VERMONT HMO CONTRACT

FRVT HMO HDHP NON-STANDARD CTR (2025)

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 Health Plan, Inc. ("MVP") and your Group or MVP and you directly, depending upon whether you purchase this contract through your employer or as an individual. Amendments, Summary of Benefits and Coverage (SBC), 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 VERMONT 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.

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

If this Contract is between You and MVP directly, then the additional paragraphs apply:

a. This is Your individual direct payment Contract for health maintenance organization coverage issued by MVP Health Plan, Inc. This Contract, together with the attached Summary of Benefits and Coverage (SBC), applications and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

b. You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid including any Contract fees or other charges.

c. **Renewability.** The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Contract or by the Enrollee upon 30 days' prior written notice to Us.

d. **Reinstatement after Default.** If the Enrollee defaults in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract.

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.

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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 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.

When you enroll as an MVP Enrollee, you and your covered dependents may choose a Primary Care Provider ("PCP") from MVP's Participating Provider Directory, but you are not required to do so. All services must be provided by MVP participating providers or providers in our affiliates' networks such as CIGNA or First Health/MagnaCare Network. 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 an 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 Pre-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 which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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. See your Summary of Benefits and Coverage (SBC) to see if you have an Embedded or an Aggregate Deductible. These are explained below.

Embedded/Stacked Deductible.
Except where stated otherwise, you must pay the Deductible amount in the SBC for Covered Services during each Plan Year before We provide coverage. If your Plan has an Embedded/Stacked Deductible and You have other than individual coverage, the individual Deductible applies to each person covered under this Contract. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Contract collectively total the family Deductible amount in the SBC in a Plan Year, no further Deductible will be required for any person covered under this Contract for that Plan Year.

Aggregate Deductible.
Except where stated otherwise, you must pay the Deductible amount in the SBC during each Plan Year before We provide coverage. If your Plan has an Aggregate Deductible and You have other than individual coverage you must pay the family Deductible in the SBC for Covered Services under this Contract during each Plan Year before We provide coverage for any person covered under this Contract. However, after Deductible payments for persons covered under this Contract collectively total the family Deductible amount in the SBC in a Plan Year, no further Deductible will be required for any person covered under this Contract for that Plan Year.

- Individual and/or Family Out of Pocket Annual Maximums. These are the maximum amounts of eligible expenses each Member must pay during any Contract Year. See your SBC to see if you have an Embedded or Aggregate Out of Pocket Maximum. These are described below. **Some payments do not count toward Annual Out of Pocket Maximums**.

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

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

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

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 1-888-687-6277.

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 Enrollee, listed on the Enrollee'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. 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.

N. Experimental or Investigational Services means health care items or services 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.

O. 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.

P. Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the

management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy**.**

Q. Health Care Facility: means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient 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. MVP Direct means individuals who enroll directly through MVP and not through Vermont Health Connect. This is a direct to MVP enrollment for individuals who do not receive cost share reductions.

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

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

V. Primary Care Provider (PCP) means a Participating Provider who has an agreement with MVP to provide covered primary health care services to Enrollees and who, within that Provider's scope of practice as defined under the relevant state licensing law, provides primary care services, and who is designated as a Primary Care Provider by a managed care organization.

W. Blueprint Primary Care Provider means any Vermont provider who meets the definition of Department of Vermont Health Access Rule 8102 and is providing general primary care services to its patient panel through the oversight of a general practice, family medicine, internal medicine, obstetrics and gynecology (OB/GYN), or pediatric medicine.

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

- physician
- hospital
- free standing ambulatory surgery center, free standing radiology/imaging center, free

- approved facility for the treatment of mental health conditions
- approved institution for the treatment of alcohol or substance dependency
- skilled nursing facility
- home care agency
- health care professional
- licensed midwife
- audiologist
- hearing aid dispenser acting within the scope of their license
- standing dialysis center, and free standing laboratory facility
- athletic trainer
- advanced practice registered nurse who is certified as a nurse midwife
- naturopath
- DME provider
- chiropractor
- podiatrist
- mental health provider
- DDS (dentist)

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

Y. 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.

Z. 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.

AA. 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.

