This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mvphealthcare.com or by calling 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -$2,000 person/$4,000 family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	In network -$6,250 person/$12,500 family. Rx out-of-pocket -$1,250 person/$2,500 family.	The out–of–pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers see www.mvphealthcare.com.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% coinsurance*	Not covered.	Deductible applies.
	Specialist visit	50% coinsurance*	Not covered.	Deductible applies.
	Other practitioner office visit	50% coinsurance*	Not covered.	Deductible applies.
	Preventive care/ screening/immunization	$0 copay	Not covered.	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance*	Not covered.	Deductible applies.
	Imaging (CT/PET scans, MRIs)	50% coinsurance*	Not covered.	Deductible applies.

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mvphealthcare.com.	Generic drugs	Retail $12 copay* Mail order $30 copay*	Not covered.	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Preferred brand drugs	40% coinsurance*	Not covered.	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Non-preferred brand drugs	60% coinsurance*	Not covered.	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered.	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	50% coinsurance*	Not covered.	Deductible applies.
	Physician/surgeon fees	50% coinsurance*	Not covered.	Deductible applies.
If you need immediate medical attention	Emergency room services	50% coinsurance*	50% coinsurance*	Deductible applies.
	Emergency medical transportation	50% coinsurance*	50% coinsurance*	Deductible applies.
	Urgent care	50% coinsurance*	50% coinsurance*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance*	Not covered.	Deductible applies.
	Physician/surgeon fee	50% coinsurance*	Not covered.	Deductible applies.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	50% coinsurance*	Not covered.	Deductible applies.
	Mental/Behavioral health inpatient services	50% coinsurance*	Not covered.	Deductible applies.
	Substance use disorder outpatient services	50% coinsurance*	Not covered.	Deductible applies.
	Substance use disorder inpatient services	50% coinsurance*	Not covered.	Deductible applies.
If you are pregnant	Prenatal and postnatal	0% coinsurance	Not covered.	Deductible waived.
	Delivery and all inpatient services	50% coinsurance*	Not covered.	Deductible applies.
If you need help recovering or have other special health needs	Home health care	50% coinsurance*	Not covered.	Deductible applies.
	Rehabilitation services	50% coinsurance*	Not covered.	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	50% coinsurance*	Not covered.	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	50% coinsurance*	Not covered.	Deductible applies.
	Durable medical equipment	50% coinsurance*	Not covered.	Deductible applies.
	Hospice service	50% coinsurance*	Not covered.	Deductible applies.
If your child needs dental or eye care	Eye exam	50% coinsurance*	Not covered.	Deductible applies. One eye exam per year to age 21.
	Glasses	$150 allowance per year to age 21.*	Same as Par Provider.*	Deductible applies.
	Dental check-up	$0 copay*	Same as Par Provider.*	Deductible applies. Two dental exams per year to age 21.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-687-6277. You may also contact your state insurance department at 1-800-637-7788 or http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: MVP Health Care at 1-888-687-6277 or your state insurance department at 1-800-637-7788 or http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.org

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."
This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,466**
- **Plan pays** $2,670
- **Patient pays** $4,796

Sample care costs:

Hospital charges (mother)	$2,714
Routine obstetric care	$2,084
Hospital charges (baby)	$852
Anesthesia	$905
Laboratory tests	$527
Prescriptions	$173
Radiology	$176
Vaccines, other preventive	$35
Total	**$7,466**

Patient pays:

Deductibles	$2000
Co-pays	$17
Co-insurance	$2629
Limits or exclusions	$150
Total	$4,796

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,490**
- **Plan pays** $2,465
- **Patient pays** $3,025

Sample care costs:

Prescriptions	$2,889
Medical Equipment and Supplies	$1,311
Office Visits and Procedures	$725
Education	$288
Laboratory tests	$137
Vaccines, other preventive	$140
Total	**$5,490**

Patient pays:

Deductibles	$2000
Co-pays	$0
Co-insurance	$1025
Limits or exclusions	$0
Total	$3,025

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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VERMONT HMO CONTRACT

[PLAN NAME]

MVP Health Plan, Inc.
625 State Street
Schenectady, New York 12305
(800) 777-4793

THIS IS YOUR CONTRACT
Issued by
MVP Health Plan, Inc.
625 State Street, Schenectady, New York 12305
800/777-4793

This Contract ("Contract") describes the benefits available to you under a Contract between MVP and your Group or MVP and you directly, depending upon whether you purchase this contract through your employer or as an individual. Amendments, schedules, riders and/or endorsements may be delivered with this Contract or added thereafter. You must make sure you understand and comply with all of the terms and conditions herein.

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

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

THIS CONTRACT IS AVAILABLE FOR SALE THROUGH THE VERONT HEALTH CONNECT EXCHANGE.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT. YOU SHOULD KEEP THIS CONTRACT WITH YOUR OTHER IMPORTANT PAPERS SO THAT IT IS AVAILABLE FOR YOUR FUTURE REFERENCE.

MVP Health Plan, Inc.

By: Denise V Gonick

Denise V. Gonick
President/CEO

Name:
I.D. No.:
Primary Care Physician:
Phone:

MVP Health Plan, Inc. is a not-for-profit health maintenance organization certified in Vermont.

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SECTION ONE – INTRODUCTION

MVP is a New York State not-for-profit corporation. MVP is certified as a health maintenance organization in New York State and the State of Vermont. MVP provides benefits for Enrollees for comprehensive health services on a prepaid basis. These services are provided by:

(1) physician and physician-hospital organizations;
(2) independent physicians and other health care professionals; and
(3) independent hospitals and other facilities through agreements with MVP.

MVP's service area includes the states of Vermont and New Hampshire, and the New York State counties of Albany, Broome, Cayuga, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Seneca, Steuben, St. Lawrence, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming and Yates. Additional counties may be added in the future.

When you enroll as an MVP Enrollee, you and your covered dependents must each choose a Primary Care Physician ("PCP") from MVP's Participating Provider Directory. You must notify MVP of your choice. You may change your PCP at any time, but you must notify MVP of your new choice before receiving services from that PCP. Your PCP is responsible for coordinating and overseeing your health care. All services must be provided by MVP participating providers. The following exceptions apply.

(1) emergency services
(2) services while temporarily outside the service area.
(3) certain gynecological services.
(4) Enrollees with certain serious conditions.
(5) Enrollees in their second or third trimester of pregnancy.
(6) services not available through a MVP provider.

These exceptions are described in detail in Section Four and other sections in this Contract. You should refer to those sections to ensure that you meet all requirements. To be eligible for benefits under this Contract, services must also be:

A. Covered Services as defined in this Contract;

B. Medically Necessary as defined in this Contract;

C. for certain services as specified later in this Contract, subject to prior authorization, and/or concurrent review; and

D. not subject to the exclusions and limitations described in this Contract.

If you receive services which are not Covered Services, MVP will not pay for those services. You will be responsible for paying all charges for those services. However, this Contract applies to benefits only, and does not stop you from receiving services that are not, or might not be, eligible for benefits. You have the right to file grievances with MVP or with the State of Vermont if you are dissatisfied with our processes, procedures, or benefit decisions. You also have certain rights to request independent external review of our decisions.

SECTION TWO – DEFINITIONS

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

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

B. Benefit Year refers to a calendar year. A Benefit Year is the date your Deductibles, out-of-pocket limits and other totals begin to accumulate. Limits on visits and other limits also begin to accumulate on the first day of your Benefit Year.

A calendar year is the twelve (12) month period beginning on January 1 and ending on December 31. If you were not covered under this Contract for this entire period, calendar year means the period from your effective date until December 31 for the initial period, and January 1 to December 31 thereafter.

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

D. Complications of Pregnancy means conditions requiring hospital admission whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy including, but not limited to:

(1) acute nephritis
(2) nephrosis
(3) cardiac decompensation
(4) missed abortion
(5) similar medical and surgical conditions of comparable severity

It does not include:

(1) false labor
(2) occasional spotting
(3) physician prescribed rest during pregnancy
(4) morning sickness
(5) hyperemesis gravidarium
(6) pre-eclampsia
(7) similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy

This term also includes non-elective cesarean section, ectopic pregnancy, and miscarriage.

E. Cost Share is the amount that you must pay, in addition to the premium, for Covered Services. You must pay any cost share directly to the provider. Cost Share in this Contract refers to any of the following as applicable.

- Coinsurance is a dollar amount, expressed as a stated percentage of the charge.
- Copayment is a fixed dollar amount.

- Deductible is a dollar amount which you must pay for Covered Services before we provide benefits under this Contract

  (i) If you have individual coverage, you must pay the individual Deductible before MVP will pay any Benefits. If you have met your individual Deductible, you do not have to pay any individual Deductible for the rest of that Benefit Year. The individual Deductible applies to each Enrollee each Benefit Year.

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

F. Covered Services means the services specified in this Contract as eligible for benefits. MVP maintains protocols to assist in determining whether a service is a Covered Service. You may request a copy of MVP's protocols by calling MVP's Customer Care Center at 1-800-348-8515.

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

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

This term also means services which, 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. Dependent 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.

I. Diagnostic Services means radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scans, electroencephalograms, electrocardiograms, organ scans, and other medical and surgical diagnostic services.

J. Domestic Partners means the two individuals in a legal or interpersonal relationship who live together and share a common domestic life but are neither joined by marriage nor a civil union.

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

L. Effective Date means the date your coverage under this Contract begins.

M. Eligible Individual, as defined by federal law, means a person on the effective date of this Contract:

i. 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;
ii. whose most recent prior coverage was not terminated based upon nonpayment of premiums or fraud; and
iii. who has elected and exhausted any available COBRA or state continuation coverage.

N. Enrollee 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. The words “you” and “your” refer to the Enrollee and his or her eligible dependents.

O. Experimental or Investigational Services 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.

P. External Prosthetic Devices are devices that replace all or some of the functions of a permanently inoperative and/or malfunctioning external body part. Examples of such devices are artificial limbs and breast prostheses.

Q. Health Care Facility: means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, impatient or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. A Health Care Facility is not a facility operated by religious groups relying solely on spiritual means through prayer or healing.

R. Mental Health Condition means a condition or disorder involving mental illness or alcohol or substance abuse that falls under a diagnostic category listed in the mental disorders section of the international classification of disease, as periodically revised.

S. Non-participating Provider means a Provider who does not have an agreement with MVP to provide Covered Services to Enrollees.

T. Participating Provider means a Provider who has an agreement with MVP to provide Covered Services to Enrollees.

U. Primary Care Physician means a Participating Provider who has an agreement with MVP to provide covered primary health care services to Enrollees.

V. Provider means a properly licensed and/or certified:

(1) physician
(2) hospital
(3) approved facility for the treatment of mental health conditions
(4) approved institution for the treatment of alcohol or substance dependency
(5) skilled nursing facility
(6) home care agency
(7) health care professional
(8) licensed midwife
(9) free standing ambulatory surgery center, free standing radiology/imaging center, free standing dialysis center, and free standing laboratory facility
(10) athletic trainer
(11) advanced practice registered nurse who is certified as a nurse midwife
(12) naturopath
(13) DME provider
(14) chiropractor
(15) podiatrist
(16) mental health provider

The provider must provide health care services within the scope of his or her practice, and must charge and bill patients for such services.

W. Qualified Health Plan or QHP means a health insurance plan that is certified by the Department of Financial Regulation and selected for offering through the Vermont Health Connect, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, coinsurance, and out-of-pocket maximum amounts), and meets other requirements.

W. Relevant document, record or other information means, that a document, record or other information shall be considered relevant if such document, record or other information was relied upon in making the benefit determination or the determination of a grievance, or was submitted, considered or generated in the course of making the benefit determination or the determination of a grievance, without regard to whether such document, record or other information was relied upon in making the benefit determination or the determination of a grievance.

X. Resident means a person who is domiciled in Vermont. It means the person intends to maintain a principal dwelling place in Vermont indefinitely. It also means that the person intends to return to Vermont if temporarily absent. One must act consistent with that intent.

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

Z. Schedule of Enrollee Payments or Schedule. The document attached to this Contract that describes Cost Share (Copayments, Deductible, Coinsurance), Annual Out of Pocket Maximums, Annual Benefit Maximums, Lifetime Benefit Maximums and similar information.

AA. Store and Forward means an asynchronous transmission of medical information to be reviewed at a later date by a health care provider at a distant site who is trained in the relevant specialty and by which the health care provider at the distant site reviews the medical information without the patient present in real time.

BB. Surgery 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.

CC. Telemedicine means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The services must be provided between health care facilities. Telemedicine does not include the use of audio-only telephone, e-mail or facsimile.

DD. Therapeutic Services means:

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

b. Dialysis means removal of waste materials when an Enrollee has acute kidney failure or chronic, irreversible kidney deficiency, and the use of equipment and disposable medical supplies.

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

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

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

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

FF. Totally Disabled or Total Disability means incapable of engaging in any employment or occupation for which the person is or becomes qualified by

reason of education, training or experience. Such person must not, in fact, engage in any employment or occupation for wage or profit.

GG. VHC means Vermont Health Connect or the Exchange.

