this Contract, your newborn natural child will automatically be covered from the moment of birth for 31 days and your adopted child or a child placed with you for adoption will automatically be covered for 31 days from the date of the adoption or placement for adoption. 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 the child to have coverage beyond the 31 days described above, you must comply with paragraph (iii) below. If you do not, we will not provide coverage beyond the 31 days.

ii. If the Subscriber only is covered under this Contract, your newborn natural child or a child placed with you for adoption will not automatically be covered from the moment of birth. You must comply with paragraph (iii) below for the child to be covered from the moment of birth. If you do not, we will not provide coverage for your child.

iii. For coverage beyond the 31 days described in paragraph (i) above, you must complete and return an enrollment form, any requested documentation, and the required premium. If you do so within 31 days of the date of birth, adoption, placement for adoption, or within 31 days of the date the child became your step child, your child will be added to your coverage effective as of the date of birth, adoption, placement for adoption, or as of the date the child became your step child. If you do not do so within 31 days of the events described, your child will be added to your coverage as of the first of the month following the next premium due date after we receive the completed form, requested documents, and applicable premium. If you do not notify us, we will not provide coverage for the child.

a. We will coordinate benefits for a newborn child or a newborn child placed with you for adoption if a natural parent of the child also has insurance coverage available for these services.

b. If a notice of revocation of adoption is filed or one of the natural parents revokes their consent to the adoption, we will cease providing benefits as of the effective date of the revocation and we will be entitled to recover the amount of benefits provided by us from the child's natural parents or other third party providing coverage to the natural parents.

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

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

6. When you, your Spouse or your child is no longer eligible for coverage. You must notify us right away of any event that affects your coverage. Such events include, but are not limited to, divorce or annulment, death of your Spouse, Medicare eligibility or coverage under another contract, policy or certificate, a child marrying or reaching the age at which coverage terminates, a change in residency and a change or termination of any medical support order.

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

8. Persons *Not* Eligible For Coverage Under This Contract

A. Any person who is eligible for Medicare due to age;

B. Any person who is not a Vermont Resident. This does not apply to children for whom the Subscriber has been ordered to provide dependent health insurance coverage pursuant to a qualified medical support order;

C. Any person who is covered for similar benefits under another individual policy or contract;

D. Any person who is or could be covered for similar benefits under a group policy, plan or contract, including COBRA or continuation coverage, and who, with coverage under this Contract, would be overinsured according to MVP's standards for overinsurance;

E. Any person who fails to provide MVP with information needed to make a decision as to eligibility or overinsurance;

F. Subject to paragraph 4(B), any child born to a Subscriber's dependent child, after 31 days from the date of birth; and

G. Any person to whom this Contract is offered as an employee or member of a small group as a means of circumventing the small group requirements of the Vermont Banking and Insurance Law.

## SECTION FOUR - PRE-EXISTING CONDITIONS

1. We will not provide benefits during the first twelve (12) months of this contract for any services for, or related to, a Pre-Existing Condition.

2. A Pre-Existing Condition means the existence of symptoms that would cause an ordinary, prudent person to seek diagnosis, care or treatment. It also means any physical or mental condition, illness, injury, disease, or ailment for which medical advice, diagnosis, care or treatment was recommended or received by a provider within the twelve (12) month period preceding your Effective Date under this Contract. An example of such a condition includes, but is not limited to, a pregnancy existing on your Effective Date under this Contract. It does not include genetic information in the absence of a diagnosis of the condition related to such information.

3. This pre-existing condition exclusion does not apply to:

   A. Any person who is an Eligible Individual.
   B. Any person who produces evidence of continuous health benefit coverage during the nine (9) months immediately prior to his or her effective date under this contract which is substantially equivalent to the coverage provided under this contract.
   C. A child placed with you for adoption, or an adopted child, when such child is placed or adopted after the effective date of this contract.
   D. A newborn natural child or a newborn child placed with you for adoption provided that the child is enrolled within thirty-one (31) days of the date of birth.

4. Creditable Coverage. If a Pre-Existing Condition exclusion applies to you, the exclusion period may be reduced. The time you were covered under Creditable Coverage, as

defined below, before you became covered under this Contract will be counted to reduce the exclusion period. This is only if there was not a break in coverage greater than 63 days between termination of the previous Creditable Coverage and your Effective Date under this Contract.

Creditable Coverage means:

i. Coverage provided under a group health plan such as an employer plan.
ii. A health insurance policy or contract.
iii. Self-insured group health benefit plans.
iv. Medicaid.
v. Medicare.
vi. Government-sponsored health benefit programs such as CHAMPUS/TRICARE, Peace Corps, or Indian Health Service.
vii. Federal Employees Health Benefits Program.
viii. A State health benefits risk pool.
ix. Coverage under any health insurance plan sponsored by a state, county or other political subdivision.

Creditable Coverage does ***not*** include:

i. Accident-only coverage.
ii. Worker's compensation or similar insurance.
iii. Automobile medical payment insurance.
iv. Limited scope dental or vision benefits.
v. Long-term care benefits provided in a separate policy.

## SECTION FIVE
## UTILIZATION MANAGEMENT AND CLAIMS FILING

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

1. Precertification. Precertification means the required approval that you must get from MVP before you get certain Covered Services. MVP reviews information about your medical condition and the proposed services in order to determine whether such services are Medically Necessary Covered Services. **It is up to you to make sure that Precertification is obtained.** If you do not obtain Precertification from us before you get certain Covered Services, your Benefits will be reduced. (See Paragraph D below). Covered Services that require Precertification are marked in **bold**.

   A. When Precertification is Required. Precertification is required for the following services:

i. All Elective (Non-Emergency) Inpatient Admissions
ii. All Outpatient Surgery (except Surgery performed in a Provider's office).
iii. Transplant Services.
iv. Durable Medical Equipment and External Prosthetic Devices
v. Inpatient Mental Health Services and Outpatient Mental Health Services whether in the outpatient department of a Hospital or facility or in a Provider's office.
vi. Inpatient Substance Abuse Services and Outpatient Substance Abuse Services whether in the outpatient department of a Hospital or facility or in a Provider's office.
vii. MRIs, CAT Scans, PET Scans, and Nuclear Imaging

B. How to obtain Precertification. If you or your Provider properly follows the steps set forth in this section, you will be deemed to have submitted a proper and timely Proof of Loss.

i. Generally. For all Elective (Non-Emergency) Inpatient Admissions (except for those involving Mental Health Services or Substance Abuse Services), Outpatient Surgery (except Surgery performed in a Provider's office), Transplant Services, and Durable Medical Equipment and External Prosthetic Devices, to request Precertification you must ensure that your Provider contacts [MVP's Utilization Management Department] at [(800) 568-0458]. Your Provider must tell us your name, MVP ID number, your Provider's name and address, the date that services are requested, and your diagnosis. If the request is Urgent, your Provider must tell us and describe the circumstances that make it Urgent. Unless your request is Urgent, your Provider must contact us at least fifteen (15) days prior to your proposed admission or service date. You must notify us if your admission date or service date changes. **You must make sure that Precertification is obtained.**

ii. Inpatient and Outpatient Mental Health Services and Substance Abuse Services. To ask for Precertification, you must ensure that your Provider contacts [PrimariLink] at [1-800-320-5895] phone, [(802) 258-3749] fax, or [PO Box 803, Brattleboro, Vermont 05302] address. Your Provider must tell us your name, MVP ID number, your Provider's name and address, the date(s) that services are requested, your diagnosis, the date services are requested and, for Outpatient services, a copy of your Provider's completed Outpatient Treatment Report. If the request is Urgent, your Provider must tell us and describe the circumstances that make it Urgent. Unless your request is Urgent, your Provider must contact us at least fifteen (15) days prior to your proposed admission or service date. You must notify us if your admission date or service date changes. **You must make sure that Precertification is obtained.**

iii. MRIs, CT Scans, PET Scans and Nuclear Imaging. To request Precertification for these services, you must ensure that your Provider contacts [National Imaging Associates] by phone at [800-642-2602] or by fax at [916-852-2601] or in writing at the following address [11050 Olson Drive, Suite 200, Rancho Cordova, CA 95670]. [Days and hours of operation are Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Standard Time]. Your Provider must tell us your name, MVP ID number, your Provider's name and address, the date(s) that services are requested, the services you will be receiving and your diagnosis. If the request is Urgent, your Provider must tell us and describe the circumstances that make it Urgent. Unless your request is Urgent, your Provider must contact us at least fifteen (15) days prior to your proposed admission or service date. You must notify us if your admission date or service date changes. **You must make sure that Precertification is obtained.**