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

CC. Summary of Benefits and Coverage (SBC). 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.

DD. 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.

EE. 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.

FF. 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).

GG. 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;

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

II. 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.

JJ. VHC means Vermont Health Connect or the Exchange.

SECTION THREE – ENROLLMENT, ELIGIBILITY AND COVERAGE

A. Who is Covered Under this Contract.

You, the Enrollee to whom this Contract is issued, are covered under this Contract. You must live, work or reside in Vermont to be covered under this Contract if you have coverage through your employer. You must live in Vermont to be covered under this Contract 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 Contract.

If You selected parent and child/children or family coverage, Children covered under this Contract 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 unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental or physical disability 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 Enrollee and all other prospective or covered Members in relation to eligibility for coverage under this Contract periodically, but no more frequently than once every year.

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

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

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

4. If You, the Enrollee, have a newborn child, your newborn child will be covered without notice or additional premium 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. Your newborn will be subject to their own Cost-Sharing for Covered services beginning on their date of birth, whether or not you add your newborn to coverage permanently. 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. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 60 days of the birth or adoption in order for coverage to continue beyond 60 days. Otherwise, coverage begins on the date on which We receive 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 required premium. If You do so

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

E. Special Enrollment Periods---This Section Applies When You Have Coverage Through Your Employer or Direct Through MVP.

You, Your Spouse or child, can also enroll for coverage within 60 days of the occurrence of one (1) of the following events if your current coverage is through your employer or was purchased direct through MVP:

1. You or Your Spouse or child loses minimum essential coverage, which includes the termination of employer contributions for You or Your Dependents' coverage;
2. Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of VHC, or a non VHC entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by VHC;
3. You adequately demonstrate to VHC that another qualified health plan in which You were enrolled substantially violated a material provision of its contract;
4. You gain a Dependent or become a Dependent through marriage, birth, adoption, placement for adoption or foster care, or through a child support order or other court order, however, foster children are not covered under this Contract;
5. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents;
6. You become eligible for new qualified health plans because of a permanent move and You, Your Spouse or Child either had minimum essential coverage for one (1) or more days during the 60 days before the move or were living outside the United States or a United States territory at the time of the move;
7. If You are an Indian, as defined in 25 U.S.C. 450b(d), You and Your Dependents may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
8. You demonstrate to VHC that You meet other exceptional circumstances as VHC may provide;
9. You are a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and You

and Your Dependents seek to enroll in coverage separate from the perpetrator of the abuse or abandonment;

10. You, Your Spouse or child apply for coverage during the annual open enrollment period or due to a qualifying event, are assessed by VHC as potentially eligible for Medicaid or Children's Health Insurance Plan, but are determined ineligible for Medicaid or Children's Health Insurance Plan after open enrollment ended or more than 60 days after the qualifying event;
11. You, Your Spouse or child apply for Medicaid or Children's Health Insurance Plan coverage during the annual open enrollment period and are determined ineligible for Medicaid or Children's Health Insurance Plan coverage after open enrollment has ended; or
12. You, Your Spouse or child adequately demonstrate to VHC that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a qualified health plan through VHC.

We must receive notice and Premium payment within 30 days of one of these events. If You enroll because You lost minimum essential coverage, your coverage will begin on the first day of the month following Your loss of coverage. If You, Your Spouse or child enroll because You gain a Dependent through adoption or placement for adoption, your coverage will begin on the date of the adoption or placement for adoption. If You, Your Spouse or child enroll because of a court order, your coverage will begin on the date the court order is effective. If You, Your Spouse or child enroll because of the death of You or Your Dependents, your coverage will begin on the first day of the month following Your application.

In all other cases, the effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month.