SECTION THREE – ENROLLMENT, ELIGIBILITY AND COVERAGE

1. Initial Enrollment. Each Enrollee must choose a PCP. If coverage is provided through a group, you must follow your group's and/or VHC's instructions for enrollment. Your group will transmit your enrollment information to VHC in paper or electronic format. If on-line enrollment is available to you, you will complete an on-line enrollment form and transmit the form to VHC. If you have been enrolled electronically, MVP may also send you a paper form to sign. Your Spouse and your adult dependents also may be required to sign the paper 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. Eligibility for enrollment in a Qualified Health Plan through the Exchange. The Exchange must determine an applicant eligible for enrollment in a Qualified Health Plan through the Exchange if he or she meets the following requirements:

      (1) Citizenship, status as a national, or lawful presence. You must be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

      (2) Incarceration. You must not be incarcerated, other than incarceration pending the disposition of charges; and

      (3) Residency. You must meet the applicable residency standard identified in this paragraph (A)(3).

         (i) For an individual who is age 21 and over, is not living in an institution, is capable of indicating intent, and is not receiving an optional State supplementary payment, the service area of the Exchange of the individual is the service areas of the Exchange in which he or she is living and:

            (a) Intends to reside, including without a fixed address; or

            (b) Has entered with a job commitment or is seeking employment (whether or not currently employed).

         (ii) For an individual who is under the age of 21, is not living in an institution, is not eligible for Medicaid based on receipt of assistance under title IV-E of the Social Security Act, is not emancipated, is not receiving an optional State supplementary payment, the Exchange service area of the individual:

            (a) Is the service area of the Exchange in which he or she resides, including without a fixed address; or

(b) Is the service area of the Exchange of a parent or caretaker, established in accordance with paragraph (A)(3)(i) of this section, with whom the individual resides.

(iii) Other special circumstances. In the case of an individual who is not described in paragraphs (A)(3)(i) or (ii) of this section, the Exchange must apply the residency requirements described in applicable federal regulations with respect to the service area of the Exchange.

(iv) Special rule for tax households with members in multiple Exchange service areas.

(a) Except as specified in paragraph (A)(3)(iv)(b) of this section if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in paragraphs (A)(3)(i), (ii), and (iii) of this section, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.

(b) If both spouses in a tax household enroll in a QHP through the same Exchange, a tax dependent may only enroll in a QHP through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard described in paragraphs (a)(3)(i), (ii), or (iii) of this section.

B. Eligibility Requirements. VHC and/or MVP will determine an applicant eligible for enrollment in a Qualified Health Plan through the Exchange if he or she meets the following additional requirements:

(1) The Enrollee and his or her dependents must meet the Group's eligibility requirements, when applicable.

(2) If the Enrollee chooses individual coverage, then only he or she is covered.

(3) If Enrollee plus Spouse only coverage is offered and the Enrollee chooses such coverage, then only the Enrollee and his or her Spouse, as described below, may be covered under this Contract. If your group allows Domestic Partners to be covered under your Plan, the following provisions also apply to Domestic Partners. If your Plan does not allow coverage of Domestic Partners, the provisions that reference Domestic Partners do not apply.

(4) If Enrollee plus child or children only coverage is offered and the Enrollee chooses such coverage, then only the Enrollee and his or her child(ren), as described below, may be covered under this Contract.

(5) If family coverage is offered and the Enrollee chooses such coverage, then the Enrollee, Spouse and child(ren), or Domestic Partner as described below, may also be covered:

(i) The Enrollee’s Spouse;

(ii) The Enrollee's dependent children until age twenty-six (26).

The child: (a) can be married or unmarried; (b) does not have to live with the Enrollee; (c) does not have to be chiefly dependent upon the Enrollee for support and maintenance; and (d) does not have to be a student. This also includes proposed adoptive children, who are dependent upon you will be covered during any waiting prior to the finalization of the child's adoption

(iii) The Enrollee's unmarried children who are over age twenty-six (26) 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 twenty-six (26). The child must live with the Enrollee and be chiefly dependent upon the Enrollee for support and maintenance. We can require you to provide documentation annually verifying that the child is qualified and continues to qualify under this section.

(iv) Children Covered Under This Contract. To be covered, the Enrollee's children must meet the requirements of (5)(ii) or (5)(iii) above. The Enrollee's children must also be related to the Enrollee in one of the following ways:

(a) The Enrollee's natural child;

(b) The Enrollee's legally adopted child;

(c) A child for whom the Enrollee is the legal guardian;

(d) The Enrollee's step child;

(e) A child under age twenty-six (26) who has been placed with the Enrollee for adoption and for whom the Enrollee has assumed and retains a legal obligation to support;

(f) A child of the Enrollee's Dependent, limited to coverage from the moment of birth for thirty-one (31) days or such other period required by law, 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 Enrollee 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 Enrollee or in the State of Vermont.

(h) A child of the Enrollee's Domestic Partner.

3. Enrollment of Enrollee's New Family Members.

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

B. To add a Domestic Partner. The Enrollee and his or her Domestic Partner must fill out and return to VHC an enrollment form, required documentation, and required premium. If you return the completed form, requested documentation, and required premium within thirty (30) days after the required nine (9) month cohabitation period, the Domestic partner will be added to your coverage as of the first of the month following the completion of the nine (9) month cohabitation period. If you do not, your Domestic Partner will not be added to your coverage until the first of the month following the next premium due date or after the next open enrollment period as applicable when the completed form, requested documents and applicable premium is received.

C. To add a child.

i. If you have Enrollee plus child or children coverage or family coverage, your newborn natural child or a newborn child placed with you for adoption, will automatically be covered from the moment of birth for 61 days or such other period required by law. Coverage is limited to benefits for otherwise covered services for injury, sickness, necessary care and treatment of medically diagnosed congenital defects or birth abnormalities, or any combination of these, and well child care. If you want to continue the child's coverage beyond 61 days or such other period required by law, you must comply with paragraph (iii) below. If you do not follow this procedure, we will not provide coverage beyond the 61 days or such other period required by law.

ii. If you have individual coverage, or Enrollee plus Spouse coverage, 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 in order for the child to be covered from the moment of birth. If you do not follow this procedure, we will not provide coverage for your child.

iii. You must complete and return to VHC an enrollment form, any requested documentation, and the required premium. If you do so within 61 days or such other period required by law of the date of birth, adoption, placement for adoption, legal guardianship, or within 61 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 legal guardianship, or as of the date the child became your step child. If you do not do so within 61 days or such other period required by law 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 the next open enrollment period when VHC receives the completed form, requested documents, and applicable premium. If you do not notify VHC, MVP will not provide coverage for the child.

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

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

4. If you and/or your Dependent[s] do not first enroll or enroll during an open enrollment period, then you and/or your Dependent[s] will most likely need to wait until the next open enrollment period before you may enroll (either for yourself or your Dependents) for coverage with MVP. However, if you or your Dependent[s] qualify for a special enrollment period then each are able to enroll. To be able to enroll during a special enrollment period you must meet one of the conditions below:

A. You or your dependent lose minimum essential coverage, including but not limited to the following:

i. loss of eligibility for coverage (but not due to failure to pay premiums on a timely basis or a rescission due to an intentional misrepresentation of material fact);

ii. termination of employer contributions; or

iii. exhaustion of COBRA eligibility.

B. You gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption;

C. If you were not previously a citizen, national, or lawfully present, but subsequently gain such status;

D. Your enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the VHC, as evaluated and determined by the VHC. In such cases, the VHC may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

E. You adequately demonstrates to the VHC that the QHP in which you are enrolled substantially violated a material provision of its contract in relation to you;

F. You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions, regardless of whether you are already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;

G. You gain access to new QHPs as a result of a permanent move;

H. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and

I. You demonstrate to the Exchange, in accordance with guidelines issued by HHS, that you meet other exceptional circumstances as the Exchange may provide.

J. If you lose eligibility under Medicaid or Children's Health Insurance Program ("CHIP") program: You and/or your Dependent is covered under a state Medicaid or CHIP program and coverage of you or your Dependent under such a plan is terminated as a result of loss of eligibility for such coverage AND you and/or your Dependent applies for coverage within sixty (60) days after the end date of such coverage; OR

K. If you become Eligible for Medicaid or Children's Health Insurance Program ("CHIP") program: You and/or your Dependent becomes eligible for group health plan premium help under a state Medicaid or CHIP plan AND you and/or your eligible Dependents apply for coverage within sixty (60) days after the date you and/or your dependent is determined to be eligible for such help.

When enrolling under this Section, coverage under this Contract will start as of the first date of loss of coverage after the qualifying event, if timely premium payment is received on your behalf.

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

6. When you, your Spouse or your child is no longer eligible for coverage. You must immediately notify VHC of any event that affects your coverage. Such events include, but are not limited to, divorce or annulment; death of your Spouse; Medicare, Medicaid, or CHP eligibility; coverage under another policy or contract; a child 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 your Group within 30 days of such event or if your Group does not provide the information to MVP in a timely manner, 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.

SECTION FOUR - ACCESS TO PROVIDERS

When you become an Enrollee, you and each member of your family must each pick a Primary Care Provider (PCP). You must tell MVP who you picked. You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as a PCP. For information on how to select a PCP and for a list of the PCPs, contact us at the Customer Care Center. Call 1-800-348-8515. You also can send e-mail from our web site (www.mvphealthcare.com).

1. Finding a PCP.
   Look in the directory. Participating Providers are on our web site too (www.mvphealthcare.com).

2. Changing your PCP.
   You may do this any time. Tell MVP before you see the new PCP. Call or write MVP's Customer Care Center. You can send e-mail from our web site (www.mvphealthcare.com).

3. No Referral Required. MVP does not require that you get a referral from your PCP for Covered Services from an MVP specialist. However, you are required to take certain actions before getting the following Covered Services.

   A. Non-Emergency In-Patient Hospital Services. You must be admitted by a Participating Provider. The provider that admits you must get prior authorization from MVP for your hospital admission.

   B. Non-Emergency Outpatient Mental Health or Alcoholism/Substance Abuse Rehabilitation Services. Your mental health/substance abuse provider must call [Primarilink at 1-800-320-5895] for prior authorization before you get such services.

   C. Non-Emergency Care Services From a Non-Participating Provider. An MVP Participating Provider must submit a prior authorization request on your behalf, and you must receive prior written approval from MVP's Utilization Management Department before you get such services.

   Talk to your PCP for all of your health care needs. Even though you do not need a referral, your PCP should play a central role in your health care. You should visit your PCP for "Primary Care Services". These are routine office visits for well care, preventive care and basic health screenings. Primary Care Services may not be covered under your contract unless your PCP does them.

4. If you need to find other MVP-participating providers in your area, please visit our Web site at www.mvphealthcare.com. Click on "Find a Doctor" on the home page.

5. Use of Non-Participating Providers by New Enrollees.

Except as provided below, we will continue to provide benefits for otherwise Covered Services to:

(a) New Enrollees who are receiving an active course of treatment for an acute episode of chronic illness or acute medical condition from the terminated provider; and
(b) New Enrollees with life threatening, disabling or degenerative conditions who are receiving an ongoing course of treatment from the terminated provider.

These benefits will be provided for ninety (90) days from the date of MVP's notice to you of the provider's termination, consistent with written transition plan goals developed and agreed to by MVP and the provider.

(a) New Enrollees in their second or third trimester of pregnancy who are receiving services from the terminated provider until postpartum care is complete.

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

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

6. Use of Non-Participating Providers when a qualified Participating Provider is not available.

Except as otherwise specifically provided in this Contract, in order for services to be eligible for benefits under this Contract, services must be provided by your PCP or by a Participating Provider. However, in circumstances where a qualified Participating Provider is not available to provide Covered Services to an Enrollee, MVP may provide benefits for Covered Services provided by a Non-Participating Provider. When seeking benefits for Non-Participating Provider services in these circumstances, your PCP must comply with the prior authorization requirements set forth in Section Six, and provide information regarding your condition, a medical opinion as to why services cannot be provided by a Participating Provider, and the name and qualifications of the proposed Non-Participating Provider.

7. Use of Non-Participating Providers when an Enrollee is temporarily outside the service area.

When an Enrollee temporarily lives, works, attends school or otherwise temporarily resides outside of the service area, requires medically necessary services that would be covered under the health benefit plan if the Enrollee were able to access care from contracted providers within the service area, and it is medically necessary that the services be provided promptly, locally and not delayed until the member's return to the service area, the managed care organization shall assist the Enrollee in locating a provider in the Enrollee's location that is contracted, otherwise affiliated or willing to arrange a single case agreement and that has the appropriate training and experience to provide the services that are medically necessary to meet the particular health care needs of the Enrollee. Coverage shall be consistent with the terms and conditions of the Enrollee's Contract for coverage of services obtained from a contracted provider within the service area. There shall be no additional liability to the Enrollee.

8. Use of Non-Participating Providers for Emergency Services. We will provide benefits for emergency services provided by a Participating or Non-Participating Provider for an Emergency Medical Condition. We will ensure that you are held harmless for any Out-of-Network Provider charges that exceed your Cost Share.