C. MVP's Response to Requests for Precertification.

i. Precertification for Urgent Care. If your request for Precertification is Urgent and you properly identify to MVP that the request is Urgent, we will we will notify you and your Provider, by telephone, of our decision within 24 hours of the time that Precertification is requested. You and your Provider will be notified, in writing, within 24 hours of the telephone notice. Requests and claims for Retrospective Review are excluded from this paragraph. If we deny Benefits, you must pay all charges.

ii. Non-Urgent Precertification Requests. If your request for Precertification is not Urgent and all necessary information is received at the time of the Precertification request, we will notify you of our decision within three (3) working days. Except in cases involving Mental Health Services or Substance Abuse Services, in the event of an adverse determination, we will also notify your Provider, by telephone of our decision. If all necessary information is not received at the time of the Precertification request, 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 the receipt of our notice to provide us with the missing information. In such cases, we will notify you and your Provider, in writing, of our decision within three (3) working days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner. If we deny Benefits, you must pay all charges.

D. **Failure to obtain Precertification. If you fail to obtain Precertification when required, MVP will reduce payment of any otherwise payable Benefit by three hundred dollars ($300.00). Additionally, if we conduct Retrospective Review and determine that any admission and/or service(s) were not Medically Necessary, we will not provide Benefits.**

2. Concurrent Notice. Concurrent Notice means the notice you must give to MVP while you are receiving certain Covered Services. MVP does not review, approve or deny Benefits at this time. Your call is necessary for MVP to establish a concurrent review schedule.

   A. When Concurrent Notice is Required. Concurrent Notice is required for the following services:

      i. All Emergency Inpatient Admissions

      ii. Inpatient Maternity Care (call after delivery)

      iii. Detoxification Admissions

      Covered Services that require Concurrent Notice Review are marked in **bold** throughout this Certificate.

   B. How to give Concurrent Notice. You must contact [us] at [1-800-568-0458] within 48 hours (or as soon as reasonably possible) after you begin receiving these services. You must provide us with your name, MVP ID number, your Provider's name and address, services you are receiving, dates of service and your diagnosis.

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

   D. **Failure to Give Concurrent Notice. If you fail to give Concurrent Notice when required, MVP will reduce payment of any otherwise payable Benefit by three hundred dollars ($300.00). Additionally, if we conduct Retrospective Review and determine that any admission and/or service(s) were not Medically Necessary, we will not provide Benefits.**

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 1, to determine whether such services continue to be Medically Necessary Covered Services. If you or your Provider properly follows the steps set forth in this section, you will be deemed to have submitted a proper and timely Proof of Loss.

   A. Obtaining Concurrent Review of Inpatient Hospital Services. MVP will contact your Provider. You must ensure that your Provider gives us the clinical information needed to conduct this review before the end of each period for which your benefits were approved.

   B. Obtaining Review of Ongoing Outpatient Mental Health and Substance Abuse Services. You must ensure that your Provider completes a written Outpatient

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

C. MVP's Response to Concurrent Review.

i. Urgent Matters

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

b. If all necessary information is not received at the time of the concurrent review request, we will deny Benefits. If we deny Benefits, we will not provide Benefits after the date that you get notice of our decision. You must then pay all Charges.

ii. Non-Urgent Matters

a. Pre-service.

(i) If all necessary information is received at the time of the concurrent review and services have not yet been provided to you, we will notify you of our decision within three (3) working days. Except in cases involving Mental Health Services or Substance Abuse Services, in the event of an adverse determination, we will also notify your Provider by telephone of our decision. If we deny Benefits, you must pay all Charges.

(ii) If all necessary information is not received at the time of the Concurrent Review, we will notify you and your Provider within five (5) days after the review of any necessary information that is needed to complete the review. You and your Provider will have 45 days from the receipt of our notice to provide us with the missing information. In such cases, we will notify you and your Provider, in writing, of our decision within three (3) working days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide

the missing information, whichever is sooner. If we deny Benefits, you must pay all Charges.

b. Post Service.

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

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

**D. Failure to obtain Concurrent Review. If you fail to give Concurrent Notice or obtain Concurrent Review when required, MVP will reduce payment of any otherwise payable Benefit by three hundred dollars ($300.00) if the information was not reasonably available to you. Additionally, if we conduct Retrospective Review and determine that any admission or service was not Medically Necessary, we will not provide Benefits.**

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 and whether and to what extent Benefits are payable. We conduct Retrospective Review on all claims.

A. How to obtain Retrospective Review.

i. Fee Agreement Provider Services. When you obtain Covered Services from Providers who have a Fee Agreement with MVP, the Provider will submit your claim and bill MVP directly.

ii. Non-Fee Agreement Provider Services. When you obtain Covered Services from a Provider who does not have a Fee Agreement with MVP, in some cases, the Provider will bill MVP directly. In other cases, you must pay the Provider and ask for reimbursement from MVP. In either

case, you or the Provider must submit a claim to MVP by following the Claims Submission instructions below.

iii. Claim Submission.

a. Services Received From a Provider with whom MVP has a Fee Agreement. MVP's timely receipt of a Fee Agreement Provider's properly completed and submitted bill will be deemed a proper filing of Proof of Loss on your behalf. If you are billed directly by a Provider with whom MVP has a Fee Agreement, you must follow the instructions set forth in paragraph b below.

b. Services Received from a Provider with whom MVP does NOT have a Fee Agreement. You or the non-Fee Agreement Provider must submit a properly completed claim form, bill, and receipts to MVP at the address below. Claim forms, bills, and receipts for a particular service must be submitted together (collectively, such items are referred to as a "claim") within 90 days of the date of service. MVP's timely receipt of a properly completed and submitted Claim, as described in this paragraph, will be deemed a proper filing of Proof of Loss by you or by a non-Fee Agreement Provider on your behalf. Claims submitted after this time period will be denied and you will be responsible for all Charges unless it was not reasonably possible to submit the Claim within this time frame. If it was not reasonably possible to submit the Claim within 90 days after the date of service, you or the non-Fee Agreement Provider must, except in the absence of legal capacity, do so not later than one year from the date of service. You may obtain claim forms by calling MVP's Member Services Department at 1-800-318-8575. You may also visit MVP's web site at **www.mvphealthcare.com** to download the claim form or to ask for a copy of the claim form. Mail your properly completed claim forms with all Provider bills and receipts by first class mail, postage prepaid, to MVP at:

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

B. MVP's Response to Retrospective Review. If all necessary information is received at the time of the claim submission, we will notify you of any adverse determination, in writing, within 30 days after our receipt of the claim. If all necessary information is not received at the time of the claim, we will notify you and your Provider within 15 days after our receipt of the claim of any missing information that is needed to decide the claim. 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 15

days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide us with the missing information, whichever is sooner.

C. How and When Benefits are Paid. Benefits payable to you will be made within 45 days of our receipt of your properly submitted claim. Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted from the amount of Benefits otherwise payable. Any claim that has not been paid to you as of the date of your death will be paid to your estate. Up to one thousand ($1,000) dollars of any Benefit payable to your estate, to someone who is a minor or someone who is not able to release MVP from its liability can be paid to any relative of yours whom MVP believes should be paid. Any payment made in good faith by MVP under this provision will relieve MVP of any additional liability for the claim so paid.