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

1. You or Your Spouse or child loses eligibility for Medicaid or Children's Health Insurance Plan; or
2. You or Your Spouse or child becomes eligible for Medicaid or Children's Health Insurance Plan.

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

F. Special Enrollment Periods---This Section Applies When Your Current Coverage is Through VHC.

Outside of the annual open enrollment period, You, Your Spouse, or Child can enroll for coverage within 60 days prior to or after the occurrence of one (1) of the following events if you purchased your coverage through VHC:

1. You, Your Spouse or Child involuntarily loses minimum essential coverage, including COBRA or state continuation coverage; including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if You have the option to renew the coverage;
2. You, Your Spouse or Child are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage;
3. You, Your Spouse or Child loses eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary and specialty care;
4. You, Your Spouse or Child become eligible for new qualified health plans because of a permanent move and You, Your Spouse or Child had minimum essential coverage for one (1) or more days during the 60 days before the move; or
5. You, Your Spouse or Child are no longer incarcerated.

Outside of the annual open enrollment period, You, the Enrollee, Your Spouse, or Child can enroll for coverage within 60 days after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child's enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of VHC, or a non-VHC entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by VHC;
2. You, Your Spouse or Child adequately demonstrate to VHC that another qualified health plan in which You were enrolled substantially violated a material provision of its contract;
3. You gain a Dependent or become a Dependent through birth, adoption or placement for adoption or foster care, or through a child support order or other court order, however, foster Children and Children for whom You are a legal guardian are not covered under this Contract;
4. You gain a Dependent or become a Dependent through marriage and You or Your Spouse had minimum essential coverage for one (1) or more days during the 60 days before the marriage;
5. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents;
6. If You are an Indian, as defined in 25 U.S.C. 450b(d), You and Your Dependents may enroll in a qualified health plan or change from one (1) qualified health plan to another one (1) time per month;

7. You, Your Spouse or Child demonstrate to VHC that You meet other exceptional circumstances as VHC may provide;
8. You, Your Spouse or Child were not previously a citizen, national, or lawfully present individual and You gain such status;
9. You, Your Spouse or Child 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;
10. You are a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and You and Your Dependents seek to enroll in coverage separate from the perpetrator of the abuse or abandonment;
11. You, Your Spouse or Child apply for coverage during the annual open enrollment period or due to a qualifying event, are assessed by VHC as potentially eligible for Medicaid or Children's Health Insurance Plan, but are determined ineligible for Medicaid or Children's Health Insurance Plan after open enrollment ended or more than 60 days after the qualifying event;
12. You, Your Spouse or Child apply for Medicaid or Children's Health Insurance Plan coverage during the annual open enrollment period and are determined ineligible for Medicaid or Children's Health Insurance Plan coverage after open enrollment has ended; or
13. You, Your Spouse or Child adequately demonstrate to VHC that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a qualified health plan through VHC.

VHC must receive notice and any Premium payment within 60 days of one (1) of these events.

If You, Your Spouse or Child are applying due to a permanent move or , You, Your Spouse or Child can meet the requirement to demonstrate coverage in the 60 days prior to the permanent move or marriage by having minimum essential coverage for one (1) or more days during the 60 days before the move or marriage; living in a foreign country or in a United States territory for one (1) or more days during the 60 days before the move or marriage; You are an Indian as defined in 25 U.S.C. 450b(d); or You lived for one (1) or more days during the 60 days before the move or marriage in a service area where no qualified health plan was available through VHC.

G. Effective Dates of Coverage for Special Enrollment Periods.

If You, Your Spouse or Child enroll because You are losing minimum essential coverage within the next 60 days, You are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, or You gain access to new qualified health plans because You are moving, and Your selection is made on or before the triggering event, then Your coverage will begin on the first day of the month following Your loss of coverage.

