VERMONT VISION CERTIFICATE

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

THIS IS YOUR CERTIFICATE OF COVERAGE
Issued by
MVP Health Plan, Inc.
625 State Street, Schenectady, New York 12305
(800) 777-4793

This Certificate of Coverage ("Certificate") describes the benefits available to you under a Contract between MVP, our partner, EyeMed, and your Group or MVP and you directly, depending upon whether you purchase this certificate through your employer or as an individual. Amendments, Summaries Of Benefits and Coverage, riders and/or endorsements may be delivered with this Certificate 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 Subscriber and his or her Dependents Covered under this Certificate unless otherwise specified.

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

The insurance evidenced by this Certificate provides Vision insurance ONLY.

By:

Christopher Del Vecchio,
Chief Executive Officer
MVP Health Plan, Inc.

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

TABLE OF CONTENTS

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 has partnered with EyeMed to provide benefits for Members for Routine Vision services.

MVP's service area includes the geographical area, designated by Us and approved by the State of Vermont, in which We provide coverage. The MVP service area includes the state of Vermont and the New York State counties of Albany, Broome, Cayuga, Chemung, 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, Schuyler, Seneca, Steuben, St. Lawrence, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates.

To be eligible for benefits under this Certificate, services must also be:

A. Covered Services as defined in this Certificate;

B. Not subject to the exclusions and limitations described in this Certificate.

If you get 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 Certificate applies to benefits only, and does not stop you from getting 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

The following terms have special meanings in this Certificate.

Allowance: Means a flat dollar amount payable under the Policy towards a Covered Expense. Allowances are shown in the Summary of Benefits. If the Providers charge is less than the Allowance we will only pay up to the providers charge.

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

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

Certificate: This Certificate issued by MVP Health Plan Inc., including the Summary of Benefits. This Certificate explains the benefits available to You.

Copayment: A fixed amount You pay directly to a Provider for an eye examination or toward the cost of materials. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments.

Covered Expense- means the benefits listed in the Summary of Benefits. The term "Covered Expense" or "Covered Expenses" does not include:

1. Any services or Materials that are not listed in the Summary of Benefits; or
2. Any services or Materials shown as "Not Covered" in the Summary of Benefits or
3. An additional exam, frame, pair of spectacle lenses or contact lenses for which you have already received either an "In-Network Benefit" or an "Out-of-Network Benefit" during any one Frequency period; or
4. More than one type of contact lenses at a time during any one Frequency period.

Covered Services: Services and materials for which reimbursement from a vision care plan is provided by a member's or subscriber's plan Certificate, or for which a reimbursement would be available but for application of the deductible, co-payment, or coinsurance requirements under the member's or subscriber's vision care plan.

Dependents: The Subscriber's Spouse, Domestic Partner and Children.

Discount: Means the percentage that an In-Network Provider has agreed to reduce their charge by for the requested service, material or procedure. Discounted vision services, materials, supplies and treatments described in the Summary of Benefits.

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

Frequency: The time period shown in the Summary of Benefits during which you are eligible for the Covered Expenses. The time period is measured from the date of your last eye examination or the date you got eyeglasses, frames, spectacle lenses or contact lenses.

Grievance: A complaint that You communicate to Us.

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

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

In-Network Provider- A provider who has entered into a contract with EyeMed as an authorized representative to provide eye examinations and/or Materials on an Allowable Charge basis.

Materials: Lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa.

Member: The Subscriber or a covered Dependent for whom Premiums have been paid. Whenever a Member is required to provide a notice, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who doesn't have a certificate with EyeMed to provide services to You.

You will pay more to see a Non-Participating Provider.

Out-of-Network Provider: Providers of Routine Vision services who have not entered into a contract with us or our authorized representatives to provide vison care services.

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

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

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

Provider: An Ophthalmologist, Optometrist or Optician. Provider's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under this Certificate.

Retail Price: means the charge made by other Providers rendering or furnishing vision care, treatment or supplies within the same geographic area.

Summary of Benefits: The form attached to this Certificate that describes the Copayments, Coinsurance, and Allowances.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Albany, Broome, Cayuga, Chemung, 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, Schuyler, Seneca, Steuben, St. Lawrence, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates Counties.

Spouse: The Subscriber's spouse under a legally valid marriage or civil union as defined by Vermont law. Spouse also includes a domestic partner.

Subscriber: The person to whom this Certificate is issued.

Us, We, Our: MVP Health Plan Inc. or any designated agents of MVP, under this Certificate.

You, Your: The Member.