SECTION FIVE – MEDICAL NECESSITY

1. We will only provide Benefits if a Covered Service is Medically Necessary. Medically Necessary or Medical Necessity means that a Covered Service is:

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

   B. 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;

   C. One which:

      i. Helps restore or maintain your health;
      ii. Prevents deterioration of or palliate your condition; or
      iii. Prevents the reasonably likely onset of a health problem or detect an incipient problem.

   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.

2. MVP maintains protocols to assist in determining whether a service is Medically Necessary. You may request a copy of such protocols by contacting MVP's Customer Care Center at 1-800-348-8515.

SECTION SIX - UTILIZATION MANAGEMENT

This Contract requires concurrent review and prior authorization by MVP before you receive certain Covered Services. All other services are subject to retrospective review. MVP's approval of services through concurrent review, or prior authorization are not a guarantee of benefits. MVP may deny benefits in cases where there is material misrepresentation or fraud by an Enrollee, and as otherwise permitted by law. Also see Section Thirteen, "Prescription Drug Coverage" for details about how to get prior authorization for prescription drugs.

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

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

   B. In cases where:

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

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

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

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

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

A. When Prior Authorization is Required.

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

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

B. If all necessary information is received at the time of the prior authorization request, we will notify you and your provider, by telephone and in writing, of our decision as soon as possible but no later than two (2) business days from receipt of the request. If all necessary information is not received at the time of the prior authorization request, we will notify you and your Provider of any missing information that is needed to decide the request. You and your Provider will have 45 days from the receipt of our notice to provide us with the missing information. MVP will make our decision and notify you and your Provider, in writing, within two (2) business days of receipt of the information or the expiration of the time allowed to provide the missing information, whichever is earlier.

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

4. Retrospective Review. Retrospective review means our review, after services have been provided to you, to determine whether such services are Medically Necessary Covered Services. We will review information about your medical condition and the services provided to you. If all necessary information is received at the time of the request for retrospective review, we will notify you of any adverse determination, in writing, within 30 days after our receipt of the request. If all necessary information is not received at the time of the request for retrospective review, we will notify you and your Provider within 5 days after our receipt of the request of any missing information that is needed to decide the request. You and your Provider will have 45 days from receipt of

our notice to provide us with the missing information. In such cases, we will notify you of any adverse determination, in writing, within 30 days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide us with the missing information, whichever is sooner. Except in cases of missing information, MVP's time to conduct retrospective review shall not exceed a total of thirty (30) days.

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

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

SECTION SEVEN – COVERED HOSPITAL INPATIENT SERVICES

1. Prior Authorization and Concurrent Review are required for all Hospital inpatient services.

2. What is a hospital? As used in this Contract, the term "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. Such facility has organized departments of medicine and major surgery, and provides twenty-four (24) hour nursing service by or under the supervision of registered nurses. The following are not within the definition of Hospital:

   - Convalescent homes.
   - Convalescent, rest or nursing facilities.
   - Facilities primarily affording custodial or educational care.
   - Health resorts, spas or sanitariums
   - Infirmaries at schools, colleges or camps
   - Facilities for the aged.
   - Any military or veteran's hospital or soldiers home, or any hospital contracted for or operated by any national government or agency thereof for the treatment of Enrollees or ex-Enrollees 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.
   - Residential Care Facilities.

3. Inpatient Services. We will provide benefits for the following when provided to you in a participating Hospital:

   A. Semi-private room.
   B. Board and general nursing services.
   C. Use of operating, recovery, delivery, endoscopic and treatment rooms and equipment.
   D. Use of intensive care or special care units and equipment.

E. Diagnostic and therapeutic items used in and provided by the Hospital, such as prescribed drugs, medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items.
F. Dressings and casts.
G. Diagnostic Services.
H. Therapeutic Services.
I. Professional services, equipment, and supplies in connection with oxygen, anesthesia.
J. Laboratory services.
K. Pathology services.
L. Medical and surgical supplies.
M. Therapy Services.

4. Maternity Care. We provide benefits for the inpatient services listed in paragraph 3 to a covered mother for childbirth for at least 48 hours after a vaginal delivery. The same benefits are provided for at least 96 hours after a cesarean delivery. The attending provider, with the mother or mother's designated representative, may determine to discharge the mother sooner. We will also provide benefits for these inpatient services for pregnancy and Complications of Pregnancy. You may get these services from a physician, licensed midwife, or an advanced practice registered nurse who is certified as a nurse midwife. You may receive these services in a facility or at your home. To receive Benefits from a midwife, or nurse midwife, the midwife, nurse midwife and facility must be Participating. Coverage is subject to the same Cost Share as any other maternity care listed on your Schedule of Enrollee Payments.

5. Newborn Care. We will provide benefits for well-baby care and an initial hospital visit for the baby while the mother is an inpatient. The attending physician, with the newborn's mother or the newborn's designated representative, may determine to discharge the newborn sooner. 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 or such other period required by law 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. We will provide benefits for the inpatient services listed in paragraph 3 in connection with an inpatient hospital stay following a mastectomy, lymph node dissection or lumpectomy for the treatment of breast cancer, and for physical complications of mastectomy, including lymphedema. We will also provide benefits for these 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.

7. Mental Health Care

A. Mental Health Conditions. We will provide benefits for the inpatient services listed in paragraph 3 for treatment of mental health conditions only when provided in a mental health facility qualified pursuant to rules adopted by the secretary of human services or in an institution approved by the secretary of

human services, that provides a mental health treatment program pursuant to a written plan. The facility must also be a Participating Provider.

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

B. Alcohol or Substance Dependency. We will provide benefits for the inpatient services listed in paragraph 3 only when 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. The institution must also be a Participating Provider.

We will not provide Benefits for the following services: long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization, delinquency or Custodial Services (see Section Two - Definitions).

8. Physical Rehabilitation Care. We will provide benefits for the services listed in paragraph 3 only when such services are Acute Services provided by a participating free standing facility licensed to provide inpatient physical rehabilitation services or by a unit of a participating Hospital designated as providing such services.

9. 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 your Skilled Nursing Facility benefits.

10. You must pay the Cost Share listed on your Schedule of Enrollee Payments for Hospital inpatient services. Newborn Care is covered in full.

SECTION EIGHT – 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 participating Hospital or a participating free standing facility:

A. Pre-surgical 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 at the hospital has been reserved for surgery.

You must pay the Cost Share listed on your Schedule.

B. Outpatient Surgery. We will provide benefits for Surgery, including sterilizations and one attempt at reversal of sterilization. These services are subject to prior authorization. You must pay the Cost Share listed on your Schedule for each surgery.

C. Therapeutic Services. We will provide benefits for outpatient Therapeutic Services. You must pay the Cost Share listed on your Schedule for each visit.

D. Contraceptive Services. We will provide benefits for outpatient contraceptive services. Contraceptive services are covered in full.

E. Treatment of Mental Health Conditions. We will provide benefits for outpatient treatment of Mental Health Conditions only when provided by a participating licensed or certified mental health provider. You must pay the Cost Share listed on your Schedule for each visit. Family and couples therapy are also covered as outpatient mental health services.

F. Treatment of Alcohol Abuse or Substance Dependency. We will provide benefits for outpatient treatment of alcohol or substance dependency only when provided by a participating licensed or certified substance abuse provider. You must pay the Cost Share listed on your Schedule for each visit.

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

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

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

Mammography screenings are covered in full, there is no cost-share for the Enrollee.

H. Diagnostic Services. We will provide benefits for outpatient Diagnostic Services. Please refer to your Schedule.

I. Laboratory Services. We will provide benefits for outpatient laboratory services. Please refer to your Schedule.

J. Diagnostic and Therapeutic Items. This section includes benefits for items used in and furnished by the outpatient department or free-standing center. This includes: drugs, medications, sera, biologicals, vaccines, intravenous preparations and visualizing dyes administered during the course of receiving Covered Services, and the administration of such items.

K. Cardiac or Pulmonary Rehabilitation. We cover up to three (3) supervised exercise sessions per week up to a total of 36 sessions for cardiac or pulmonary rehabilitation programs. For cardiac rehabilitation, we cover an additional 36 sessions for each new acute cardiac event.

SECTION NINE – COVERED SKILLED NURSING FACILITY SERVICES

1. Prior Authorization and Concurrent Review are required for all Skilled Nursing Facility services.

2. What is a Skilled Nursing Facility (SNF)? – A skilled nursing facility is a licensed facility that provides 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. The SNF must be a Participating Provider.

3. Conditions for SNF Services. We will provide benefits for SNF services only if the following conditions are met:

   A. your admission is for ongoing treatment of the condition for which you were hospitalized;
   B. you would otherwise require skilled care as a hospital inpatient if you were not admitted to the SNF; and
   C. you require inpatient skilled nursing or Therapy Services on a daily basis.

4 Skilled Nursing Facility Services. We will provide benefits for the inpatient skilled nursing facility services listed below. Please refer to your Schedule.

   A. Room and board in a semiprivate room.

   B. Skilled nursing care.

   C. Therapy Services.

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

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

SECTION TEN – SPECIAL COVERED SERVICES

1. Home Care.

   A. Prior Authorization is required for all Home Care Services. Concurrent Review is required for out of network Home Care Services.

   B. What is a home care agency? A home care agency is a hospital or agency licensed or certified to operate as a home care agency.

   C. Conditions for Home Care Services. We will provide benefits for home care services under the following conditions.

i. The services are supervised by a participating physician under a written treatment plan.
ii. The services are provided by a participating home care agency.
iii. Without these services you would need to be admitted to a Hospital or Skilled Nursing Facility.

D. Home Care Services. We will provide benefits 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. Therapy Services if provided by home health agency personnel.

iv. Medical supplies, drugs, the purchase or rental of durable medical equipment, and laboratory services, to the same extent that such laboratory services would have been covered if you were an inpatient in a Hospital or Skilled Nursing Facility.

E. Payment. You must pay the Cost Share listed on your Schedule for each home care visit and for any Durable Medical Equipment.

2. Ambulance Services. We will provide benefits for Hospital, municipal, professional, or licensed voluntary ambulance services to and from a Hospital, between Hospitals, and between a Hospital and a Skilled Nursing Facility. These services are subject to prior authorization. Please refer to your Schedule.

3. Hospice Services.

A. What is 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 and must be a Participating Provider.

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. You and your physician consent to a written Hospice care plan.

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

i. Skilled nursing visits - up to 2 visits per day.
ii. Home health aide visits - up to 100 hours per month for personal care services only.

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

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

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

vi. Durable Medical Equipment

viii. Prescription drugs.

4. Private Duty Nursing

A. You must get Prior Authorization for private duty nursing.

B. We cover skilled nursing Services by a private-duty nurse outside of a hospital, subject to these limitations:

i. We limit Benefits for private duty nursing to $2,000 per Enrollee, per year.

ii. We provide Benefits only if you receive Services from a registered or licensed practical nurse. We do not Cover private duty nursing Services provided at the same time as home health care nursing Services.

5. We will cover Telemedicine services delivered to a patient in a Health Care Facility under the same terms and conditions as if services were provided by in-person consultation. Services are available In-Network or Out-of-Network only if your plan allows you to see Out-of-Network Providers for in-person consultations. Services are subject to the applicable Cost Share. Store and Forward services will be available for teleopthalmolgy or teledermatology.

SECTION ELEVEN - COVERED EMERGENCY SERVICES AND URGENTLY NEEDED CARE

1. Emergency Services. We will provide benefits for emergency services provided by a Participating or Non-Participating Provider only if your condition is an Emergency Medical Condition.

A. **Emergency Condition.** A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

(2) Serious impairment to such person’s bodily functions;

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of such person.

B. **Emergency Services**. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

C. **Cost Sharing.** Out of Network Emergency Services are subject to the same cost share as In-Network Emergency Services.

D. **Prior Authorization.** Emergency Services are not subject to prior authorization requirements.

E. You, your Provider, or a member of your family must call MVP at 1-888-MVP-MBRS within 48 hours, or as soon as reasonably possible, after receiving Emergency services.

F. Your PCP must coordinate your care after you receive Emergency services.

G. **Your Payments.** You must pay the Cost Share listed on your Schedule for Emergency services. We will ensure that you are held harmless for any Out-of-Network Provider charges that exceed your Cost Share. You will not have to pay the Cost Share for Emergency Services if you are admitted to a Hospital right away. You will have to pay the Cost Share for Hospital inpatient services.

2. Urgently-Needed Care. We will provide benefits for Urgently Needed Care provided by a Participating or a Non-Participating Provider. However, you must first call your PCP and follow his or her instructions as to what you should do.

A. Urgently-Needed Care provided by a Participating Provider means Medically Necessary Covered Services to treat an illness or condition that if not treated within 24 hours presents a serious risk of harm.

B. Urgently-Needed Care provided by a Non-Participating Provider means Medically Necessary Covered Services to screen and stabilize a condition that if not treated within 24 hours presents a serious risk of harm, so that you can be safely transported to a Participating Provider; provided that such services were received because you were unable to receive services from a Participating Provider.