5. Filing Claims for Prescription Drug Benefits

A. When you bring a prescription to a Preferred Pharmacy, the pharmacist will be able to make an immediate benefit inquiry to MVP.

i. Prescription Filled by Pharmacy. If the pharmacist's benefit inquiry indicates that you have met all eligibility and coverage requirements, the pharmacist will fill your prescription and submit a claim to MVP for payment. You must pay the applicable Coinsurance to the Preferred Pharmacy.

ii. Prescription Not Filled by Pharmacy. If the pharmacist's benefit inquiry indicates that you have not met all eligibility and coverage requirements, the pharmacist will tell you the results of the benefit inquiry. You may then do one of the following:

a. Ask the pharmacist to fill the prescription, pay the pharmacy's Charge for the prescription, and submit a Claim for Retrospective Review, as described in paragraph 4(A)(iii) above. You must also have the pharmacist sign the claim form and attach the original receipt for the prescription. Mail the claim form to the address listed on the form.

b. Decline to have the pharmacist fill the prescription and ask for Precertification as described in paragraph 1 above.

## SECTION SIX – COVERED HOSPITAL INPATIENT SERVICES

1. **Inpatient Admissions are subject to Precertification and Concurrent Review**. **Your Benefits will be reduced if you do not get Precertification or if we are not able to conduct Concurrent Review.** To get Benefits for Inpatient Services, you must be a registered inpatient in a Hospital, as defined below, and be under the care of a licensed

physician. Your Benefits will be reduced if we do not get the information needed to conduct Length of Stay Review. We will only provide Benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

Hospital means a duly licensed, short-term, acute care facility that primarily provides diagnostic and therapeutic services for diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians. It must have organized departments of medicine and major surgery. It must provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. The following are ***not*** Hospitals:

- Convalescent homes;
- Convalescent, rest or nursing facilities or nursing homes;
- Facilities primarily affording custodial or educational care;
- Health resorts, spas or sanitariums;
- Infirmaries at schools, colleges or camps;
- Facilities for the aged;
- Any military or veterans hospital or soldiers home, or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered for Emergency Medical Conditions, where a legal liability exists for charges made to the individual for such services; and
- Residential Care Facilities and Long Term Care Facilities.

2. Inpatient Services. We will provide Benefits for the Inpatient Services listed below when provided to you in a Hospital.

   A. Semi-private room (**If you have a private room, you will be responsible for any Charges in excess of the Allowable Charge for a semi-private room and such excess Charges will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible**);

   B. Board and general nursing services;

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

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

   E. Dressings and casts;

   F. Diagnostic Services, Supplies and Equipment. **Precertification is required for MRIs, CT Scans, PET Scans and Nuclear Imaging. Your Benefits will be reduced if you do not get Precertification for these services.**;

   G. Therapeutic Services.

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

I. Laboratory services; and

J. Medical and surgical supplies, including blood and blood plasma.

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

4. Maternity Care. **Concurrent Notice is required. Your Benefits will be reduced if you do not give Concurrent Notice.** We provide benefits for Inpatient Services to a covered mother for childbirth for at least 48 hours after a non-cesarean delivery or for at least 96 hours after a cesarean delivery in a Hospital or birthing center. The attending physician, with the mother or mother's designated representative, may decide to discharge the mother sooner. We will also provide benefits for Inpatient Services for pregnancy and complications of pregnancy.

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

6. Breast Cancer Care. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** We will provide Benefits for Inpatient Services in connection with an inpatient Hospital stay following a mastectomy, lymph node dissection or lumpectomy for the treatment of breast cancer. We will provide Benefits for physical complications of mastectomy, including lymphedemas. We will provide Benefits for Inpatient Services in connection with an inpatient Hospital stay following reconstruction of the breast on which a mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. These surgical services will be performed in the manner that your attending physician, in consultation with you, determines is appropriate. We will also provide Benefits for breast prostheses required as a result of covered Breast Cancer Care.

7. Mental Health Services. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** 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 that is a Preferred Provider or in an institution approved by the secretary of human services that is a Preferred Provider and such facility or institution provides a mental health treatment program pursuant to a written plan. **Preferred Providers Only**.

8. Substance Abuse Services. **Precertification is not required for Detoxification Admissions. You must give Concurrent Notice. Your Benefits will be reduced if you do not give Concurrent Notice. Precertification is required for all other Inpatient Substance Abuse Services. Your Benefits will be reduced if you do not get Precertification.** We will provide Benefits for Inpatient Services and Substance Abuse Services only when such services are provided pursuant to a written treatment plan in an institution approved by the secretary of human services that provides a program for the treatment of alcohol or substance dependency and is a Preferred Provider. **Preferred Provider Only**.

9. Inpatient Physical Rehabilitation Care. **Precertification is required except when such care is immediately preceded by an inpatient Hospital stay. Your Benefits will be reduced if you do not get Precertification.** We will provide Benefits for up to 30 days per Member per Calendar Year. **Subject to Annual Benefit Maximum**.

## SECTION SEVEN – COVERED OUTPATIENT SERVICES

1. Outpatient Services. We will provide Benefits for the following Outpatient Services. Such services must be provided to you in the outpatient department of a Hospital or in a free-standing ambulatory care facility. We will only provide benefits if a Covered Service is Medically Necessary.

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

      i. Your physician has ordered the tests; and

      ii. An operating room and inpatient bed at the Hospital have been reserved.

      iii. Surgery occurs within seven (7) days of the tests.

      iv. You are physically present at the Hospital for the tests.

      You must pay any applicable Coinsurance and Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

   B. Outpatient Surgery. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** You must pay any applicable Coinsurance and Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

C. Therapeutic Services. You must pay any applicable Deductible.

D. Diagnostic Services. **Precertification is required for MRIs, CT Scans, PET Scans and Nuclear Cardiology. Your Benefits will be reduced if you do not get Precertification for these services.** You must pay any applicable Coinsurance and Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

E. Mental Health Services. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** Services must be provided by a Hospital or a facility that is a licensed or certified mental health provider and that is a Preferred Provider. **Preferred Provider Only**. You must pay any applicable Deductible.

F. Substance Abuse Services. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** Services must be provided by a Hospital or a facility that is a licensed or certified substance abuse provider and that is a Preferred Provider. **Preferred Provider Only**. You must pay any applicable Deductible.

G. Mammography Screenings. We will provide the following Benefits:

i. For Members under age 50, we will provide Benefits for mammography screening when recommended by a participating physician; and

ii. For Members age 50 and older, we will provide Benefits for an annual mammography screening.

These services must be performed at a facility that is accredited by the American College of Radiologists. You must pay any applicable Coinsurance and Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

H. Laboratory Services. You must pay any applicable Coinsurance and Deductible.

I. Physical, Occupational and Speech Therapy. We will provide Benefits for up to a combined 60 visits per Member per Calendar Year for physical therapy, occupational therapy, and speech therapy when such services are provided under the direction of a physician by a Hospital or a facility or in a Provider's office as described in Section Eleven. You must pay any applicable Deductible. **Subject to Annual Benefit Maximum**. **If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such**

**Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**

J. Cardiac Rehabilitation Care. We will provide Benefits for up to 36 visits per member per Calendar Year. You must pay any applicable Deductible. **Subject to Annual Benefit Maximum**. **If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**

## SECTION EIGHT – COVERED SKILLED NURSING FACILITY SERVICES

1. We will only provide Benefits if a Covered Service is Medically Necessary. **Subject to Annual Benefit Maximum**. **If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.** You must pay any applicable Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

2. What is a Skilled Nursing Facility (SNF)? – A Skilled Nursing Facility is a licensed facility that provides 24 hour inpatient skilled nursing care and related services. It is certified as a participating SNF by Medicare or accredited as an SNF by the Joint Commission on Accreditation of Healthcare Organizations. A SNF is not, other than occasionally, a place that provides minimal, custodial, ambulatory or part-time care services.

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

   A. You are under the supervision of a licensed physician;

   B. You have been confined in a Hospital for at least three (3) consecutive days within twenty-eight (28) days immediately preceding your admission to the Skilled Nursing Facility. (This does not apply to readmission to a SNF if such readmission occurs within sixty (60) days of the previous SNF discharge date.); and

   C. The services are for the purpose of receiving care for the condition that caused the Hospital confinement.

4. Skilled Nursing Facility Services. We will provide Benefits for the inpatient Skilled Nursing Facility Services listed below for up to 30 days per Calendar Year. However, the days shall be consecutive. You may not select the day or days for which we will provide benefits. We will provide benefits for the day you are admitted. We will not provide benefits for the day you are discharged. If you are admitted and discharged on the same day, we will provide benefits for that day.