SECTION THREE – ENROLLMENT, ELIGIBILITY AND COVERAGE

A. Who is Covered Under this Certificate.

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work or reside in Vermont to be covered under this Certificate if you have coverage through your employer. You must live in Vermont to be covered under this Certificate if you have Individual or MVP Direct coverage. Members of your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage.

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

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

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

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

C. Children Covered Under this Certificate.

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

Any dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain

covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

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

D. When Coverage Begins--This Section Applies If You Have Coverage Through Your Employer or Direct Through MVP.

Coverage under this Certificate will begin as follows if you have coverage through your employer or Direct Through MVP:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed 90 days.

2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.

3. If You, the Subscriber, marry while covered, and We get notice of such marriage within 30 days thereafter, coverage for Your Spouse and child starts on the first day of the month following such marriage. If We do not get notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or child.

4. If You, the Subscriber, have a newborn child, your newborn child will be covered for the first 60 days from the moment of birth. Your adopted newborn child will be covered for 60 days from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 60 days of the birth or adoption in order for coverage to continue beyond 60 days. Otherwise,

coverage begins on the date on which We get notice, provided that You pay any additional Premium when due.

5. To continue the child's coverage beyond 60 days, You must complete and return an enrollment form, any requested documentation, and the premium. If You do so within 60 days of the date of birth, adoption, placement for adoption, legal guardianship, legal custody, or within 60 days of the date the child became Your step child, Your child will be added to Your coverage and will be covered effective as of the date of birth, adoption, placement for adoption, or legal guardianship, legal custody, or as of the date the child became Your step child. If You do not do so within 60 days of the events described, You will not be able to add Your child to Your coverage until the first day of the month following the next premium due date after the next open enrollment period when We get the completed form, requested documents, and premium. Remember, a newborn child is always covered for the first 60 days. If You belong to a Small Group with no open enrollment period, Your child will be added to Your coverage as of the date MVP gets Your completed enrollment form, any requested documents and premium. If You do not notify us, we will not provide coverage for the child beyond the first 60 days.

E. Domestic Partner Coverage.

This Certificate covers domestic partners of Subscribers as Spouses if you are covered direct through MVP. This Certificate covers domestic partners of Subscribers as Spouses if you have coverage with your employer and your employer group allows coverage of domestic partners. If You selected family coverage, Children covered under this Certificate also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
    a. The affidavit must be notarized and must contain the following:
        - The partners are both 18 years of age or older and are mentally competent to consent to certificate;
        - The partners have been living together on a continuous basis prior to the date of the application;
        - Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and

b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
    - A joint bank account;
    - A joint credit card or charge card;
    - Joint obligation on a loan;
    - Status as an authorized signatory on the partner's bank account, credit card or charge card;
    - Joint ownership of holdings or investments;
    - Joint ownership of residence;
    - Joint ownership of real estate other than residence;
    - Listing of both partners as tenants on the lease of the shared residence;
    - Shared rental payments of residence (need not be shared 50/50);
    - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
    - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
    - Shared household budget for purposes of getting government benefits;
    - Status of one (1) as representative payee for the other's government benefits;
    - Joint ownership of major items of personal property (e.g., appliances, furniture);
    - Joint ownership of a motor vehicle;
    - Joint responsibility for child care (e.g., school documents, guardianship);
    - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
    - Execution of wills naming each other as executor and/or beneficiary;
    - Designation as beneficiary under the other's life insurance policy;
    - Designation as beneficiary under the other's retirement benefits account;
    - Mutual grant of durable power of attorney;
    - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
    - Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
    - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

F. 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.

SECTION FOUR - ACCESS TO PROVIDERS

1. Finding a Participating Provider.
   Participating Providers can be found on our website at **mvphealthcare.com**.

2. Use of Non-Participating Provider. We have benefits for use of a non-participating provider; however, you will have more benefits if the provider is participating with our partner, EyeMed. Refer to your Summary of Benefits for what is available to you at both participating and non-participating providers.

SECTION FIVE – VISION CARE

Please refer to the Summary of Benefits attached to this Certificate for Copay, Cost-Sharing requirements, frequency limits, and differences between in-network and out-of-network services.

Benefit Maximums, Allowances and Frequency Limits

The amount we pay for your benefits is subject to your benefit maximums, allowances and frequency limits. We will not pay for vision care services that go over your benefit maximums or allowances, or for services that are received more than the allowed frequency limits. Benefit maximums, allowances, and frequency limits are stated in the Summary of Benefits.

Your Cost Share Requirements

We will pay up to the maximum allowable amount for covered services. You may be required to pay a part of the maximum allowable amount. This is called your cost share amount. Copayments are an example of a cost share amount. See the Summary of Benefits for your cost share amount for covered services.