C. You, your Provider, or a member of your family must call MVP at 1-888-MVP-MBRS within 48 hours, or as soon as reasonably possible, after receiving Urgently-Needed Care that results in an inpatient admission.

D. Your PCP must coordinate your care after you receive Urgently-Needed Care.

E. You must pay the applicable Cost Share listed on your Schedule. You will not have to pay the Cost Share for Urgently-Needed care if you are admitted to a Hospital right away. You will have to pay the Cost Share for Hospital inpatient services.

3. Ambulance Services. We will provide benefits for ambulance services, when used for an Emergency Medical Condition. Please refer to your Schedule.

SECTION TWELVE – COVERED PROFESSIONAL CARE AND SERVICES

1. After Hours PCP Services. PCPs must provide or arrange for on-call coverage 24 hours per day, seven 7 days per week. If you become sick or injured outside of the PCP's regular office hours, you should call his or her office, identify yourself as an MVP Enrollee, and follow the PCP or covering physician's instructions. If you require Emergency Services or Urgently-Needed Care, you must follow the procedures set forth in Section Eleven.

2. Covered Services. We will provide benefits for the following professional care and services at the office of a Participating Provider. Except as otherwise provided, you must pay the Cost Share listed on your Schedule of Enrollee Payments for each visit. You will be held harmless if a Participating Provider engages services on Your behalf that You could not reasonably be expected to know were provided by a Non-Participating Provider.

   A. Preventive Care Services. These services must be provided by a Participating Provider, but need not be Medically Necessary.

      i. Well Child Care. We will provide benefits for Well Child Care for covered children from the date of birth through attainment of age 19, when provided by your PCP. Well Child Care means an initial newborn check-up in the hospital and well child visits. Well child visits include a medical history, a complete physical examination, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit. Such laboratory tests must be performed in the office or in a clinical laboratory. All well child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics. Well Child Care also includes immunizations against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type B, and hepatitis B, and other necessary immunizations.

      ii. Periodic Health Evaluations. We will provide benefits for periodic routine physical examinations and immunizations for covered persons age 19 and older as determined appropriate by age and sex, when provided by your PCP.

      iii. Gynecological Health Care Services. We will provide benefits for gynecological health care services provided by a Participating Provider. Gynecological health care services means preventive and routine reproductive health and gynecological care, including contraceptive

services. Such services include annual screening, counseling and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. We will also provide benefits for follow-up services required as a result of problems identified during such visits. However, the Provider must discuss the services and treatment plan with your PCP. The Provider must provide your PCP with all relevant and necessary medical information relating to your treatment. For a list of Participating Providers who specialize in obstetrics or gynecology, contact the Customer Care Center at 1-800-348-8515.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

vii. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;

viii. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and

ix. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

The preventive services referenced above shall be covered in full when received from In-Network Providers. Cost Sharing may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

A list of the preventive services covered under this paragraph is available on our website at www.mvphealthcare.com, or will be mailed to you upon request. You may request the list by calling the Customer Care Center at 1-800-348-8515.

B. Participating Provider Office or Home Visits. We will provide benefits for the examination, diagnosis, and treatment of an injury, illness or condition, and for prenatal and postpartum care, and laboratory services provided at the time of such visit. Coverage includes injections given during a covered office visit.

C. Health Education and Nutrition Counseling. We will provide benefits for health education and nutritional counseling when provided by Participating Providers as part of a medical treatment program. There is no limit on the number of visits for nutritional counseling for treatment of diabetes. For all other nutritional counseling, we cover up to three (3) outpatient nutritional counseling visits each Benefit Year. You must receive nutritional counseling from one of the following Network Providers or we will not provide Benefits:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- nutritionist licensed in Vermont;
- certified diabetic educator (C.D.E.);
- naturopathic physician (N.D.); or
- nurse practitioner.

D. Consultations. We will provide benefits for inpatient or office consultations by Participating Providers when requested by your attending physician for the evaluation of your condition. A report must be given to your PCP.

E. 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 are not required to have a second surgical opinion. The second opinion must be given by a participating board-certified specialist who examines you and who, by reason of his or her specialty, is competent to consider the proposed surgery.

F. Treatment of Mental Health Conditions. We will provide benefits for treatment of mental health conditions only when provided by a licensed or certified mental health professional who is a Participating Provider.

G. Treatment of Alcohol or Substance Dependency. We will provide benefits for treatment of alcohol or substance dependency only when provided by a substance abuse counselor or other person approved by the secretary of human services who is a Participating Provider.

H. Chiropractic Treatment. We will provide benefits for clinically necessary chiropractic services, for treatment of conditions related to subluxations, joint dysfunctions, and neuromuscular and skeletal disorders, when such services are provided by a participating licensed doctor of chiropractic (D.C.). 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.

I. 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 participating certified, registered, or licensed health care professional with specialized training in the education and

management of diabetes. You must pay the Cost Share for prescription drugs set forth on your Schedule.

J. Allergy Tests and Treatment. We will provide benefits for diagnosis and treatment of allergies by Participating Providers, including test and treatment materials. Cost Share applicable to office visits applies.

K. Inpatient Medical Care. We will provide benefits for medical services rendered when you are receiving covered inpatient services in: (1) a participating Hospital or Skilled Nursing Facility; (2) a participating mental health care facility or institution for the treatment of alcohol or substance dependency; or (3) a participating physical rehabilitation facility. We will only provide benefits for one visit per day per Participating Provider. MVP may provide benefits for Covered Services provided by a Non-Participating Provider when a qualified Participating Provider is not available (see Section Four). Please refer to your Schedule for the required cost-share.

L. Surgery. We will provide benefits for surgery and surgical care rendered by a Participating Provider. These services, when provided in the outpatient department of a hospital or in a free standing ambulatory surgery center, are subject to prior authorization.

M. Breast Cancer Care. We will provide benefits for mastectomy and treatment of physical complications of mastectomy such as lymphedema, lymph node dissection, or lumpectomy for the treatment of breast cancer. Following a covered mastectomy, even if paid for by a prior insurer, we will provide benefits for all stages of reconstruction of the breast on which the mastectomy was performed, 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 also provide benefits for breast prostheses required as a result of covered breast cancer care, but you must pay the Cost Share listed on your Schedule for external prosthetic devices. These services must be rendered by a Participating Provider.

N. Anesthesia Services. We will provide benefits for anesthesia services provided by a Participating Provider in connection with Covered Services. You must pay the Cost Share listed on your Schedule.

O. Anesthesia for Certain Dental Procedures. We will cover general anesthesia for certain dental procedures in a hospital or ambulatory surgical center given by a Participating Provider who is licensed to give anesthesia. You must obtain Prior Authorization from MVP before receiving benefits. You must pay the Cost Share listed on your Schedule. Anesthesia services are provided:

i. for children age seven (7) or younger who, as declared by a licensed dentist, are not able to get Medically Necessary dental care in an outpatient setting. The treating Provider must certify that hospitalization and general anesthesia are a must to treat the patient; or

ii. for children twelve (12) years of age or younger with a diagnosed phobia or Mental Health Condition whose dental needs are significantly complex and urgent such that delaying treatment can be expected to cause

infection, loss of teeth, or other increased oral or dental morbidity; or for those for whom a good result cannot be expected from dental care given under local anesthesia and a better result can be expected if care is given under general anesthesia. Or.

iii. for any person who has exceptional medical needs or a developmental disability which place the person at serious risk.

iv. Benefits are only for general anesthesia and any related hospital or facility charges. MVP will not provide benefits for the dental procedure. The anesthesia must be given by a fully accredited specialist in pediatric dentistry, a fully accredited specialist in oral and maxillofacial surgery or a dentist who has hospital rights

P. Laboratory Services.

Q. Diagnostic Services. These services must be provided by a Participating Provider.

R. Therapeutic Services. These services must be provided by a Participating Provider.

S. Casts and Dressings. These services must be provided by a Participating Provider.

T. Medical Foods. We will provide benefits for low protein modified food products, enteral formulae, and medical foods prescribed by a participating provider for use under the direction of a participating 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. You must pay the Cost Share listed on your Schedule.

U. Craniofacial Disorders. We will provide benefits for Participating Provider services 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. Surgical procedures require a second opinion as set forth in paragraph 2(E) above, and are subject to prior authorization requirements. 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 will also not provide benefits for prescription or non-prescription drugs prescribed or recommended by a dentist. You must pay the Cost Share applicable to the particular services you receive.

V. Therapy Services. These services must be provided by a Participating Provider. Benefits for these services are limited to thirty (30) visits for Rehabilitative and thirty (30 visits for Habilitative Services.

W. Durable Medical Equipment. We will provide benefits for the purchase, rental, procurement, repair or replacement of Durable Medical Equipment authorized by a Participating Physician and obtained from a Participating Provider. The option

of whether to rent or purchase authorized Durable Medical Equipment is at the sole discretion of MVP. You must pay the Cost Share listed on your Schedule.

X Disposable Medical Supplies. We will provide benefits for disposable medical supplies including, but not limited to dressings for cancer or burns, catheters, colostomy bags and related supplies, oxygen, diapers, chux, sponges, syringes, needles, diabetic test strips, lancets and glucometers for the treatment of diabetes, incontinence pads, reagent strips, catheters, elastic support stockings, compressive garments, dressings, and bandages.

Y. Transplant Services/Donor Costs. We will provide benefits for organ and bone marrow Transplant Services, including transplant surgeries only when such services are obtained through MVP's Transplant Network. You may obtain a description of this Network by calling the MVP Customer Care Center at 1-800-348-8515. Transplant Services are subject to prior authorization. MVP will also provide benefits for live donor medical expenses up to your coverage limitations and after payment of your expenses. You must pay the Cost Share amounts applicable to the particular services you receive.

Z. Clinical Trials for Cancer Patients. We will provide benefits, to the extent required by law, to cover routine costs for patients who participate in an approved cancer clinical trial. If you participate in a clinical trial administered by a cancer care provider that is not in our network, your routine follow-up care must be provided within our network, unless the cancer care provider determines this would not be in your best interest.

AA. Dental. We will only provide Benefits for dental treatment due to accidental injury to sound natural teeth within twelve (12) months of the accident and care or treatment necessary due to congenital disease or anomaly; and for temporomandibular joint disease or dysfunction where such disease or dysfunction is medical in nature.

BB. External Prosthetic Devices. We will provide benefits for the purchase, repair and replacement of External Prosthetic Devices, and for medical appliances, including breast prostheses and ostomy supplies, when authorized by a Participating Physician and obtained from a Participating Provider. Custom prosthetics will not be covered if a standard device exists, unless a custom device is Medically Necessary. You must pay the Cost Share listed on your Schedule. We only cover devices (and related supplies) surgically implanted or worn as anatomic supplement to replace:

- all or part of an absent body organ (including contiguous tissue and hair);
- hair lost due to chemotherapy or disease (excluding male pattern baldness);
- the lens of an eye; or
- all or part of the function of a permanently inoperative, absent or malfunctioning body part.

The Benefit covers prosthetic devices attached to (or inserted into) prosthetic shoes, and which replace a missing body part. We only cover eyeglasses or contact lenses that replace the lens of an eye when the lens was not replaced at the time of Surgery. We cover only:

- one set of accompanying eyeglasses or contact lenses for the original prescription; and
- one set for each new prescription

Also, we cover dental prostheses only if required:

- to treat an accidental injury (except injury as a result of chewing or biting); or
- to correct gross deformity resulting from major disease or Surgery;
- to treat obstructive sleep apnea; or
- to treat craniofacial disorders, including temporomandibular joint syndrome

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

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

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

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

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

      i. necessary to develop skills and abilities for the maximum reduction of physical or mental disability and for restoration of an individual to his or her best functional level, or to ensure that an individual under the age of 21 achieves proper growth and development;
      ii. provided or supervised by a nationally board-certified behavior analyst or by a licensed provider, so long as the services performed are within the provider's scope of practice and certifications.

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

   e. Early childhood developmental disorder means a childhood mental or physical impairment or combination of mental and

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

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

i. behavioral health treatment;

ii. pharmacy care (medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need for or effectiveness of a medication);

iii. psychiatric care (direct or consultative services provided by a licensed physician certified in psychiatry by the American Board of Medical Specialties;

iv. psychological care (direct or consultative services provided by a psychologist licensed pursuant to 26 V.S.A. chapter 55.); and

v. therapeutic care (services provided by licensed or certified speech language pathologists, occupational therapists, or physical therapists).

2. Benefits.

a. We will provide coverage for the evidence-based diagnosis and treatment of early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at birth and continuing until the child reaches age 21.

b. The amount, frequency, and duration of treatment described in this section shall be based on medical necessity and is subject to prior authorization.

c. We will provide coverage for applied behavior analysis when the services are provided or supervised by a licensed provider who is working within the scope of his or her license or who is a nationally board-certified behavior analyst.

d. We will provide coverage for services under this section delivered in the natural environment (home or child care setting) when the services are furnished by a provider working within the scope of his or her license or under the direct supervision of a licensed

provider or, for applied behavior analysis, by or under the supervision of a nationally board-certified behavior analyst.

e. Except for inpatient services, if you are receiving treatment for an early developmental delay, we may require treatment plan reviews based on your needs, consistent with reviews for other diagnostic areas and with rules established by the department of financial regulation. We may review the treatment plan for children under the age of eight once every six months.

f. Diagnosis and Treatment of Early Childhood Developmental Disorders are subject to the same Cost Share that is required for the diagnosis and treatment of other mental health conditions.

g. You must pay the applicable Cost Share listed on your Schedule.

h. We will not provide Benefits to an individual for services provided under an individualized family service plan, individualized education program, or individualized service program.