A. Room and board in a semiprivate room. (**If you have a private room, you will be responsible for Charges in excess of the Allowable Charge for a semi-private room and such excess Charges will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible**.)

B. Skilled nursing care.

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

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

## SECTION NINE – SPECIAL COVERED SERVICES

1. Home Health Agency Services. We will only provide Benefits if a Covered Service is Medically Necessary. **Subject to Annual Benefit Maximum**. **If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.** You must pay any applicable Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

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

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

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

      ii. The services are provided by a Home Health Agency.

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

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

   C. Home Health Agency Services. We will provide Benefits for up to 40 visits per Calendar Year for the services listed below.

      i. Part time or intermittent skilled nursing care by or under the supervision of a registered nurse.
      ii. Part time intermittent home health aide services, provided that such services consist primarily of caring for the patient and do not include Custodial Care.

iii. Physical Therapy Services if provided by Home Health Agency personnel.

iv. Medical supplies and drugs prescribed by a physician and laboratory services, to the same extent that laboratory services would have been covered if you were an inpatient at a Hospital or Skilled Nursing Facility.

2. Hospice Services. We will only provide Benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

A. What is a Hospice? Hospice is an organization engaged in providing services to terminally ill persons. It must be federally certified to provide hospice services or accredited as a hospice by the Joint Committee of Accreditation of Health Care Organizations.

B. Conditions for Hospice Services.

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

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

ii. The Hospice Services are supervised by a physician under a written Hospice Care Plan; and

iii. You consent to the written Hospice Care Plan.

C. Hospice Services. We will provide Benefits for Hospital Inpatient Services, physician services and Home Health Agency Services provided pursuant to a written Hospice Care Plan.

D. Hospice-Related Counseling. We will also provide Benefits for five (5) visits for bereavement counseling for your family either before or after his your death are also covered.

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

3. Prescription Drugs.

A. Generally. We will provide Benefits for Medically Necessary prescription drugs (except prescription drugs excluded under MVP's Drug Formulary) up to a thirty (30) day supply per dispensing. Prescriptions that require the mixing of two or more ingredients must contain at least one ingredient that requires a prescription. However, we will not provide Benefits for a compounded product that exists in a comparable commercially available form or that are compounded for the convenience or ease of administration of the Member. We will also provide Benefits for prescription contraceptives and prescription contraceptive devices

approved by the Federal Food and Drug Administration. Benefits for prescription drugs (including prescription contraceptives and contraceptive devices) are limited to $5,000.00 per Member per Calendar Year. **Prescriptions must be filled at a Preferred Pharmacy. Prescriptions are subject to a Calendar Year Prescription Drug Deductible. The amount is listed on your Schedule. Prescriptions are also subject to an Annual Benefit Maximum**. **If you incur Charges for these services in excess of this Annual Benefit Maximum or if you incur Charges at a non-Preferred Pharmacy, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Prescription Drug Deductible or your general Deductible. Also, the amounts you pay toward your Prescription Drug Deductible do not count toward your general Deductible. The Prescription Drug Annual Benefit Maximum does not count toward your Annual Calendar Year Maximum Benefit , but does count toward your Lifetime Maximum Benefit.** Once you have met your Prescription Drug Deductible**,** you must pay a Coinsurance per each prescription filled and refilled. The Prescription Drug Coinsurance is listed on your Schedule. Additionally, if your prescribed dosage is not commercially available, you may be required to make more than one Coinsurance 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 be required to make one payment for the 20 milligram dosage and a second payment for the 30 milligram dosage.

Please see below for more information on MVP's Formulary.

B. Filling Prescriptions. You must present your MVP ID card, pay the applicable Deductible and Coinsurance to the Preferred Pharmacy. You may inquire whether a particular Pharmacy is a Preferred Pharmacy by calling MVP's Member Services Department at 1-800-318-8575 or by visiting MVP's web site at **www.mvphealthcare.com**.

C. Pharmacy and Therapeutics Committee and MVP's Formulary. MVP's Pharmacy and Therapeutics Committee, which includes physicians, pharmacists and other health care professionals, evaluates prescription drugs and determines which drugs MVP will approve for coverage. The list of approved drugs is called the Formulary. Drugs that MVP has not approved for coverage are called Non-Formulary Drugs. At least two drugs in each therapeutic class will be included on the Formulary, unless there are clinically equivalent over-the-counter products readily available. MVP's Pharmacy and Therapeutics Committee reviews and must approve new drugs prior to such new drugs being included on the Formulary.

i. Getting Formulary Information. At any time, you may get a copy of the Formulary or ask if a drug is listed on the Formulary by calling MVP's Member Services Department at 1-888-MBRS. You may also check

MVP's web site at **www.mvphealthcare.com** and enter the name of a drug to see if it is listed on MVP's Formulary or to ask for a copy of the Formulary.

ii. Changes to the Formulary. MVP gives at least 30 days prior written notice to affected Members when we delete previously approved drugs from the Formulary. MVP also provides written notice to all Members when new drugs are added to the Formulary.

iii. If MVP does not give the 30 day prior written notice described in paragraph 2 above and you try to have your prescription filled in accordance with this Contract, MVP will provide coverage for a three (3) day supply. You must then contact the Provider who wrote the prescription to change your prescription. You may also file a claim for benefits by following the instructions in Section 5 of this Contract.

D. In addition to the Exclusions Section of this Contract, the following items are excluded from coverage.

i. Any over-the-counter drugs, including vitamins and prenatal vitamins that, by federal law, do not require a prescription, even if one is written. However, insulin shall be covered as described in Section Eleven.

ii. Any prescriptions filled at a non-Preferred Pharmacy.

iii. Drugs used in connection with Non-Covered Services.

iv. Refills needed because the Member lost or misused his or her supply, even if ordered by a Provider.

v. Drugs for cosmetic reasons, including those meant to improve your appearance, such as products to:

a. grow or regain hair.

b. prevent skin wrinkling.

c. affect the color, tone or texture of the skin.

vi. Vaccines and immunizations.

vii. Any refill in excess of the amount specified by the prescription.

viii. Any refill dispensed more than one year from the date the prescription was written.

ix. Drugs prescribed for uses and conditions other than those approved by the U.S. food and Drug Administration.

x. Smoking cessation drugs.

xi. Medical and non-medical supplies, including ostomy supplies, medical and non-medical devices and equipment except contraceptive devices.

xii. Experimental or Investigational Drugs.

xiii. Drugs used in connection with assisted reproductive technologies.

xiv. Appetite suppressing and weight loss drugs.

xv. Drugs used in connection with elective or voluntarily induced abortion, including drugs such as the "morning after pill".

xvi. Non-Formulary Drugs. We will not provide Benefits for Non-Formulary drugs unless such Non-Formulary Drug is:

a. Medically Necessary for you; and

b. The Formulary drug:

(i) has not been effective in treating your condition; or

(ii) causes or is reasonably expected to cause adverse or harmful reactions in you.

c. You must get Precertification for Non-Formulary Drugs.

(i) You or your Provider must submit a request to MVP for Precertification for a Non-Formulary Drug. You must follow the instructions set forth in Section 5, paragraph 1(B) of this Contract. You must get Precertification before you fill the prescription.

(ii) MVP will respond to the Precertification Request as described in Section 5, 1(C) of this Contract. If MVP denies the request, we will send you and your Provider a written adverse determination notice explaining why the claim was denied. You may then file an appeal as described in the Internal Appeals and Independent External Review Section of this Contract.

## SECTION TEN - COVERED EMERGENCY SERVICES

1. Emergency Services.

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

   B. Emergency Services. We will provide Benefits for Emergency Services only if your condition is an Emergency Medical Condition. We will only provide benefits if a Covered Service is Medically Necessary. You must pay any applicable Coinsurance and Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

   C. You, your Provider, a family member, or other representative must call MVP at 1-888-MVP-MBRS (1-888-687-6277) within 48 hours, or as soon as reasonably possible, after receiving Emergency Services or an Emergency inpatient admission to a Hospital or other facility.