If You, Your Spouse or Child enroll because You got married, your coverage will begin on the first day of the month following Your selection of coverage. If You, Your Spouse or Child enroll because You gain a Dependent through adoption or placement for adoption, your coverage will

begin on the date of the adoption or placement for adoption. If You, Your Spouse or Child enroll because of a court order, your coverage will begin on the date the court order is effective.

If You have a newborn or adopted newborn Child, your newborn child will be covered for the first 60 days from the moment of birth. In order to avoid a gap in your child's coverage after the first 60 days, you must notify VHC of such birth within the first 60 days after the birth. If notice of the birth is given to VHC beyond the first 60 days after birth, coverage begins on the date on which VHC receives notice. We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, you must also notify VHC 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 VHC receives notice, provided that You pay any additional Premium when due.

If You, Your Spouse or Child enroll because of the death of You or Your Dependents, your coverage will begin on the first day of the month following Your selection.

In all other cases, the effective date of Your coverage will depend on when VHC receives Your selection. If Your selection is received between the first and fifteenth day of the month, your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then.

H. Domestic Partner Coverage.

This Contract covers domestic partners of Enrollees as Spouses if you are covered with VHC or you purchase coverage direct through MVP. This Contract covers domestic partners of Enrollee s 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 Contract 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 contract;
        - 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 receiving 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.

I. 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.

J. When you, your Spouse or your child is no longer eligible for coverage. You must immediately notify MVP or 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 CHIP 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.

K. If, because of the event, you want to change your coverage tier 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 are encouraged but are not required to pick a Primary Care Provider (PCP).

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

2. No Referral Required. MVP does not require that you get a referral from your Participating Provider for Covered Services from an MVP specialist. However, you must get Pre-Authorization for certain services (see below)_, except for any admission, item, service, treatment, or procedure ordered by a Blueprint Primary Care Provider. Prescription Drugs and Out-of-Network services require Prior Approval regardless of ordering provider. For instance, if appropriate services are not available with a Network Provider, you must get Pre-Authorization. This does not include Emergency Medical Services.

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

   B. Non-Emergency Care Services From a Non-Participating Provider. An MVP Participating Provider must submit a Pre-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 Participating Provider for all of your health care needs. Even though you do not need a referral, your Participating Provider should play a central role in your health care. You should visit your Participating Provider 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 Participating Provider provides them.

3. If you need to find other MVP Participating Providers in your area, please visit our Web site at **mvphealthcare.com**. Click on "Find a Doctor" on the home page.

4. Use of Non-Participating Providers When Your Provider Leaves the Network.

   If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Pre Authorization, Referrals, and a treatment plan approved by Us. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

5. Use of Non-Participating Providers by New Enrollees in a Course of Treatment.

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

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

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 a Participating Provider or a Provider in our affiliate's First Health/MagnaCare Network. 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. MVP will work with you or your provider as necessary to find a provider to provide the services you need. When seeking benefits for using a Non-Participating Provider for your health care services, some information we will need to know: 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. This information is best provided by your PCP or other specialty physician you may be seeing. Your provider can provide this information to MVP by following the Pre-Authorization requirements set forth in Section Six.

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.

9. Out-of-Network Providers at Network Facilities. If you receive Medically Necessary, Covered Services from an Out of Network Provider at a Network facility without your informed consent, we will cover your care as if you had been treated by a Network Provider. You must pay any Cost-Sharing amounts required under your Contract, which will in no event be more than as if you received those services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. Under federal law, unless you give your informed consent, providers are prohibited from billing you for these services beyond your Cost-Sharing amounts. If the Out of Network Provider requests any payment from you other than your Cost-Sharing amounts, please contact us at the number on the back of your ID card so that we can work directly with the Provider to resolve the request.