DD Tobacco Cessation Services. We will cover the cost of starting a tobacco cessation program per Enrollee per Benefit Year. We will also cover up to two 3-month supplies per year of tobacco cessation products including over-the-counter drugs when prescribed by a Participating Provider. You will be required to pay the applicable prescription drug Cost Share listed on your Schedule.

EE Weight Loss Services. We will provide Benefits for any Medically Necessary Covered Services or care set forth in your Contract, Certificate or Group Health Plan when rendered in connection with weight reduction or dietary control, including, but not limited to, laboratory services, and gastric stapling, gastric bypass, gastric bubble or other surgery for treatment of obesity.

We will provide Benefits for bariatric surgery only when such surgery is performed at a participating bariatric center of excellence. You can get a list of participating centers of excellence by calling the MVP Customer Care Center at 1-800-348-8515.

We will not provide coverage for dietary supplements, exercise classes, or gym memberships.

FF Pediatric Vision.

i. Exam. We will provide Benefits for one (1) routine eye examination (refraction) per Covered child every Benefit Year. A vision exam means an eye care exam for prescribing or determining your need for eyeglasses or contact lenses, and fittings for the contact lenses. The exam must be provided by a participating optometrist or ophthalmologist. This Benefit is per child until the end of the year in which they turn twenty-one (21). Please see your Schedule for your Cost Share obligations.

ii. Eyewear. We will provide Benefits for the price of one (1) pair of prescription eyeglasses OR for prescription contact lenses, up to a maximum of $150.00. See your Schedule of Enrollee Payments to

determine if this amount applies to the deductible. We will provide this Benefit once per enrolled child, until the end of the year in which they turn twenty-one (21), every Benefit Year. This Benefit applies to the retail price of lenses and/or frames or the retail price of contact lenses, material, training, the initial lens care kit and medically necessary follow-up visits for a period of two months. You may purchase the eyeglasses or contact lenses from any provider. After you make your purchase, you must follow the instructions in paragraph (c) below to get reimbursed. We will not provide Benefits for the following:

(1) Repairs to eyeglasses; or
(2) Safety glasses required by employment or sport.
(3) Non prescription eyewear

iii. Reimbursement. You must pay the provider's charge for the eyeglasses or contact lenses at the time of purchase. To get reimbursed up to the maximum Benefit stated above, you must send us the original receipt and a written request for reimbursement for the eyeglasses or contact lenses. Please include your MVP Enrollee Identification Number on your request. Mail both the receipt and request to the address on the claim form.

[GG. Pediatric Dental.

This Section of the contract describes benefits provided by dentists and dental hygienist and other licensed professionals who may legally provide covered services. Pediatric Dental benefits are provided to Enrollees up to the age of 21. Please refer to the Schedule of Benefits for Cost-Sharing requirements that apply to these benefits. The Allowed Amount for Pediatric Dental Services is a percentage of billed charges. Whenever the estimated cost of a dental treatment plan exceeds $200, you must submit your claim for pre-determination of benefits.

Benefits are categorized according to the type of service provided: Diagnostic & Preventive dental services (Class I), Basic Restorative dental services (Class II), Major Restorative dental services (Class III) and Orthodontics (Class IV).

i. Diagnostic & Preventive Dental Services (Class I)[1]

Preventive dental services consist of routine oral exams and dental prophylaxis (cleaning and scaling teeth) including periodontal prophylaxis once in any six (6) consecutive month period; fluoride treatments once in any 12 consecutive month period and bite-wing X-rays as part of a routine exam (once in any six consecutive month period); X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals or panoramic x-rays at thirty-six (36) month intervals, other x-rays; palliative treatment for dental pain when no other treatment but X-rays is given; Sealants on unrestored permanent molar teeth. Sealant is provided only to eligible persons through age (14). The sealant is covered for the application to caries-free (no decay) and restoration free permanent molars only and no more than once in a lifetime per tooth.

[1] Fluoride supplements for children without fluoridated drinking water in their home are covered in full with no deductible or other cost-sharing.

Unilateral and bilateral space maintainers are covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth. Space maintainers are covered through age fifteen (15)

ii. Basic Restorative Dental Services (Class II)

Basic Restorative dental services consist of:

a. Fillings
Silver (amalgam), silicate, plastic, porcelain, and composite and sedative fillings; reinforced pins.

b. Periodontics / Surgical Dental Services
Periodontics or surgical dental services consist of simple and surgical extractions and cutting procedures in the mouth (oral surgeries, i.e.: biopsy of oral tissue, incision and drainage of an intraoral abscess, Gingival Curettage, Osseous Surgery, Gingivectomy, Apioectomy); periodontal scaling and root planning; X-rays if performed on the same day the above procedures are performed; and treatment of jaw fractures and dislocations; and local anesthetics for oral surgery, fractures, dislocations and treatment of gums. Extra charges for removing stitches, exams after surgery is not covered.

General anesthesia, nitrous oxide, intravenous sedation, when administered in a dental office and in conjunction with: an extraction; tooth reimplantation; surgical exposure of a tooth; surgical placement of implant body biopsy; transseptal fiberotomy; alveeoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and/or frenuloplasty.

c. Endodontics
Endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, and root canal therapy where Hospitalization is not required.

d. Fixed Prosthodontics
Fixed Prosthodontics consist of fixed partial denture pontics and fixed partial denture retainers such as crowns. Fixed partial dentures are limited to 1 per tooth per 2 years.

e. Other
Prefabricated Crowns limitied to 1 per tooth per 2 years.

iii. Major Restorative Dental Services (Class III)

Major Restorative Dental services consists of cast crowns and complete dentures, immediate dentures, overdentures and partial dentures including repair pins to replace missing natural teeth. The teeth that are being replaced must be lost while the person is covered. Crowns are covered when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations. Also covered are denture

adjustments, repairs, rebases and relines. Immediate dentures are limited to 1 per arch per lifetime. Denture adjustments and repairs are limited to 1 per denture per 180 days. Denture rebases and / or relines are limited to 1 per denture per 2 years. Inlays are not a covered benefit. Removable or fixed partial dentures are not benefits for patients under the age of twelve (12).

iv. Orthodontics (Class IV)

Orthodontic services consists of necessary treatment and procedures required for the correction of malocclusion.

Prior Authorization is required for all orthodontic treatment. Patients must meet one (1) major criteria or two (2) minor diagnostic criteria. Major criteria include: cleft palate, two (2) impacted cuspids, posterior crossbite of three (3) or more teeth or severe craniofacial syndrome (treacher-Collins syndrome, Marfan syndrome, Pierre Robin syndrome, etc.). Minor criteria are: One (1) impacted cuspid, two (2) blocked cuspids, three (3) congenital missing teeth, open bite of four (4) or more teeth, crowding, anterior cross bite of three (3) or more teeth, traumatic deep bite impinging on palate, or overjet of 8mm.

1. Orthodontic benefit limitations:

   (a) For treatment commenced while a patient is eligible for orthodontic benefits, MVP will initiate payment of its liability up to the Maximum once bands or orthodontic devices are placed.
   (b) For patients who become eligible after orthodontic treatment has commenced, MVP will pro-rate its liability based on the number of remaining months of active treatment compared to the total number of months of active treatment.
   (c) Active treatment includes procedures undertaken and appliances used with those procedures for the purpose of bringing teeth into proper position and alignment. Active treatment does not include space maintainers, palate expanders or other devices used to prepare the patient for services to position and align teeth.

2. Clear orthodontic appliances are included in orthodontic benefits provided that upon the consulting Dentist's review of pretreatment radiographs it is indicated that the patient has full adult dentition. Clear appliances are subject to all orthodontic limitations and conditions and are subject to review by a consulting Dentist. Patient is responsible for any difference between the cost of the clear orthodontic treatment and the cost of conventional orthodontic procedures.

3. MVP will make one (1) payment at the start of treatment followed by monthly payments throughout the length of treatment up to a maximum of twenty-four (24) months for its total liability.

4. Placement of an appliance must take place for MVP to make payment on diagnostic records. Diagnostic casts, photographs and other diagnostic records are included in the total case fee. If banding does not take place, MVP has no liability beyond its share of the allowable fee for a comprehensive oral evaluation.

5. The replacement or repair of an orthodontic appliance is not a covered benefit if done by the same orthodontist who placed the appliance. If performed by an orthodontist who did not originally place the appliance, payment will be made for one repair per lifetime. Pediatric Dental Care. We Cover the following dental care services for Children up to age 19. Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. The Allowed Amount for Pediatric Dental Services is a percentage of billed charges.]

SECTION THIRTEEN – PRESCRIPTION DRUG COVERAGE

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

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

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

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

B. A **Participating Pharmacy** (this includes Retail, Mail or Specialty Pharmacies) is a pharmacy within MVP's Provider Network. You may get a list of Participating Pharmacies by calling MVP's Customer Care Center at 1-800-348-8515 or by viewing the list online at www.mvphealthcare.com.

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

D. **Annual Out of Pocket Maximum Expense for Prescription Drugs** is the maximum amount you will pay out of pocket each year for Cost Sharing amounts for your prescription drug benefit.

The Annual Out of Pocket Maximum Expense for Prescription Drugs, including specialty drugs, is limited to the Qualified High Deductible Health Plan minimum Deductible amounts each year. These amounts are set by the United States Internal Revenue Code and are subject to change annually. Please see your Schedule for the current individual and family out of pocket maximum expense for prescription drugs. You will be notified of any changes to these amounts annually.

- Qualified High Deductible Health Plan (HDHP),
  If you are in a HDHP you must first meet your HDHP Medical Deductible before any allowed expenses for prescription drugs are applied towards your Annual Out of Pocket Maximum Expense for Prescription Drugs.

  If you reach the HDHP Medical Out of Pocket Maximum before the Annual Out of Pocket Maximum Expense for Prescription Drugs, your medical and prescription drug expenses will be covered in full.

  If you meet your Annual Out of Pocket Maximum Expense for Prescription Drugs before you reach your HDHP Medical Out of Pocket Maximum, your prescription drug expenses will be covered in full.

- Standard Plan (Non-HDHP)
  If your prescription drug coverage or Contract has a Deductible, the Allowable Charges that apply to the Deductible will also apply to the Annual Out of Pocket Maximum Expense for Prescription Drugs.

Only Allowable Charges for prescription drugs will be applied to the Annual Out of Pocket Maximum Expense for Prescription Drugs. The following do not apply:

- Any Cost Share for Medical expenses,
- Any credit given to you by use of a manufacture's coupon,
- Any Cost Share related to services not covered by your Contract, and Amendments and/or Schedules.
- Any differences in the cost of the brand prescription drug and the cost of the generic drug when applicable.

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

- Tier 1 is the lowest payment choice. It includes drugs selected for their effectiveness and utilization. Many generic drugs have a Tier-1 cost share.
- Tier 2 is a mid-range payment choice. It includes drugs selected for their effectiveness and utilization. Many brand drugs have a Tier-2 cost share.

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

F. **Brand/Generic Difference**. If you have a covered prescription filled with a brand name drug, as defined by MediSpan® and there is a generic equivalent drug for that brand name drug, you must pay the Tier 1 Cost Share, plus the difference in cost between the generic and the brand name drug, not to exceed the cost of the drug, for each 30 day supply. The amount you pay for the difference between generic and brand will not apply to any maximum benefit, out of pocket maximum or deductible.

G. Value Based Insurance Design (or VBID) Drugs. MVP provides certain prescriptions at a reduced Cost Share to assist those with chronic conditions to better manage those conditions. See MVP's website for a list of VBID Drugs. See your Schedule for your Cost Share for VBID Drugs. VBID prescription coverage may not be available with your plan. Please refer to your Schedule.

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

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

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

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

(i) You may get prescription drugs listed on MVP's Mail Order List at either an MVP Participating Retail Pharmacy or at MVP's Mail Order Pharmacy. You or your prescribing provider may get a copy of MVP's Mail Order List or ask if a prescription drug is available through MVP's mail order pharmacy program by calling MVP's Customer Care Center at 1-800-348-8515 or by contacting us online at www.mvphealthcare.com and following the instructions.

(ii) You must get prescription drugs listed on MVP's Specialty Pharmacy List at MVP's Specialty Pharmacy Vendor, upon prior authorization from MVP. You or your prescribing provider may ask if a drug is listed on MVP's Specialty Pharmacy List by calling MVP's Customer Care Center at 1-800-348-8515. You can also view the list online. Go to www.mvphealthcare.com and follow the instructions.