2. Emergency Ambulance Services (other than Air Ambulance Services). **Precertification is NOT required for Emergency Ambulance Services. If your condition is not an Emergency Medical Condition, you must pay all Charges.** We will provide Benefits for Ambulance Services, when used for an Emergency Medical Condition. We will only provide Benefits for local transportation to the nearest appropriate facility. We will not provide Benefits for Ambulance Services if you could have safely ridden in a private car, whether or not one was available. We will only provide benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

3. Air Ambulance Services. **Precertification is NOT required for Emergency Air Ambulance Services. If your condition is not an Emergency Medical Condition, you must pay all Charges.** We will provide Benefits for Air Ambulance Services only when used for an Emergency Medical Condition that requires special medical treatment not available in the immediate area or when ordered by a physician in non-Emergency situations. We will only provide Benefits for transportation to the nearest appropriate facility having the services/supplies needed to treat the critical sickness or injury. Air Ambulance Services must be provided in an aircraft used primarily for transporting sick or injured persons. You must pay any applicable Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

## SECTION ELEVEN – COVERED PROFESSIONAL CARE AND SERVICES

1. Covered Services. We will provide Benefits for the following professional care and services at the office of a Provider. We will only provide Benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible. You must also pay the difference, if any, between the Allowable Charge and the Provider's Charge.

A. Physician Office Visits. We will provide Benefits for the examination, diagnosis, and treatment of an injury, illness or condition, and laboratory services provided at the time of such visit. Coverage includes shots given during a covered office visit, including shots for allergies.

B. Second Surgical Opinions. We will provide Benefits for a second surgical opinion when your Provider has made a recommendation on the need for covered elective Surgery. You do not have to have a second surgical opinion. If you do, the second opinion must be given by a board-certified specialist who examines you and who, by reason of his or her specialty, is competent to consider the proposed Surgery.

C. Consultations. We will provide Benefits for inpatient or office consultations when requested by your attending physician for the evaluation of your condition.

D. Mental Health Services. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** We will provide Benefits for Mental Health Services only when such services are provided by a licensed or certified mental health professional that is a Preferred Provider. **Preferred Provider Only.**

E. Substance Abuse Services. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** We will provide Benefits for Substance Abuse Services only when such services are provided by a substance abuse counselor or other person approved by the secretary of human services that is a Preferred Provider. **Preferred Provider Only**.

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

i. for members under age 50, we will provide benefits for mammography screening when recommended by a physician; and

ii. for members age 50 and older, we will provide benefits for an annual mammography screening.

These services must be performed at a facility that is accredited by the American College of Radiologists.

G. Chiropractic Treatment. We will provide Benefits for clinically necessary chiropractic services, provided by a licensed chiropractic physician, for treatment of conditions related to subluxations, joint dysfunctions, and neuromuscular and skeletal disorders. We will not provide Benefits for:

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

ii. treatment of any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs.

H. Diabetes Treatment. We will provide Benefits for equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if such equipment, supplies and training are prescribed by a licensed, participating health care professional legally authorized to prescribe such items. We will provide Benefits for the self-management training and education, including medical nutrition therapy, described above only if provided by a certified, registered, or licensed health care professional with specialized training in the education and management of diabetes. **Diabetic equipment and supplies are subject to the Prescription Drug Deductible. You must also pay the Prescription Drug Coinsurance. Diabetic equipment and supplies are also subject to the Annual Benefit Maximum for Prescription Drugs.**

I. Inpatient Medical Care. We will provide Benefits for medical services rendered when you are receiving Covered Services in: (1) a Hospital or Skilled Nursing Facility; or (2) a mental health care facility or institution for the treatment of alcohol or substance dependency. We will only provide Benefits for one visit per day per Provider.

J. Office-Based Surgery.

K. Breast Cancer Care. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** We will provide Benefits for mastectomy and treatment of physical complications of mastectomy such as lymphedema, lymph node dissection, or lumpectomy for the treatment of breast cancer. Following a covered mastectomy, we will provide Benefits for all stages of reconstruction of the breast on which the mastectomy was performed. We will also provide benefits for surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined appropriate by your Provider, in consultation with you. We will provide Benefits for breast prostheses required as a result of covered breast cancer care.

L. Anesthesia Services. We will provide Benefits for Anesthesia Services provided in connection with Covered Services.

M. Laboratory Services.

N. Diagnostic Services. **Precertification is required for MRIs, CT Scans, PET Scans and Nuclear Cardiology. Your Benefits will be reduced if you do not get Precertification for these services.**

O. Therapeutic Services.

P. Casts and Dressings.

Q. Medical Foods. We will provide Benefits for low protein modified food products and medical foods prescribed by a Provider for use under the direction of a physician for the Medically Necessary dietary treatment of an inherited metabolic disease. A low protein modified food product must be specifically formulated to have less than one gram of protein per serving. A medical food means an amino acid modified preparation. Benefits are limited to $2,500 per Member per Calendar Year. **Subject to Benefit Maximum**. **If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**

R. Craniofacial Disorders. We will provide Benefits for diagnosis and treatment, including surgical and non-surgical procedures, of a musculoskeletal disorder that affects any bone or joint in the face, neck or head provided that such disorder is the result of accident, trauma, congenital defect, developmental defect, or pathology. We will not provide Benefits for the diagnosis and treatment of dental conditions or disorders or for dental pathology primarily affecting the gums, teeth, or alveolar ridge. We also will not provide Benefits for crowns that correct vertical dimension, splints, orthopedic repositioning appliances, bite plates and equilibration treatments (including splint equilibration and adjustments), bite, functional or occlusal registration, with or without splints, and kinesiographic analysis, any orthodontic treatment, including extraction of teeth, study models, except for the complete model made necessary when surgical extraction is completed. Surgery for correction of orthognapic conditions is covered. We will also not provide Benefits for prescription or non-prescription drugs prescribed or recommended by a dentist.

S. Physical, Occupational and Speech Therapy. We will provide Benefits for up to a combined 60 visits per Calendar Year for physical therapy, occupational therapy, and speech therapy when such services are provided under the direction of a physician by a Hospital or a facility or in a Provider's office as described in Section Seven. **Subject to Annual Benefit Maximum**. **If you incur Charges for these services in excess of this Annual Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**

T. Durable Medical Equipment. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** We will provide Benefits for the purchase or rental of standard Durable Medical Equipment. Durable Medical Equipment means equipment that is primarily and customarily used only for a medical purpose. Such equipment is appropriate for use in the home, and is designed for prolonged and repeated use. It is generally not useful to a person in the absence of an illness, injury or condition. Durable medical equipment includes, but is not limited to wheelchairs, hospital beds, walkers, traction equipment, and respirators. The option of whether to rent or purchase Durable Medical Equipment is at the sole discretion of MVP. You must pay any applicable Deductible. **Subject to Lifetime Benefit Maximums**. **If you receive Durable Medical Equipment in excess of this Lifetime Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible. If you receive non-standard Durable Medical Equipment, you will be responsible for any Charges in excess of the Allowable Charge for standard Durable Medical Equipment and such excess Charges will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**

U. External Prosthetic Devices. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** We will provide Benefits for the purchase of standard artificial limbs and artificial eyes. You must pay any applicable Deductible. **Subject to Lifetime Benefit Maximums**. **If you receive External Prosthetic Devices in excess of this Lifetime Benefit Maximum, you will be responsible for such Charges and they will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible. If you receive non-standard artificial limbs or artificial eyes, you will be responsible for any Charges in excess of the Allowable Charge for standard items and such excess Charges will not be considered as Covered Services. In addition, such excess Charges will not count toward your Deductible.**

V. Transplant Services/Donor Costs. **Precertification is required. Your Benefits will be reduced if you do not get Precertification.** We will provide Benefits for human organ and bone marrow Transplant Services, including transplant surgeries only when such services are obtained through a Preferred Transplant Provider. You may ask if a Provider is a Preferred Transplant Provider by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). MVP will also provide Benefits for live donor medical expenses up to your coverage limitations and after payment of your expenses if the donor's expenses are not covered by other insurance. **Any donor expenses you incur will not count toward your Deductible.**

## SECTION TWELVE – EXCLUSIONS

These exclusions are in addition to those exclusions and limitations described in other sections of this Contract.