Your cost share amount may vary depending on whether you get vision care from a network or non-network provider. You may be required to pay higher cost sharing amounts when using non-network providers.

We will not pay for vision care that is not covered under this plan. You must pay all charges for vision care that is not covered. Vision care that you get after you have met any benefit maximums or benefit frequency limits are also not covered.

We cover the following vision services:

A. Routine Exam: A routine eye exam is defined as an office visit for the purpose of checking vision, screening for eye disease, and/or updating eyeglass or contact lens prescriptions. Routine eye exams can produce diagnosis that includes nearsightedness, farsightedness or astigmatism.

B. Lenses: You have a choice of lenses under this plan that include the following:

- **Single Vision:** glasses lenses that only offer ONE type of vision correction**.** This means that they are crafted to help people see better at farther or shorter distances

(nearsighted or farsightedness), but never both.

- **Bifocal:** a lens that b one portion for viewing distant objects, and another for viewing close objects.

- **Trifocal**: lenses look and perform similar to bifocal lenses, with an added viewing zone to help correct vision in the intermediate field, and two visible lines where the viewing zones change.

- **Lenticular**: a corrective lens type that requires a very high power to correct your vision. High power often means a very thick and heavy eyeglass. To keep the lens from being so thick that it'd be hard to wear, eyeglass manufacturers created the lenticular lens.

- **Standard Progressive:** characterized by a gradient of increasing lens power, added to the wearer's correction for the other refractive errors. The gradient starts at the wearer's distance prescription at the top of the lens and reaches a maximum addition power, or the full reading addition, at the bottom of the lens.

- **Premium Progressive**: referred to as "free-form design" or "wave-front technology". Premium progressive lenses provide a much wider, distortion-free reading area.

C. Frames: You have a benefit allowance towards your choice of frames. You may apply that allowance towards the frames of your choice. If the frame you select is more than your allowance then you are responsible for the difference.

D. Contact Lenses: Your lens benefit may apply to eyeglass lenses, elective contact lenses, or non- elective contact lenses. Non-elective lenses are lenses that are prescribed for certain conditions such as, Anisometropia, High Ametropia, Keratoconus. If you get elective or non-elective contact lenses, an eyeglass lens benefit will not be available until your benefits renew. The Summary of Benefits tells you the benefit frequency for lenses.

SECTION SIX - EXCLUSIONS

No coverage is available under this Certificate for the following:

A. Employment: Any Vision Examination, or any corrective eyewear required as a condition of employment, such as safety eyewear.

B. Sunglasses: Non-Prescription sunglass lenses or accompanying frames.

C. Non-Prescription Lenses: Any non-prescription lenses, eyeglasses, contacts or plano lenses. This also includes any lenses that have no refractive power.

D. Lost or Broken Lenses, Frames or Contacts: Any lost or broken lenses, frames or contacts will not be covered until you reach a new benefit period.

E. Duplicates: Two pair of glasses in lieu of bifocals.

F. Government: services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.

G. Medical Services: We do not Cover vision services that are medical in nature, including any Hospital charges or prescription drug charges, including pathological and/or surgical treatment of the eye, eyes or supporting structures.

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

I. Services Provided by a Family Member: We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

SECTION SEVEN - 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 Certificate 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 get continuation and conversion coverage.

   B. Termination of Group Contract. If the group contract under which this Certificate 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 get continuation and conversion coverage.

   D. Dissolution of Marriage or Civil Union. If you become divorced, or your marriage or civil union is annulled or 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 get continuation and conversion coverage.

   E. Termination of the Domestic Partnership. If the Subscriber'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 Subscriber 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 Certificate will automatically terminate on the last day of the month following the date to which your premium is paid or on the last day of the year following the date 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 get continuation and conversion coverage.

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 Certificate. 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 Certificate. We discontinue the entire class of Certificates to which this Certificate 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 Certificate.

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. Non-payment of Premiums and

i. the three month grace period required for Members getting 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.

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

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

If your coverage under this Certificate 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 Members. Continuation and/or conversion coverage is not available for individual Members.

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. Subscribers 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 Certificate, subject to the terms of your Group's contract. Subscribers 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 Subscriber was not covered under this Certificate on the date of the qualifying event;
ii. the Subscriber is covered as an employee, enrollee or dependent by any other insured or uninsured arrangement which provides vision coverage; or
iii. the Subscriber's termination of employment was due to misconduct as defined by Vermont law.

1. Written Request for Continuation:

(a) A Subscriber 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 getting notice of the qualifying event. The Subscriber'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 Subscriber's benefits under this Certificate 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 Subscriber fails to make timely payment of a premium payment; or

(c) the person is covered by any other group insured or uninsured arrangement that provides vision coverage; or

(d) 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 Subscriber 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 Subscriber was not entitled to or did not properly elect Continuation Coverage; (2) the person is covered for similar benefits by another individual contract or policy; or (3) 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 over insurance according to MVP's standards.