3. Benefits Available. Prescription drugs are covered up to a thirty (30) day supply ("Standard Supply"). You may get two vacation supplies per Benefit Year. This means that you may get up to an additional 30 day supply for vacation periods two times per Benefit Year. You must pay the applicable multiple payments for a vacation supply. Prescription contraceptive drugs and devices approved by the FDA are covered subject to the applicable Cost Share.

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

A. Retail Pharmacy Benefit. For covered prescription drugs that you get at an MVP Participating Retail Pharmacy, MVP will provide coverage subject to our Allowable Charge for up to a thirty (30) day supply per dispensing (Standard Supply) and subject to the Cost Share requirements set forth on your Schedule of Enrollee Payments.

B. Mail Order Pharmacy Benefit. For covered prescription drugs listed on MVP's Mail Order List and that you get through MVP's Mail Order Pharmacy MVP will provide coverage subject to our Allowable Charge for up to a ninety (90) day supply per dispensing (Standard Mail Order Supply) and subject to the Cost Share requirements set forth on your Schedule.

How to Use the Mail Order Program Through Express Scripts Mail.

1. New Prescriptions. You must fill out a Mail Order Pharmacy Form. You may ask for a copy of the Form by calling MVP's Customer Care Center at 1-800-348-8515. You may also visit MVP's web site at www.mvphealthcare.com to download the Form or ask for a copy. Complete and sign the Form and attach the 90-day prescription with your check or credit card number for your payment. Then, mail everything to the address listed on the Form.

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

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

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

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

3. Getting the Mail Order Drug List. You may only get drugs approved by MVP for mail order through the mail order pharmacy program or at approved retail pharmacies. You may get a copy of the list of drugs approved for mail order or ask whether a drug is an approved maintenance drug by calling MVP's Customer Care Center at 1-800-348-8515. You may also visit MVP's web site at **www.mvphealthcare.com** and enter the name of a drug to find out if it is approved for mail order or to ask for a copy of the list of drugs approved for mail order.

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

C. Specialty Pharmacy Benefit. This is not the same as the mail order benefit. For covered prescription drugs listed on MVP's Specialty Pharmacy List that are obtained through an MVP Specialty Pharmacy Vendor, MVP will provide coverage subject to our Allowable Charge for up to a thirty (30) day supply per dispensing (Standard Supply) and subject to the Cost Share requirements set forth on your Schedule.

How to Use the Specialty Pharmacy Vendor Program.

1. New Prescriptions. If your prescription is on the Specialty Pharmacy Drug List, your doctor should provide the Specialty Pharmacy Vendor with your prescription by telephone, fax or mail. Once the vendor gets your prescription, an account will be set up. The vendor may call you for shipping and billing information or you may also contact the vendor.

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

3. Getting the Specialty Pharmacy Drug List. At any time, you may get a copy of the list of drugs that you must get through MVP's Specialty Pharmacy Vendor or ask whether a drug must be obtained through MVP's Specialty Pharmacy Vendor by calling MVP's Customer Care Center at 1-800-348-8515. You may also visit MVP's web site at www.mvphealthcare.com and enter the name of a drug to find out if you must get it through MVP's Specialty Pharmacy Vendor or to ask for a copy of the list of drugs that you must get through MVP's Specialty Pharmacy Vendor.

   Following is the current list of specialty drugs that do not require Prior Authorization:

   [Avonex
   Betaseron
   Copaxone
   Rebif
   Roferon A
   Intron A
   Gleevec

Xeloda
Temodar0
Hycamtin Oral
Hepsera
Tyzeka
Baraclude
Egrifta
Zortress
Fuzeon
Epivir HBV]

You will be notified of changes to those drugs as described in paragraph 4.

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

4. MVP Prescription Drug Formulary.

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

A. Getting Formulary Information. At any time, you may get a copy of the Formulary, ask whether a drug is listed on the Formulary, or ask if a drug requires Prior Authorization by calling MVP's Customer Care Center at 1-800-348-8515. You may also visit MVP's web site at **www.mvphealthcare.com** and enter the name of a drug to find out if it is listed on MVP's Formulary or to ask for a copy of the Formulary.

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

5. Prior Authorization Requirements. In some cases, MVP may require that your prescribing provider satisfy MVP Prior Authorization Requirements before a prescription is filled at the pharmacy. Drugs that must be Prior Authorized before they are filled are identified on the Formulary. They are also listed by therapeutic categories on our Formulary. MVP notifies Providers, in writing, when we change these requirements.

New FDA approved prescription medications are subject to Prior Authorization for a minimum of six (6) months. All compounded prescriptions over $250 require Prior Authorization. Compounds containing non-FDA approved drugs may also require Prior Authorization.

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

B. When prior authorization is required, your provider must submit a request for coverage to MVP that includes what is being requested, the intended use, and clinical information relating to your treatment of the requested use. Forms for this are available to your provider on the MVP website. Prior authorization and prescription drug override requests can be submitted via fax to 1-800-376-6373, or submitted online at www.mvphealthcare.com.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Non-Medically Necessary drugs.

B. Experimental or Investigational Drugs (unless directed to be covered pursuant to Independent External Appeal). This term means drugs that are either not generally accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by medical or scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed. However, we will provide benefits, to the extent required by law, to cover routine

costs for off-label drugs used in connection with approved cancer clinical trials. See paragraph 1.A within this Section Thirteen.

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

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

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

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

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

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

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

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

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

- The American Hospital Formulary Service Drug Information); or

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

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

L. Any prescription that is illegally obtained.

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

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

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

A. **STEP ONE**: Have your provider write a prescription and complete any required Prior Authorization requirements.

B. **STEP TWO**: Bring your prescription along with your MVP ID Card to an MVP Participating Retail Pharmacy or, as applicable, complete a Mail Order Pharmacy Order Form or Specialty Pharmacy Order Form and mail the completed order form along with your prescription to the address listed on the form. If the pharmacist fills your prescription and charges you in accordance with your prescription drug benefit, then you will have completed the Claim filing process. If the pharmacist does not fill your prescription or in your opinion has not properly applied your benefit, then you must proceed to **STEP THREE** to complete the Claim filing process.

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

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

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

8. How to file a Claim for Mail Order Pharmacy Benefits. To file a Claim you, your designee or your prescribing provider, must mail a completed claim form to the address listed on the form. To complete the form, you must fill in all required information; you must have the dispensing pharmacist sign the form; and, you must attach the original receipt for the prescription to the form. You may get claim forms by calling MVP's Customer Care Center at 1-800-348-8515 or by visiting MVP's website. Claims must be

properly submitted within one (1) year from the date the prescription was filled, or as soon as reasonably possible thereafter. MVP will make a decision on your Claim within the timeframe set forth in your Contract.

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

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

11. Restricted Enrollees. If MVP determines that you have received contraindicated, excessive or duplicative pharmacy services, MVP may impose one or more of the following restrictions on the provision of benefits to you under your Contract:

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

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

    Before MVP will impose any of the above restrictions, we will give you at least ninety (90) days prior written notice. The notice will specify the effective date and scope of the restrictions, explain the reasons for the restrictions, your right to file a complaint and/or appeal and the procedures for filing a complaint or appeal. You may request a copy of MVP's protocols regarding contraindicated, excessive or duplicative services by calling MVP's Customer Care Center at 1-800-348-8515. Nothing in this Subsection shall limit MVP's ability to terminate your coverage under your Contract for any of the reasons set forth in your Group Contract or Contract.

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

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

SECTION FOURTEEN - EXCLUSIONS

In addition to any 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 charge for a semi-private room, if a semi-private room is available.

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

   C. Any inpatient days that are 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. We will pay for the appropriate level of care,

   E. We will not provide benefits for inpatient services for dental services. This also applies to procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, fram implants and ramus mandibular stapling). However, we will provide benefits for anesthesia for certain dental procedures in accordance with Section Twelve, Paragraph 2.N. of this Contract.

   F. We will not provide benefits for charges because you did not leave your room at the discharge time.

   G. We will not provide benefits for non-medical or items including, but not limited to, telephone, television, beauty and barber services, guest trays, guest services and accommodations.

   H. We will not provide benefits for items that you take home from the Hospital.

   I. Treatment for willfully uncooperative or intractable patients.

2. <u>Services Not Covered</u>. We will also not provide benefits for the following:

   A. <u>Services Starting Before Coverage Begins</u>. If you are receiving services on the day your coverage under this Contract begins, we will not provide benefits for any services you receive:

      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, program or plan.

If the service is not covered and is not required to be covered under any other health benefits Contract, program or plan, MVP will provide benefits provided that 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 or any service that is related to services not covered under this Contract. We will not provide Benefits for any services in excess of any limitations or maximums described in this Contract or in your Schedule.

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

D. Non-Participating Provider Services. Except as specifically provided, we will not provide benefits for any services from a Non-Participating Provider.

E. Services Not Provided By Your PCP or other Participating Provider. Except as specifically provided in this Contract, we will not provide Benefits for any services not provided by your PCP or other Participating Provider.

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

G. Alternative Services. We will not provide benefits for alternative or complementary health services, products, remedies, treatments and therapies including, but not limited to acupuncture, biofeedback, massage therapy, hypnosis and hypnotherapy, 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.

H. Bulk immunizations (those provided to a group of people, such as employees in an office setting) or fluoride treatments performed in school.

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

J. Certification Examinations. Except as specifically provided in Section Twelve, paragraph 2(A)(ii), we will not provide benefits for any services related to routine physical examination and/or testing to certify health status, including, but not limited to, examinations required for school, employment, insurance, marriage, licensing, travel, camp, sports, or adoption.

K. Cosmetic Services and Surgery. We will not provide benefits for any services or surgery which are primarily intended to improve your appearance. We will provide benefits for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, including breast reconstruction and symmetry surgery as described in Section Seven, paragraph 6 and Section Twelve, paragraph 2(M). 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 Seven, paragraph 5 for information about covered newborn children.

L. Court-Ordered Services. We will not provide benefits for court-ordered services or services required as a condition or probation or parole. Such services include, but are not limited to special medical reports not directly related to treatment and reports prepared in connection with legal actions unless they are Medically Necessary Covered Services.

M. Criminal Behavior. We will not provide benefits for any services related to an intentionally self-inflicted injury or 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. Injuries caused by an act of domestic violence or a medical condition, including both physical and Mental Health Conditions, are not part of this exclusion.

N. Custodial Services. We will not provide benefits for Custodial Services or for bed rest or convenience reasons.

O. Dental Services. We will not provide benefits for dental services, including, but 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 also not provide benefits for temporomandibular joint disease or dysfunction where such disease or dysfunction is dental in nature. We will also not provide benefits for inpatient or outpatient hospital services in connection with dental services unless such services are Medically Necessary and Prior Authorized by MVP.

P. Dietician Services. Except as specifically provided in Section Twelve, paragraph 2.C, we will not provide benefits for dietician services. We will not provide benefits for homemaker services, home delivered meals, or other food or food-related services.

Q. Educational Services. We will not provide benefits for services required to determine appropriate educational placements or services or for other educational testing. We will also not provide benefits for special education and related services, and assistive technology devices and assistive technology services determined to be needed as a result of such educational evaluations, including, but not limited to therapy services, cognitive retraining and rehabilitation, treatment of behavioral disorders and behavioral training, services

for remedial education, evaluation and treatment of learning disabilities, interpreter services and lessons in sign language.

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

S. Experimental or Investigational Services. Except as specifically provided in this paragraph, we will not provide benefits for services which we determine are Experimental or Investigational Services. However, we will provide benefits, to the extent required by law, tocover routine costs for patients who participate in approved cancer clinical trials. See Section Two paragraph Z.

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

U. Family Services. We will not provide benefits for services provided by your immediate family.

V. Foot Care. Unless Medically Necessary for the treatment of diabetes (see section Twelve, paragraph), we will not provide benefits for routine or palliative foot care, including but not limited to any services in connection with corns, callouses, flat feet, fallen arches, weak feet, toenails, chronic foot strain, or symptomatic complaints of the feet.

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

X. 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.

Y. Government Hospital. We will not provide benefits for services you receive 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 Seven are satisfied or for otherwise covered services provided for non-military service related conditions.

Z. Home Modifications and Fixtures. We will not provide benefits for the purchase, rental, repair, replacement or maintenance of home modifications and fixtures including but not limited to 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, 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.

AA. Late Submitted Charges. We will not provide benefits for charges for services rendered by Participating Providers which are submitted to MVP more than one hundred eighty (180) days after the date of service, except when coordination of benefits applies and MVP is the secondary payor. You will not be responsible for such charges. We will not provide benefits for charges for services rendered by Non-Participating Providers which are submitted to MVP more than twenty-four (24) months after the date of service, except when coordination of benefits applies and MVP is the secondary payor. You will not be responsible for such charges.

BB. 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.

CC. No-Fault Automobile Insurance. We will not provide benefits for any service which is covered by mandatory automobile no-fault benefits or applied to the no-fault deductible. This exclusion applies even if you do not make a proper or timely claim for benefits available to you under any available no-fault policy 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 receive money from that lawsuit and have repaid the medical expenses you received payment for under the no-fault policy.