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

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

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

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

   D. An inpatient stay while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available to you;

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

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

   G. Any services provided by a private duty nurse;

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

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

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

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

      i. prior to your Effective Date; or

      ii. 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 Contract.

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

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

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

E. Preferred Provider Only Services. We will not provide Benefits for Preferred Provider Only Services if such services are provided by a non-Preferred Provider.

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

G. Abortion. We will not provide Benefits for an elective or voluntarily induced abortion.

H. 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.

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

J. 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.

K. Certification Examinations. We will not provide Benefits for any services related to routine physical examinations, well child visits, 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, medical research, licensing, travel, camp, or sports.

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

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

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

O. Cosmetic Services and Surgery. We will not provide Benefits for any services or surgery that are mostly meant to improve your appearance. This includes but is not limited to, plastic surgery and scar repair or revision. We will provide Benefits for services for reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part. This includes breast reconstruction and symmetry surgery as described in Section Six, paragraph 6 and Section Eleven, paragraph 1(K) (Breast Cancer Care). We will also provide Benefits for reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect. Please see Section Three paragraphs 3(F) and 4(B) for more information about covered newborn children.

P. Court-Ordered Services. We will not provide Benefits for court-ordered services, 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.

Q. Criminal Behavior and War. We will not provide Benefits for any services related to an illness, injury or condition arising out of your participation in a felony, riot or insurrection. The felony, riot, or insurrection will be determined by the law of the state where the criminal behavior occurred. We also will not provide Benefits for any services related to an illness, injury or condition that results from an act of declared or undeclared war.

R. Custodial Services. We will not provide Benefits for this service or for bed rest or convenience reasons.

S. Dental Services. Except as provided in Section Eleven paragraph 1(R) (Craniofacial Disorders), and except for accidental injury to sound, natural teeth, we will not provide Benefits for dental services. This includes, but is not limited to, services related to the care, filling, removal or replacement of teeth and

treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, bony impacted teeth, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, dental implants, and prosthetic restoration of dental implants. We will not provide Benefits for temporomandibular joint disease or dysfunction where it is dental in nature.

T. Dietician Services. We will not provide Benefits for dietician services, homemaker services, home delivered meals, or other food or food-related services, including nutritional counseling, except nutritional counseling for persons with diabetes.

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

V. 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.

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

X. Experimental or Investigational Services. Except as specifically provided in this paragraph, we will not provide Benefits for services that we determine are Experimental or Investigational Services. We will provide Benefits for Experimental or Investigational Services if we determine: (a) that the proposed service has demonstrated promise in treating the underlying condition through a Phase III or Phase IV clinical trial sanctioned by the United States Food and Drug Administration; and (b) that an expert panel with quality assurance and technology assessment expertise has reviewed the proposed service and deemed it appropriate. Except as required by applicable law, Phase I and II clinical trials, whether or not sanctioned by the United States Food and Drug Administration, are excluded. MVP will also provide Benefits for routine patient care costs, but only to the extent required by applicable law.

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

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

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

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

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

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

EE. 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.

FF. Late Submitted Charges. We will not provide Benefits for charges for services submitted to MVP more than twenty-four months after the date you receive the Provider's bill, except when coordination of benefits applies and MVP is the secondary payor. In such cases, we will not provide Benefits for charges for services submitted to MVP more than two years from the date of service.

GG. Outside the United States. Except for Emergency Services, we will not provide Benefits for services accessed outside the United States and its possessions.

HH. Military Service-Connected Illnesses, Injuries and Conditions. We will not provide Benefits for any services in connection with any military service-connected illness, injury, or condition if the Veteran's Administration is responsible for providing such services.

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

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

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

LL. Private Duty Nursing.

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

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

OO. Self-Help Education and Training. Except as specifically provided, we will not provide Benefits for biofeedback, self-diagnosis, self-treatment or self-help training and/or materials, including parent education, breast feeding education, Lamaze and similar childbirth preparation classes, lactation counseling and support services.

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

QQ. 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.

RR. Support Therapies. Except as provided in Section Nine, paragraph 2 (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.

SS. 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 Certificate.

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

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

VV. 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.

WW. 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 not provide Benefits for the expense of purchasing corrective lenses or hearing aids or similar items.

XX. Weight Loss Services. We will not provide Benefits for any services or programs in connection with weight reduction, dietary control, dietary supplements and replacements, and exercise classes We will not provide Benefits for surgical weight loss procedures. This includes, but is not limited to, gastric stapling, gastric by-pass, and gastric bubble. We will provide Benefits for Medically Necessary Covered Services for the treatment of morbid obesity. Morbid obesity is defined as having a body mass index greater than 40 or a body mass index greater than 35 with at least 2 severe comorbidities such as diabetes and heart disease.

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

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

## SECTION THIRTEEN - PREMIUMS

1. Amount of Premiums – The premiums for this contract are approved by the Vermont Department of Banking, Securities, Insurance and Health Care Administration (BISHCA). The approved premium will be charged for the period for which it has been approved, unless an increase or decrease has been approved by BISHCA and we provide you with the notice described in paragraph 2 below.

2. Change in Premiums – The premiums for this Contract will change each year based on the attained age of the Subscriber and his or her Dependents. The change will be made on the Contract renewal date. We will give you at least 30 days prior written notice of any increase or decrease in the premiums.

3. Payment of Premiums – The Subscriber, on behalf of himself/herself and his or her Dependents, is responsible for timely payment of all premiums due under this Contract.

You will not become covered under this contract until the first premium has been paid to us. All premiums for this contract are due and payable in advance on or before the last day of each prior month (the "Premium Due Date").

A. Misstatement of Age. If the age of a Member has been misstated on the application for this Contract, the Subscriber shall be responsible for the difference between premiums paid and premiums owed had the Member's age been correctly stated. This provision shall not limit MVP's rights under any other section of this Contract or applicable law.

4. Grace Period. Notwithstanding paragraph 3 above, MVP will allow you thirty (30) days from the missed Premium Due Date for all premiums except for the first premium (the "Grace Period"). If MVP does not receive your payment within the Grace Period, then your coverage will automatically terminate as of the missed Premium Due Date. If this Contract is terminated for any reason, you will continue to be held liable for all premium payments due and unpaid before the termination. In the event that you do not pay these premiums, MVP shall be entitled to all remedies provided for in law and equity, including but not limited to attorneys' fees, costs of suit and interest.

A. Special Rule for Children Covered Pursuant to Qualified Medical Support Orders – If we do not receive your payment on or before the Premium Due Date, we will send a termination notice to both of the child's parents and all other persons or agencies identified in the Medical Support Order. If we receive the required premium payment within forty-five (45) days of the termination date specified in the notice, we will reinstate coverage effective from the termination date.

5. Reinstatement. MVP, in its sole discretion, may accept premium payments after expiration of the Grace Period and allow for reinstatement of your Contract. In the event that MVP does allow for reinstatement, your Contract will begin again upon your payment of the appropriate premium subject to the following limitations:

A. MVP may accept the premium without a new enrollment application. If MVP does not ask for a new enrollment application, this Contract will be reinstated on the date MVP accepts your premium.

B. MVP may ask for a new enrollment application or conditionally accept premium payment. If this happens, the Contract will begin again, with a new Effective Date, when one of the following happens:

i. When the enrollment application is approved by MVP; or

ii. Forty-five (45) days after the premium is paid unless MVP notifies you that we will have disapproved your new enrollment application within that timeframe.

## SECTION FOURTEEN –
## TERMINATION AND SUSPENSION OF YOUR CONTRACT AND/OR COVERAGE

This section describes how this Contract and/or your coverage under this Contract may terminate. When this Contract or your coverage terminates, benefits stop at 12:00 midnight on the termination date, unless you are eligible for Benefits after termination as described below.

1. Automatic Termination

   A. On Your Death – If you have individual coverage, this Contract will automatically terminate on the date of your death. If you have family coverage, this Contract will automatically terminate as of the date to which the last premium before your death was paid. However, your Spouse and/or Dependents may ask for substantially similar replacement coverage. Your Spouse or Dependents must notify us of your death right away (or as soon as reasonably possible).