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

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

SECTION NINE – GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW

1. Grievances. A grievance means a written or verbal complaint submitted to MVP by or on behalf of a Member expressing dissatisfaction regarding the availability, delivery or quality of health care services, claims payment, handling or reimbursement for health care services, or expressing dissatisfaction regarding matters governed by or related to this Certificate, 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 help. 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. At your request, MVP will provide reasonable access to copies of these documents, records and other information relevant to your grievance within two (2) business days. Copies may be provided to you or 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 Certificate. This means that you must commence and complete a First Level Grievance before you may seek any other internal or external remedy, including Independent External Review or court action.

2. Grievance Reviewers.

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

   (b) Second Level Grievances. Second level grievances are reviewed by a panel comprised of MVP senior medical and administrative staff and/or board members with the necessary education, training and experience to resolve the matter. The

medical staff participating in at least one level of grievance review will have appropriate training and experience in the field of medicine involved in the particular grievance, and will be actively practicing in the same or similar specialty who typically treats the condition or provides the services that is the subject of the grievance. Alternatively, MVP may engage independent organizations to provide medical specialists practicing in the same or similar specialty as consultants for a particular grievance. Second level grievances are reviewed by persons not involved in making the initial decision or the first level grievance decision and who are not subordinate to such persons. Further information about the panel reviewing your grievance is included in MVP's written response to the grievance.

3. First Level Grievances - General Information.

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

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

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

D. For any grievances relating to an adverse 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 getting 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., Attn: Member Appeals 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 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 you 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 Pre-Authorization request is urgent.

MVP will let you and your treating provider (if known) know 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 your 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 your treating provider (if known) of our determination (whether adverse or not) not later than fifteen (15) calendar days after receipt of the grievance.

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

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

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.

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 voluntary second level grievance. 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 getting 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. MVP 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 your 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 Pre-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 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.

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 your 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 Member's exhaustion of MVP's first level internal grievance process unless as noted above.

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

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

(i) You get 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.

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

C. Your Right to an Immediate External Appeal. If we fail to adhere to the appeals 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 independent review organization is binding on MVP, the member, the provider, and the group. If the independent review 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 independent review organization decides in your favor, we will provide benefits subject to all other terms and conditions of this Certificate. 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 TEN - GENERAL PROVISIONS

1. Assignment. Only you are eligible for benefits under this Certificate. You cannot assign your right any benefits due under this Certificate 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. Get, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Get 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. 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 getting a (pension, welfare) benefit or exercising your rights under ERISA.

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

D. 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 help in getting documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

4. Changes to this Certificate.

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

   B. This Certificate 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 Certificate 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 Certificate. 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 Certificate 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 Members.

MVP does not control the treatment or other professional actions of providers. MVP's decisions relate only to whether we will provide benefits under this Certificate and are not a substitute for the professional judgment of your provider. Further, the persons making these decisions for MVP do not get incentives to limit or deny benefits and are not paid based upon the quantity or type of such decisions. 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 Members the provider serves. This fixed amount is paid regardless of how many or how few services are provided to MVP Members 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 Members 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 Members between the date of notice of termination or the date of termination and ten (10) business days after notice is mailed, shall continue to be Covered Services. Thereafter, we will not provide benefits for services rendered by the terminated provider. It is your responsibility to ensure that a provider is a Participating Provider at the time you get services.

11. 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 MVP 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.

12. Furnishing Information. You must, within 30 days of our request, provide us with all information and records that we may need to perform our obligations under this Certificate. In the event of a dispute concerning the provision or denial of benefits, MVP

may require that a Member be examined, at MVP's expense, by a provider designated by MVP.

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

14. Recovery of Overpayments. If we make a payment to you in error, we will 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.

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

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

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

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

19. **Enrollees have the right to get information about MVP.** You have the right to get the information in this Certificate. 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 866-895-3278.
2. Information about your coverage.	2. This is in your **Certificate.**
3. Member responsibility to pay premiums, Coinsurance, Copayments, and Deductibles.	3. This is in your **Certificate** and your **Summary of Benefits**.
4. Member payment for non-Covered Services.	4. This is in your **Certificate.**
5. What to do when you have a grievance.	5. This is in your **Certificate.**
6. MVP addresses and telephone numbers.	6. These are in your **Certificate**.

20. Interpreter/Translation Services. MVP provides these services. Call MVP's Customer Care Center at 866-895-3278 for help.