DD. Orthotic Devices. We will not provide benefits for orthotic devices, including but 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.

EE. 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 including, but not limited to, massage services, spa services, and other provider services, central or unit air conditioners, air or water purifiers, waterbeds, 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.

FF. Reproductive Procedures. We will not provide benefits for any services for or related to artificial means to induce pregnancy, including but 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, gender selection, 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.

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

HH. Special Charges. We will not provide benefits for stand-by services, missed appointments, new patient processing, interest, copies of provider records or completion of claim forms.

II. Support Therapies. We will not provide benefits for support therapies including, but not limited to, pastoral or religious counseling, sex counseling, or other social counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, and stress management.

JJ. Travel and Transportation Costs. Except as specifically provided, we will not provide benefits for travel and transportation expenses and related expenses such as meals and lodging.

KK. Unlicensed Provider. We will not provide benefits for services provided by an unlicensed provider or are outside of a provider's scope of practice.

LL. Vision and Hearing Examinations, Therapies and Supplies. Except as provided in Section Twelve, paragraph 2(DD), we will not provide benefits for any services related to eye or hearing examinations for prescribing, fitting, or determining the need for eyeglasses, lenses, frames, contact lenses, or hearing aids, for eyeglasses, lenses, frames, contact lenses or hearing aids, for vision or hearing therapy or training, vision perception training or orthoptics, or for the correction of refractive errors by means of any surgical or other procedures, including radial keratotomy, or for services for disorder of vision correction or accommodations. However, we will provide for Medically Necessary eye and ear care.

MM. 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 receive benefits under a workers' compensation act or similar law. This exclusion applies even if you do not receive 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 receive money from that lawsuit and you have repaid the medical expenses you received payment for under the workers' compensation act or similar law.

SECTION FIFTEEN - TERMINATION OF YOUR COVERAGE

This section describes how your coverage may terminate. When 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. Your coverage will automatically terminate in the event of any of the following:

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

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

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

D. 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 will automatically terminate on the date of dissolution, or the date to which your premium is paid, whichever is sooner. You must immediately notify us of any such dissolution. See Section Sixteen as to how your Spouse may obtain continuation and conversion coverage.

E. Termination of the Domestic Partnership. If the Enrollee's domestic partnership ends, the domestic partner's coverage will automatically terminate. Coverage will end on the earlier of the date the domestic partnership ends or the date to which premium is paid. The Enrollee or domestic partner must notify MVP right away, in writing, when the domestic partnership ends.

F. Termination of Coverage of a Child. Your child's coverage under this Contract will automatically terminate on the last day of the month following the date to which your premium is paid or the child reaches age 26, whichever is sooner. If your child is covered pursuant to Section Three, paragraph 2(D)(iii), the child's coverage will automatically terminate on the earliest of the date the child is no longer incapable of self-sustaining employment, is no longer disabled, or is no longer chiefly dependent upon you for support and maintenance. You must immediately notify us when your child is no longer eligible for coverage. See Section Sixteen as to how your child may obtain continuation and conversion coverage.

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:

(b) the order is no longer in effect, or

(c) the child is or will be enrolled in comparable coverage through another insurer which will take effect not later than the date coverage under this Contract would terminate.

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

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

A. Fraud or Misrepresentation. MVP will immediately terminate your coverage for any fraud or intentional misrepresentation of material fact made by you when you enrolled or when you filed any claim under this Contract. 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.

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

C. Residency. If you are no longer a resident of Vermont as otherwise provided in this Contract.

D. Regulatory. Any reason found to be acceptable to the Department of Financial Regulation (DFR) authorized by the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations thereunder.

E. Ineligibility, You are no longer eligible for Coverage in a QHP through the VHC.

F. Non-payment of Premiums and

i. the three month grace period required for Enrollees receiving advance payments of the premium tax credit has been exhausted; or

ii. any other applicable grace period not described by this section has been exhausted.

G. Your Qualified Health Plan terminates or is decertified by the VHC.

H. You change from one MVP QHP to another plan's QHP during an annual open enrollment period or special enrollment period.

3. Your Option to Terminate Coverage. You may terminate your coverage at any time by giving us fourteen (14) days' prior written notice.

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

5. Benefits After Termination. If you are Totally Disabled on the date your coverage terminates, and such Total Disability occurred before your coverage terminated, we will continue to provide benefits for otherwise covered services which are directly related to the illness, injury or condition causing the Total Disability. This extension of benefits will continue until the earliest of: (1) the date you are no longer Totally Disabled; or (2) twelve months from the date your coverage would 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. Other than Individual Coverage. If you have coverage other than individual coverage under this Contract, this extension of benefits covers only the Enrollee with the Total Disability. Coverage of other family members who were covered under this Contract will terminate as of the termination date.

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.

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

If your coverage under this Contract terminates under the circumstances described below, you may be able to continue coverage in some circumstances or to purchase a new contract available to non-group Enrollees. Continuation and/or conversion coverage is not available for individual Enrollees.

1. Continuation Coverage:

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

   B. Under Vermont Law. If your employer does not have to offer COBRA coverage as set forth above, you, your Spouse and your Dependents may be able to get continuation of coverage under state law. If your Group is an employer group

and your coverage would end because of the occurrence of a qualifying event, you may be able to continue your coverage under this Contract, subject to the terms of your Group's contract. Enrollees should call or write your Group or us to find out if your employer offers state continuation coverage and, if so, whether you are eligible for such coverage.

A qualifying event is:

i. loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage;

ii. divorce, dissolution, or legal separation of the covered employee from the employee's spouse or civil union partner;

iii. a dependent child ceasing to qualify as a dependent child under the generally applicable requirements of the policy; or

iv. death of the covered employee or member.

Such coverage will not be available to you if:

i. the deceased or terminated Enrollee was not covered under this Contract on the date of the qualifying event;
ii. the Enrollee seeking continuation coverage is covered by Medicare;
iii. the Enrollee is covered as an employee, enrollee or dependent by any other insured or uninsured arrangement which provides dental coverage, hospital, surgical or medical coverage for individuals in a group under which the Enrollee was not covered immediately prior to the qualifying event, and no preexisting condition exclusion applies; provided, however, that the person shall remain eligible for continuation coverages which are not available under the insured or uninsured arrangement; or
iv. the Enrollee's termination of employment was due to misconduct as defined by Vermont law.

1. Written Request for Continuation:

(a) An Enrollee who wishes to elect continuation coverage must notify the insurer, or the policyholder, or the contractor, or agent for the group if the policyholder did not contract for the policy directly with the insurer of such election in writing within 60 days after receiving notice of the qualifying event. The Enrollee's applicable premium contribution must be included with this election which shall include payment for the period from the qualifying event through the end of the month in which the election is made.

(b) Contributions shall be due on a monthly basis in advance to the insurer or the insurer's agent, and shall not be more than 102 percent of the group rate for the insurance being continued under the group policy on the due date of each payment

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

(a) 18 months after the date the Enrollee's benefits under this Contract would otherwise have terminated because of the qualifying event; or

(b) the end of the period for which premium payments were made, if the Group or the Enrollee fails to make timely payment of a required premium payment; or

(c) the Enrollee is covered by Medicare; or

(d) the person is covered by any other group insured or uninsured arrangement that provides dental coverage or hospital and medical coverage for individuals in a group, under which the person was not covered immediately prior to the occurrence of a qualifying event, and no preexisting condition exclusion applies; provided, however, that the person shall remain eligible for continuation coverages which are not available under the insured or uninsured arrangement; or

(e) the date on which the group's contract with MVP is terminated or, in the case of an employee, the date the decedent's or terminated employee's employer terminates participation under the group policy. However, in such event, if coverage is replaced by similar coverage under another Group Contract:

(i) The Enrollee shall have the right to become covered under the replacement Group Contract for the balance of the period that he would have remained covered under the prior Group Contract;

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

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

2. Conversion to a Direct Contract: Any person whose insurance under the group policy would terminate because of the death or loss of employment of the employee or member shall be entitled to have a converted policy issued to him by the insurer under whose group policy he was insured, without evidence of insurability

3. Circumstances Under Which Conversion is Not Available. MVP is not required to provide Conversion Coverage if: (1) the Enrollee was not entitled to or did not properly elect Continuation Coverage; (2) the person is or could be covered by Medicare; (3) the person is covered for similar benefits by another individual contract or policy; or (4) the person is or could be covered for similar benefits under any insured or self insured group arrangement, or by reason of any state or federal law, and together with this Conversion Coverage, would result in overinsurance according to MVP's standards.

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

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

i. voluntarily or involuntarily enter upon active duty (other than for the purpose of determining your physical fitness and other than for training); or

ii. have your active duty voluntarily or involuntarily extended during the period when the President in office authorized to order units of the ready reserve or members of the reserve component to active duty; provided that such additional duty is at the request and for the convenience to the Federal Government.

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

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

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

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

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

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

SECTION SEVENTEEN – EFFECT OF MEDICARE

1. When you become eligible for Medicare, you must notify MVP in writing and, except as described below, Medicare then becomes your Primary Plan. We will not provide benefits for any service or care for which benefits are payable under Medicare. When you are eligible for Medicare, we will reduce our benefits by the amount Medicare would have paid for the services or care. This reduction is made even if: you fail to enroll in Medicare; you do not pay the premiums or other charges for Medicare; or you receive services at a hospital or from a provider that cannot bill Medicare.

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

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

      1. the Enrollee is in "current employment status" (working actively and not retired) with the Group Contract Holder; and
      2. the Enrollee's employer maintains or participates in an employer group health plan that is required by law to have this Contract pay benefits before Medicare.

      In this case, Medicare is the Secondary Plan.

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

      1. the Enrollee is in “current employment status” (working actively and not retired) with the group contract holder; and

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

      In this case, Medicare is the Secondary Plan.

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

its benefits before we provide benefits under this Contract (this means that Medicare is the Primary Plan after this waiting period).

3. MVP as Primary Plan.

   A. If this exclusion does not apply and MVP is the Primary Plan, MVP will provide benefits under the terms of this Contract.
   B. The benefits provided by Medicare will be reduced to provide benefits only to the extent not provided by MVP.

4. MVP as Secondary Plan. If this exclusion does not apply and MVP is the Secondary Plan, you must follow Medicare's rules, the terms of this Contract, and pay all applicable Cost Share before MVP will provide benefits. The benefits provided by MVP will be reduced to provide benefits only to the extent not provided by Medicare.

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 EIGHTEEN - COORDINATION OF BENEFITS

This Section applies only if you have other group health benefits with another group health plan.

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

2. The following are considered to be health plans:

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

   B. Any 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 and any plan whose benefits are, by

law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and

E. Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.

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 an Enrollee and under the other plan as a dependent, the plan which covers you as an Enrollee 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:

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

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

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

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

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

E. A plan which covers you as an active employee or 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 2(E) is ignored.

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

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

4. MVP as Secondary Plan. In the event that MVP is considered to be the secondary payor, you are required to follow the rules and procedures of the primary plan before MVP will make payment. If MVP is to make payment on a secondary basis, the rules and procedures of MVP as otherwise stated in this Contract must also be followed. 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. However, 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 under this provision, we have the right to recover the overpayment from you or from any other person, insurance company, or organization which may have gained from our overpayment. When the overpayment includes services which you received under this Contract, the amount of the overpayment will be based on prevailing rates for those services. You agree to do whatever is necessary to help us to recover our excess payment, including but not limited to: (1) agreeing to complete and file claim forms with other organizations or insurance companies and endorsing checks over to us, and (2) authorizing MVP to complete and file claim forms with other organizations or insurance companies on your behalf. Whether MVP is the primary or secondary plan, you will be responsible for all applicable Cost Share.

   In the event that you receive 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. Cost Share When You are Enrolled in Two MVP Plans. If you are covered under MVP as an Enrollee and also a Dependent of a separate MVP plan, you are responsible for the Cost Share under the primary plan only.

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

SECTION NINETEEN - THIRD PARTY LIABILITY AND RIGHTS OF REPAYMENT

1. Introduction. If MVP provides benefits to an Enrollee 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 Enrollee.

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

3. Right to Reimbursement. When MVP has provided benefits as described above and the Enrollee or Enrollee's representative has recovered such costs from the third party, MVP is entitled to reimbursement from the Enrollee for the full cost of benefits. As a condition of coverage under this Contract, each Enrollee 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 Enrollee, 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 Enrollee, 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 an Enrollee 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 undersinsured 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 an Enrollee 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. Enrollee'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:

      (1) signing and delivering, within 30 days of a reasonable request to do so, any documents needed to secure MVP's subrogation claim, to protect MVP's right to reimbursement, or to effect the assignment or lien described in paragraph 3 above;
      (2) providing any relevant information;
      (3) obtaining the consent of MVP before releasing any party from liability for payment of medical expenses;
      (4) taking such other actions as may be needed to assist MVP in making a full recovery of the cost of all benefits provided; and
      (5) not taking any action that prejudices MVP's rights to reimbursement or subrogation, including but not limited to making any settlement or recovery which specifically attempts to reduce or exclude the full cost of benefits provided by MVP.