   B. Dissolution of Marriage or Civil Union – If you become divorced, or your marriage or civil union is annulled or otherwise legally dissolved, your Spouse's coverage under this Contract will automatically terminate on the date of dissolution. You must notify us of any such dissolution right away (or as soon as reasonably possible).

   C. Termination of Coverage of a Child – Your child's coverage under this Contract will automatically terminate on the earliest of the end of the month in which the child reaches age 19 (or age 25 if a full time student at an accredited college or university), marries, ceases attending an accredited college or university, or is no longer chiefly dependent upon you for support and maintenance. If your child is covered pursuant to Section Three, paragraph 2(C), the child's coverage will automatically terminate on the earliest of the end of the month in which the child is no longer incapable of self-sustaining employment, is no longer disabled, or is no longer chiefly dependent upon you for support and maintenance. You must notify us when your child is no longer eligible for coverage right away (or as soon as reasonably possible).

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

         a. the order is no longer in effect, or

         b. the child is or will be enrolled in comparable coverage through another insurer that will take effect not later than the date coverage under this contract would terminate. You must notify us of these circumstances right away (or as soon as reasonably possible).

2. MVP's Termination of Your Coverage – MVP may terminate your Contract for the following reasons.

   A. Non-Payment of Premiums – You do not make your required premium payments as specified therein. Your coverage will terminate as described in Section Fourteen.

   B. Fraud or Misrepresentation – MVP will terminate this Contract right away for any fraud or material misrepresentation made by you when you enrolled under this Contract, provided any initial or continuing eligibility information, or when you filed any claim under this Contract. We will provide you with written notice of such termination. The termination will be effective as of the date of the fraud or intentional misrepresentation and MVP shall be entitled to all remedies provided for in law and equity, including but not limited to recovery from you for the charges for benefits provided, attorneys fees, costs of suit, and interest.

   C. Discontinuance of Class of Contract – We discontinue the entire class of contracts to which this Contract belongs. We will give you 30 days prior written notice.

   D. Withdrawal from the Non-Group Market – We withdraw from the non-group market as permitted by Vermont law and regulation.

   E. Residency – You are no longer a Resident of Vermont. MVP will also refuse to renew your coverage if you will not be a resident of Vermont on or after the renewal date of this Contract. This does not apply to children for whom the Subscriber has been ordered to provide dependent health insurance coverage pursuant to a qualified medical support order.

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

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

5. Benefits After Termination – If you are Totally Disabled or pregnant on the date this contract terminates, and such Total Disability or pregnancy occurred before this Contract terminated, we will continue to provide Benefits for otherwise covered services that are directly related to the illness, injury or condition causing the Total Disability or the pregnancy. This extension of Benefits will continue until the earliest of: (1) the date you are no longer Totally Disabled; (2) the date that your pregnancy is complete; or (3) twelve months from the date your coverage would otherwise have terminated. However, we will not provide more Benefits than would otherwise have been provided if your coverage under this Contract had not been terminated and we will not provide Benefits for any services covered or required to be covered under any other insurance plan or contract.

A. Two-Person or Family Coverage – If you have two-person or family coverage under this contract, this extension of benefits covers only the Member with the Total Disability or pregnancy. MVP will terminate the coverage of other family members who were covered under this Contract as of the termination date.

B. Other Exceptions – If your coverage under this Contract was terminated for the reasons set forth in subparagraphs 2(A), (B), or (E), we will not provide this extension of Benefits.

6. MVP's Right to Recover – If we incorrectly provide Benefits after your coverage or this Contract has been terminated, MVP may recover from you the charges for Benefits provided, and any attorneys fees, costs, and interest.

7. Suspension of Coverage – If you are a member of the Armed Forces of the United States or a member of a reserve component of the Armed Forces of the United States, including the National Guard, you may, upon written request, have your coverage suspended during a period of active duty as described below. MVP will refund any unused premium during the period of suspension. You will be entitled to resume coverage upon written application and payment of the required premium within sixty (60) days after the date of termination of the period of active duty, with no limits or conditions imposed as a result of such period of active duty, except as described in this subsection. Coverage will be retroactive to the date of termination of the period of active duty. There will be no exclusion period in connection with the resumption of coverage, unless:

A. The condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty; or

B. Any exclusion described in this Contract was not completed prior to the suspension. In no event shall the sum of the exclusion period imposed prior to and subsequent to the period of suspension exceed the length of the exclusion originally imposed.

This Section applies only if you are: (1) a member of the Armed Forces of the United States; or (2) a member of a reserve component of the Armed Forces of the United States, including the National Guard, you serve no more than five (5) years of active duty, and you either voluntarily or involuntarily enter upon active duty (other than for purposes of determining your physical fitness and other than for training); or have your active duty voluntarily or involuntarily extended during the period when the President in Office authorized to order units of the ready reserve or members of the reserve component to active duty; provided that such additional duty is at the request and for the convenience of the federal government.

## SECTION FIFTEEN – EFFECT OF MEDICARE

1. When you become eligible for Medicare, you must notify MVP in writing.

2. If you are eligible for Medicare, you must enroll under both Part A and Part B. If you are eligible, but do not enroll, the amount of benefits that Medicare would have provided will be subtracted from any Benefits that we will provide.

3. If you are covered under Medicare, MVP will coordinate Benefits with Medicare.

4. MVP as Secondary Plan – If MVP is the secondary plan, you must follow Medicare's rules as well as the terms of this Contract, and pay any applicable Deductible before MVP will provide Benefits.

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

## SECTION SIXTEEN - COORDINATION OF BENEFITS

This Section applies only if you have other health benefits.

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

2. The following are considered to be health plans:

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

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

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

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

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

i. No-Fault auto insurance;

ii. Group auto insurance;

iii. traditional fault-type auto insurance;

iv. uninsured or underinsured motorists insurance;

v. automobile-medical payment insurance;

vi. homeowner's insurance;

vii. personal injury protection insurance;

viii. financial responsibility insurance;

ix. medical reimbursement insurance coverage that you did not purchase; or

x. any other property and liability insurance providing medical payment benefits.

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

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

B. If you are covered under one plan as a subscriber and under the other plan as a dependent, the plan that covers you as a subscriber is the Primary Plan.

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

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

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

ii. If no such court decree exists or if the Plan of the parent designated under such a court decree as responsible for the child's health care expenses does

not have actual knowledge of the court decree, benefits for the child are determined in the following order:

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

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

c. Finally, the Plan of the parent not having custody of the child.

E. A plan that covers you as an active employee or as that employee's dependent is primary. A plan which covers you as a laid off or retired employee (or as that employee's dependent) is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on which plan is primary, this subsection 3(E) is ignored.

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

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

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

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

In the event that you get benefits or services under this Contract, including but not limited to coverage for drugs (prescription or otherwise), after coverage has lapsed or has been

terminated, MVP is entitled to recover payment for such services through any and all reasonable means, including but not limited to, the collections process.

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

## SECTION SEVENTEEN
## THIRD PARTY LIABILITY AND RIGHTS OF REPAYMENT

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

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

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

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

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

6. Member's Obligations

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

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

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

ii. providing any relevant information;

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

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

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

7. Consequence of Failure to Comply – If the Member fails to comply with the requirements of paragraph 6, that Member shall be responsible for all Benefits provided by MVP in addition to costs, attorneys' fees, and interest incurred by MVP in obtaining repayment.

## SECTION EIGHTEEN – INTERNAL APPEALS AND INDEPENDENT EXTERNAL REVIEW

1. Internal Appeals. An internal appeal means a written or verbal complaint submitted to MVP by or on behalf of a Member expressing dissatisfaction regarding the availability, delivery or quality of health care services, claims payment, handling or reimbursement for health care services, or expressing dissatisfaction regarding matters governed by or related to this Contract, including requests that MVP change decisions that services are not Medically Necessary or are not Covered Services. You, your designated representative (such as a family member, friend, or lawyer), or a Provider acting on your behalf, may submit an internal appeal. You must call MVP at 1-888-MVP-MBRS (1-888-687-6277) in order to designate a representative. Your decision as to whether or not to submit an internal appeal has no effect on your rights to any other Benefits under this Contract. Upon request and free of charge, MVP will provide you with reasonable access to and copies of documents, records, and other information relevant to your appeal.