SECTION FIVE – MEDICAL NECESSITY

1. We will only provide Benefits if a Covered Service is Medically Necessary. Medically Necessary or Medical Necessity means a Covered Service, including diagnostic testing, preventive services and aftercare that is:

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

   B. Informed by generally accepted medical or scientific evidence and 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. Must be informed by the unique needs of each individual patient and each presenting situation;

   D. One which:

      i. Helps restore or maintain your health; or
      ii. Prevents deterioration of or palliate your condition; or
      iii. Prevents the reasonably likely onset of a health problem or detects 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 1-888-687-6277.

SECTION SIX - UTILIZATION MANAGEMENT

This Contract requires concurrent review and Pre-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 Pre-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 Pre-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 Pre-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) in the case of a pregnant woman, could place the health of an unborn child in serious jeopardy;

         (c) 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, 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. Pre-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 Participating Provider must get from MVP before you receive any services from a Non-Participating Provider, except for any admission, item, service, treatment, or procedure ordered by a Blueprint Primary Care Provider. Prescription Drugs and Out-of-Network services require Pre-Authorization regardless of ordering provider. We do not require Pre-Authorization for Emergency Medical Services.

A. When Pre-Authorization is Required.

i. For In-Network Services. Check with your MVP Participating Provider. He or she will ask for Pre-Authorization from MVP on your behalf when it is needed for In-Network services. You need Pre-Authorization for services on our Prior Approval list, even if you use a Network Provider except for any admission, item, service, treatment, or procedure ordered by a Blueprint Primary Care Provider. MVP makes a list of these services available to Participating Providers. Go to MVP's website at **mvphealthcare.com** if you would like to see the list of In-Network services that need Pre-Authorization. You may also call MVP's Customer Care Center at 1-888-687-6277 to ask if a service is on the list.

ii. For Out-of-Network Services. You must get Pre-Authorization from MVP for yourself when the services are Out-of-Network regardless of the ordering provider.

iii. For Prescription Drugs. You must get Pre-Authorization from MVP for Prescription Drugs regardless of ordering provider.

B. Urgent Pre-Authorization Requests.

i. We shall approve, deny, or inform you or your health care provider if any information is missing from a pre-authorization request from your or your prescribing health care provider within 24 hours following receipt of the request.

ii. If We inform You or your health care provider that more information is necessary for Us to make a determination on the request, You or your health care provider will have 45 days from the receipt of our notice to provide us with the missing information. We shall have 24 hours to approve or deny the request upon receipt of the necessary information.

C. Non-Urgent Pre-Authorization Requests.

i. We shall approve or deny a completed Pre-Authorization request from You or Your prescribing health care provider within two business days following receipt of the request.

ii. We shall acknowledge receipt of the Pre-Authorization request within 24 hours following receipt and shall inform You or Your health care provider at that time if any information is missing that is necessary for Us to make a determination on the request.

iii. If We notify You or your health care provider that more information is necessary pursuant to paragraph ii above, You or your health care provider will have 45 days from the receipt of our notice to provide us with the missing information. We shall have 24 hours to approve or deny the request upon receipt of the necessary information.

D. If We do not, within the time limits set forth above, respond to a completed Pre-Authorization request, acknowledge receipt of the request for Pre-Authorization, or request missing information, the Pre-Authorization request shall be deemed to have been granted.

E. Pre-Authorization approval for a prescribed or ordered treatment, service, or course of medication shall be valid for the duration of the prescribed or ordered treatment, service, or course of medication or one year, whichever is longer; provided, however, that for a prescribed or ordered treatment, service, or course of medication that continues for more than one year, a health plan shall not require renewal of the Pre-Authorization approval more frequently than once every five years.

F. If You are stable on a treatment, service, or course of medication, as determined by a health care provider, that was approved for coverage under a previous health plan, We shall not restrict coverage of that treatment, service, or course of medication for at least 90 days upon Your enrollment in this plan.