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

SECTION TWENTY – GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW

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

2. Grievance Reviewers.

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

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

reviewed by persons not involved in making the initial decision or the first level grievance decision and who are not subordinate to such persons. Further information about the panel reviewing your grievance is included in MVP's written response to the grievance.

3. First Level Grievances - General Information.

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

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

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

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

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

F. Time Limit for Submitting a First Level Grievance. You must submit a grievance within 180 days of receiving our decision regarding the matter that is the subject of the grievance. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral grievance by calling MVP at 1-800-348-8515. You may submit a written grievance to MVP Health Plan, Inc., 625 State Street, Schenectady, New York 12305.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Commence a Voluntary Second Level Grievance with MVP as described in paragraphs 11-16 below Paragraphs 11-16 are not applicable to enrolles in individual health plans. If you are in an individual health plan, please proceed directly to paragraph 17. If you do so, your time to commence court action will not start until you receive MVP's response to the Voluntary Second Level Grievance.

10. Additional Provisions.

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

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

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

11. Voluntary Second Level Grievances - General Information. (Paragraphs 11-16 are not applicable to enrolles in individual health plans. If you are in an individual health plan, please proceed directly to paragraph 17.)

A. In cases not involving Mental Health or Substance Abuse Services, if you are not satisfied with MVP's decision in response to the first level grievance, you may submit a second level grievance. If you proceed, you are not required to make a Voluntary Second Level Grievance in order to pursue any external remedy that may be available to you.

B. MVP Shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. Independent External Review.

A. You have the right to an "independent external review" of an appealable decision made by MVP. An independent external review is an independent review of our decision by a third party known as an independent review organization. Independent review organizations ("IRO") are selected by the DFR and must not have any conflict of interest associated with the review.

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

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

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

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

(i) You receive written documentation of MVP's final grievance decision and notice of appeal rights; or
(ii) MVP waives the required grievance process; or

(iii) MVP is deemed to have waived the grievance process by failing to adhere to grievance process time requirements.

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

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

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

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

SECTION TWENTY ONE - GENERAL PROVISIONS

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

2. Notices. Any notice which we give you will be mailed to you at your address as it appears in our records. You must immediately notify MVP of any change of address. 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. Statement of ERISA Rights. If your group's plan is covered by the Federal Employee Retirement Income Security Act of 1974 ("ERISA"), you are entitled to certain rights and protections under ERISA, as described below:

ERISA provides that all plan participants shall be entitled to:

A. Receive Information About Your Plan and Benefits. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts

and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. To request a certificate of creditable coverage from MVP contact the Customer Care Center at 1-800-348-8515. TTY users should call 1-800-662-1220.

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

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

costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

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

E. Health and Cancer Rights Act of 1998 ("WHCRA") If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

(i) all stages of reconstruction of the breast on which the mastectomy was performed;

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(iii) prostheses; and

(iv) treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Cost Share as applicable to other similar medical and surgical benefits provided under this Contract as is set forth on the Schedule of Enrollee Payments.

If you would like more information on WHCRA benefits, you may call the Customer Care Center at 1-800-348-8515.

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, 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 reviewing a treatment or claim, or in connection with a complaint or quality of care review;

   B. give reports about your care, treatment and condition to assist us in reviewing a treatment of claim; and

   C. permit MVP to review and copy your records.

   Further, at any time requested by us, you will provide us with a signed authorization to obtain your records for these purposes. We have the right to deny benefits under this Contract if you refuse to provide us with such authorization. We will maintain your medical records in accordance with state and federal confidentiality laws. However, you automatically authorize us to provide your medical records to DFR or other quality oversight organizations.

4. Changes to this Contract.

   A. We may change the terms of this Contract and modify or eliminate any of the benefits if approved by DFR. Enrollees have no vested rights to any benefits or other provisions of this Contract. We will provide you with at least 30 days prior written notice.

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

5. Time to File Claims. Claims for services rendered by Participating Providers under this Contract must be submitted to us for payment within 180 days after the date of service. Claims for services rendered by Non-Participating Providers must be submitted to us for payment within 24 months after the date of service. You will not be responsible for payment of late submitted charges by providers.

6. Who Receives Payment Under this Contract. Payments for Covered Services provided by a Participating Provider will be made by us directly to the provider. When services are provided by a Non-Participating Provider, you or the provider must submit a claim to MVP. Payments may be made to you or to the provider.

7. Legal Action. No legal action may be maintained against us prior to exhaustion of the grievance process specified in Section Twenty. You must start any lawsuit against us within 3 years from the date we made a second level grievance decision. 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.

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

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

   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 receive incentives to limit or deny benefits and are not paid based upon the quantity or type of such decisions. MVP pays most Participating Providers on a fee for service basis, which means that providers bill MVP for services rendered and MVP pays the providers according to an agreed upon fee structure. MVP also has arrangements with some Participating Providers, which allows MVP to withhold a certain percentage of the agreed upon fee during the course of a year and to keep all or a part of this withheld amount if medical costs have exceeded a certain budgeted amount. Some Participating Providers are paid through a capitation arrangement. This means that MVP pays the provider a fixed amount on a regular basis, usually monthly, based upon the number of MVP Enrollees the provider serves. This fixed amount is paid regardless of how many or how few services are provided to MVP Enrollees during the month. If services are rendered by a Non-Participating Provider, MVP may pay the provider's charges or a different rate negotiated with the provider or with an out of system provider network.

10. Termination of Participating Providers. A provider's participation with MVP may be terminated at any time by MVP or the provider. In such event, MVP shall provide notice to affected Enrollees within fifteen (15) days of our receipt of a notice of termination without cause or the date of a termination for cause. Covered Services rendered by the provider to Enrollees between the date of notice of termination or the date of termination and ten (10) business days after notice is mailed, shall continue to be Covered Services. Thereafter, we will not provide benefits for services rendered by the terminated provider. If your PCP is the terminated provider, you must select another PCP. If a non-primary care physician is the terminated provider, you must be referred by his or her PCP to another Participating Provider. It is your responsibility to ensure that a provider is a Participating Provider at the time you receive services. However, we will continue to provide benefits for otherwise covered services for Enrollees with life threatening, disabling or degenerative conditions who are receiving an ongoing course of treatment from the terminated provider until the earlier of: (1) sixty (60) days from the date of the notice of termination or (2) the date you are accepted by a Participating Provider. We will also continue to provide benefits for Covered Services for Enrollees in their second or third trimester of pregnancy who are receiving services from the terminated provider until the completion of postpartum care. We will provide these benefits only if the terminated provider agrees to abide by MVP's payment rates, quality of care standards and protocols, and to provide MVP with any necessary clinical information.

13. 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 VHC and your premiums must be paid in full. We may terminate your Coverage if you allow another person to wrongfully use an MVP identification card.

14. 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. In the event of a dispute concerning the provision or denial of benefits, MVP may require that an Enrollee be examined, at MVP's expense, by a provider designated by MVP.

15. 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.

16. Recovery of Overpayments. If we make a payment to you in error, we will explain the problem to 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.

17. Waiver. MVP's waiver or failure to insist on strict performance of this Contract shall not be considered a waiver or act as a bar to any decision or action for subsequent acts of non-performance.

18. Time Limit on Certain Defenses. After 3 years from the effective date of this Contract, no misstatements, except fraudulent misstatements, made by the Enrollee 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 3 year period.

19. Choice of Law. Unless federal law applies, this Contract shall be governed by the laws of Vermont.

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

21. Travel Time **-** You should not usually have to travel more than 30 minutes from home or work for:
    - PCP services
    - Routine office-based mental health and substance abuse treatment

    You should not usually have to travel more than 60 minutes for:
    - Prescription drugs
    - Labs
    - X-rays

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

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

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

You will have reasonable access to specialty care such as:

- Major burn care
- Organ transplants (other than kidney)
- Specialty pediatric care

Some Enrollees may get services at "centers of excellence" outside Vermont.

22. **Waiting Times for Appointments**

You shall have instant access to Emergency care.

Appointment: You should not usually have to wait longer than:

- 24 hours for Urgently Needed Care.
- Two weeks for routine initial treatment. Prompt follow-up visits and visits to specialists, if needed.
- Thirty days for routine lab, x-ray, general optometry and all other routine services.
- Ninety days for preventive care. This includes routine physical exams.

23. **Enrollees have the right to get information about MVP.** You have the right to get the information in this Contract. You will also get MVP's *Healthy News*, which gives updates about health news and changes to your coverage. You have the right to certain additional information:

You have a right to this information.	You can find this information here.
1. A list of providers, updated every 6 months.	1. This is in your **Provider Directory**, which is updated twice a year. The **Provider Directory** is posted on MVP's Web site too, where it is updated more frequently. You may also get a hard copy or an electronic copy from MVP's Customer Care Center. Call **[**1-800-348-8515].
2. Information about your coverage.	2. This is in your **Contract and Riders.**

You have a right to this information.	You can find this information here.
3. Information on prior authorization and UM.	3. This is in your **Contract**.
4. A description of the financial arrangements between MVP and Participating Providers.	4. This is in your **Contract.**
5. Enrollee responsibility to pay premiums, Coinsurance, Copayments, and Deductibles.	5. This is in your **Contract, Riders**, and your **Schedule of Enrollee Payments**.
6. Enrollee payment for non-Covered Services.	6. This is in your **Contract.**
7. MVP's process for picking Participating Providers	7. This is in your **Contract.** Call the **Credentialing Department** for more information.
8. What to do when you have a grievance.	8. This is in your **Contract.**
9. Enrollees as part of MVP's quality improvement program.	9. This is in your **Contract. Call MVP's Customer Care Center** at **[**1-800-348-8515] **for more information.**
10. How MVP decides whether services are Medically Necessary. UM staff and procedures.	10. This is in your **Contract.**
11. Getting Emergency care and Urgently Needed Care.	11. This is in your **Contract**.
12. MVP addresses and telephone numbers.	12. These are in your **Contract** and **Riders**.
13. The rules for picking and changing PCPs.	13. This is in your **Contract**.
14. Waiting and travel time standards.	14. This is in your **Contract**.
15. How providers are paid and that they can see non-MVP patients.	15. This is in your **Contract**.
16. The services offered by the Vermont Department of Financial Regulation.	16. This is in your **Contract**.
17. Access to Enrollee medical records	17. Call **MVP's Customer Care Center**

You have a right to this information.	You can find this information here.
and procedures to keep medical records private.	at **[**1-800-348-8515]for more information.
18. Access to Prescription Drug Formulary	18. This is in your **Contract**. You can also Call **MVP's Customer Care Center** at **[**1-800-348-8515] or check the MVP website.

24. Services for Hearing-Impaired Enrollees:
Call a Verizon relay operator at 1-800-662-1220. The operator will call MVP.

25. Interpreter/Translation Services
MVP provides these services. Call MVP's Customer Care Center at **[**1-800-348-8515] for help.

26. Quality Improvement (QI)
MVP wants you to get good health care. We also want you to be happy with MVP's services and Preferred Providers. Different kinds of Enrollees and Preferred Providers are on our QI Committee. It helps make decisions about our QI Program.

The main goals of the Program are:

- To measure and improve Enrollee satisfaction.
- To make sure Preferred Providers meet our standards.
- To offer Enrollee health programs, like MVP's Asthma and Diabetes Management Programs. To learn more, please call the numbers at the end of this book.
- To set and monitor goals for access, availability and outcomes of care.

MVP involves Enrollees in policy development and development of QI activities.

At least a third of the seats on MVP's Board of Directors are for Enrollees. The Board sets the policies for the plan. The Board approves new QI activities.

MVP welcomes your ideas about policies and QI activities. Call 1-800-318-8575 or write to this address:

Vermont Vice President
MVP Health Care
66 Knight Lane, Suite 10
Williston, VT 05495

MVP reviews all ideas.

IMPORTANT TELEPHONE NUMBERS

Customer Care Center	1-800-348-8515
Relay Services (for the hearing impaired)	1-800-662-1220
MVP After Hours	1-800-318-8575
Healthy Starts Program (8:30 a.m. to 5:00 p.m. Mon.-Fri.) (for pregnant Enrollees)	1-888-357-4687
Little Footprints (8:30 a.m. to 5:00 p.m. Mon.-Fri.) (for Enrollees with pregnancy problems)	1-800-777-4793 ext. 2398
MVP Asthma Care Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.)	1-888-357-4687
MVP Diabetes Care Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.)	1-888-357-4687
MVP Cardiac Care Program (8:30 a.m. to 5:00 p.m. Mon. - Fri.)	1-888-357-4687
MVP Low Back Pain Program (8:30 a.m. to 5:00 p.m. Mon. - Fri.)	1-888-357-4687
Personal Health Improvement Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.) (for Enrollees with stress-induced symptoms and chronic pain)	1-888-357-4687
Mail Order Pharmacy - Call toll free	1-800-716-3752
Vermont Office of HealthCare Advocate A free statewide program to help Vermonters resolve problems and complaints with their health insurance.	1-800-919-7787
Vermont Department of Financial Regulation Contact for assistance in submitting an appeal.	1-800-964-1784