2. Internal Appeal Reviewers.

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

   B. Second Level Internal Appeals. Second level internal appeals are reviewed by a panel comprised of MVP senior medical and administrative staff with the necessary education, training and experience to resolve the matter. The medical staff participating in at least one level of appeal 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 that typically treats the condition or provides the services that is the subject of the appeal. Alternatively, MVP may engage independent organizations to provide medical specialists practicing in the same or similar specialty as consultants for a particular appeal. Second level appeals are reviewed by persons not involved in making the initial decision or the first level appeal decision and who are not subordinate to such persons. Further information about the panel reviewing your appeal is included in MVP's written response to the appeal.

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

4. Time Limit for Submitting a First Level Internal Appeal. You must submit a first level internal appeal within 180 days of receiving our decision regarding the matter that is the subject of the appeal. 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 appeal by calling MVP at 1-888-MVP-MBRS (1-888-687-6277). You may submit a written appeal to MVP Health Insurance Company, 625 State Street, P.O. Box 1076, Schenectady, New York 12301-1076.

5. MVP's Response to First Level Internal Appeals. MVP will respond to first level internal appeals as follows:

   A. First Level Internal Appeals related to Emergency Services or Urgent Care. MVP will make a decision within 72 hours after our receipt of the information needed to decide the appeal and will notify you of the decision, by phone or fax as soon as possible after the decision. MVP will also send you written confirmation of the decision within 48 hours after the decision is made. In cases involving Mental Health Services or Substance Abuse Services, a licensed mental health review agent will make a decision within 24 hours of the date the appeal is submitted.

B. First Level Internal Medical Appeals for Services Not Yet Provided. MVP will make a decision within 15 days after our receipt of the information needed to decide the appeal. MVP will send you written confirmation of the decision within 48 hours after the decision is made. In cases involving Mental Health Services or Substance Abuse Services, a licensed mental health review agent will make a decision within 10 days of the date the appeal is submitted.

C. All other First Level Internal Appeals. MVP will make a decision within 30 days after our receipt of the information needed to decide the appeal. MVP will send you written confirmation of the decision within 7 days after the decision is made. In cases involving Mental Health Services or Substance Abuse Services, a licensed mental health review agent will make a decision within 10 days of the date the appeal is submitted.

6. Time Limit for Submitting a Second Level Internal Appeal. In cases not involving Mental Health Services or Substance Abuse Services, if you are not satisfied with MVP's decision issued in response to the first level internal appeal, you may submit a second level internal appeal. You must submit this appeal within 180 days of receiving our decision issued in response to the first level appeal. 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 appeal by calling MVP at 1-888-MVP-MBRS (1-888-687-6277). You may submit a written appeal to MVP Health Insurance Company, 625 State Street, P.O. Box 1076, Schenectady, New York 12301-1076. As described in paragraph 2, second level internal appeals are reviewed by a panel. You also have the right to appear before the panel to discuss your appeal. If you cannot appear before the panel in person, you may communicate with the panel by conference call or other appropriate technology. For cases involving Mental Health Services or Substance Abuse Services, please see paragraph 8 below.

7. MVP's Response to Second Level Internal Appeals. MVP will respond to second level internal appeals as follows:

A. Second Level Internal Appeals related to Emergency Services or Urgent Care. MVP will make a decision within 48 hours after our receipt of the information needed to decide the appeal and will notify you of the decision, by phone or fax as soon as possible after the decision. MVP will also send you written confirmation of the decision within 48 hours after the decision is made.

B. Second Level Internal Medical Appeals for Services Not Yet Provided. MVP will make a decision within 30 days after our receipt of the information needed to decide the appeal. MVP will send you written confirmation of the decision within 48 hours after the decision is made.

C. All other Second Level Internal Appeals. MVP will make a decision within 45 days after our receipt of the information needed to decide the appeal. MVP will

send you written confirmation of the decision within 7 days after the decision is made.

8. Review of First Level Internal Appeal Decisions in Cases Involving Mental Health Services or Substance Abuse Services. In cases involving Mental Health Services or Substance Abuse Services, if you are not satisfied with the decision issued in response to the first level appeal, you, your Provider, or your authorized representative may submit an appeal to the Independent Panel of Mental Health Care Providers established by the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("BISHCA"). You must contact BISHCA at 1-800-631-7788 for assistance in submitting this appeal.

9. Independent External Review.

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

   B. You must ask for this review within 90 days of receiving MVP's second level adverse decision. To ask for an independent, external review, you must call BISHCA at 800-631-7788.

   C. An independent external review will be provided ONLY if BISHCA determines the service that is the subject of the review reasonably appears to be a Covered Service.

   D. You may not request an external review unless we have issued a second level internal appeal decision. This means that you must exhaust our internal process before requesting an external review.

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

10. Effect of Review Organization's Decision; Coverage. The decision of the review organization is binding on MVP. If the organization decides in our favor, we will not change our decision or provide benefits for the service that is the subject of the review. If the organization decides in your favor, we will provide benefits subject to all other terms and conditions of this Contract. We will not provide benefits for any service that is not a Covered Service.

11. Women's Health and Cancer Rights Act of 1998. Federal law requires us to notify you of our benefits for reconstructive surgery following mastectomy. The Women's Health and Cancer Rights Act of 1998 requires that we provide benefits for reconstruction of the breast on which a mastectomy has been performed and/or the other breast (to produce a symmetrical appearance). We also cover prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as required by the Act. Benefits for the above services are subject to all terms and conditions of your Contract. For example, they require the same Coinsurance and Deductibles as the rest of your coverage. If you have any questions about your rights under this Act, please contact MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

## SECTION NINETEEN - GENERAL PROVISIONS

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

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

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

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

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

   C. permit MVP to review and copy your records.

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

4. Changes to this Contract.

   A. We may change the terms of this Contract and change or eliminate any of the benefits if approved by BISHCA. Members have no vested rights to any benefits or other provisions of this Contract. We will give you at least 30 days prior written notice of a change.

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

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

6. Legal Action. You may not commence any legal action against MVP prior to the expiration of sixty (60) days after written Proof of Loss was submitted to MVP in accordance with Section 5 of this Contract. In addition, you may not start a legal action against MVP prior to exhausting the second level appeal process outlined in Section Eighteen. Finally, you may not bring any legal action against MVP after the expiration of three (3) years from the date written Proof of Loss was required to be submitted to MVP in accordance with Section 5 of this Contract. Service or process must be made upon an officer of MVP at 625 State Street, Schenectady, New York 12305 or otherwise in accordance with state or federal law.

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

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

7. Venue for Legal Action. You must start any lawsuit against us in a court in Vermont. You agree not to start a lawsuit against us in a court located anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action we bring against you.

8. Time Limit on Certain Defenses. After 2 years from the effective date of this Contract, no misstatements, except fraudulent misstatements, made by the Subscriber or his or her Dependents in the enrollment application for this Contract, shall be used to void this Contract or used as a basis to deny a claim after the expiration of such 2-year period.

9. MVP's Relationship with Providers. Providers are not agents or employees of MVP and MVP is not an agent or employee of any Provider. This Contract does not require any particular Provider to accept you as a patient and we do not guarantee such acceptance by any particular Provider. Providers are solely responsible for all services rendered or not rendered to Members. MVP does not control the treatment or other professional actions of providers. MVP's decisions relate only to whether we will provide Benefits under this Contract and are not a substitute for the professional judgment of your Provider. Further, the persons making these decisions for MVP do not get incentives to limit or deny Benefits and are not paid based upon the quantity or type of such decisions.

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

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

12. Furnishing Information. You must, within 30 days of our request, provide us with all information and records that we may need to perform our obligations under this Contract.

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

14. Recovery of Overpayments. If we make a payment to you in error, we will tell you and you must return the amount of the overpayment to us within 60 days. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we make to you.

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

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

17. Entire Contract. The Member's enrollment/change forms, this Contract, and any riders, amendments, endorsements, and schedules delivered with the contract or added thereafter shall constitute the entire agreement between MVP and the Member, and shall supersede any prior arrangements, agreements, negotiations, and discussions between the parties, whether written or oral.