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. Pre-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:

   - Semi-private room.
   - Board and general nursing services.
   - Use of operating, recovery, delivery, endoscopic and treatment rooms and equipment.
   - Use of intensive care or special care units and equipment.
   - 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.
   - Dressings and casts.
   - Diagnostic Services.
   - Therapeutic Services.
   - Professional services, equipment, and supplies in connection with oxygen, anesthesia.
   - Laboratory services.
   - Pathology services.
   - Medical and surgical supplies.
   - 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. In the event the mother elects to leave the Hospital following delivery and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, we will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our coverage of this home care visit shall be in addition to home health care visits under this Contract and shall not be subject to any Cost-Sharing amounts in the Summary of Benefits and Coverage (SBC) that apply to home care benefits.

   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 SBC.

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, we will also provide benefits for a covered newborn from the moment of birth through 60 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.

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 and Substance Use Care

   A. Mental Health Conditions. We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. 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. We will also provide benefits for mental health residential treatment centers. The facility must also be a Participating Provider.

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

B. Alcohol or Substance Use Disorders. We will provide benefits for the inpatient services listed in paragraph 3 only when provided pursuant to a written treatment plan in a facility approved by the secretary of human services that provides a program for the treatment of alcohol or substance use disorders. We will also provide benefits for substance use residential treatment centers. The facility must also be a Participating Provider.

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

11. Gender Reassignment Services for Gender Dysphoria. We will provide benefits for medically necessary Gender reassignment services.

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:

      - Your physician has ordered the tests; and
      - An operating room at the hospital has been reserved for surgery.

      You must pay the Cost Share listed on your Summary of Benefits and Coverage (SBC).

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

      If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:

      For the procedure with the highest Allowed Amount; and
      50% of the amount We would otherwise pay for the other procedures.

      We also provide benefits for abortion services, male and female sterilizations and one attempt at reversal of sterilization. These services are subject to Pre-Authorization. Voluntary sterilization procedures for females and males are covered with no Cost Share. Voluntary sterilization procedures for males are subject to the deductible for members in plans that are titled "MVP High Deductible" (an IRS HSA Qualified High Deductible Health Plan).

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

   D. Contraceptive Services. We will provide benefits for outpatient contraceptive services as per HRSA guidelines for all FDA approved contraceptive methods

including office visits, consultations, and follow-up services. We will provide benefits for office visits associated with insertion, removal, counseling, and monitoring of contraceptive devices as medically necessary. 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 SBC for each visit. Covered services include outpatient individual, group, and family therapies, medication management, psychological/neuropsychological testing, intensive outpatient and partial hospitalization programs, Transcranial Magnetic Stimulation (TMS), and Electroconvulsive Therapy (ECT).

F. Treatment of Alcohol or Substance Use Disorders. We will provide benefits for outpatient treatment of alcohol or substance use only when provided by a participating licensed or certified substance use provider. You must pay the Cost Share listed on your SBC for each visit. Covered services include outpatient individual, group, and family therapies, medication management, Medication Assisted Treatment (MAT), opioid treatment programs, and intensive outpatient and partial hospitalization programs.

G. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

(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.

We also Cover screening by ultrasound for an Enrollee for whom the results of a screening mammogram were inconclusive or who has dense breast tissue, or both.

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 SBC.

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

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.

L. Out of Pocket costs for treatment of victims of sexual assault. Treatment and examinations for victims of sexual assault are subject to the deductible for members in plans that are titled "MVP High Deductible" (an IRS HSA Qualified High Deductible Health Plan).

M. Gender Reassignment Services for Gender Dysphoria. We will provide benefits for medically necessary Gender reassignment services.

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

We Cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) non-hospital breast pump per pregnancy for the duration of breast feeding from a Participating Provider or designated vendor.

O. Abortion Services**.** We Cover abortion services. Coverage for abortion services includes any Prescription Drug prescribed for an abortion, including both Generic Drugs and Brand-Name Drugs, even if those Prescription Drugs have not been approved by the FDA for abortions, if the Prescription Drug is a recognized medication for abortions in one of these reference compendia:

- The WHO Model Lists of Essential Medicines;
- The WHO Abortion Care Guidelines; or
- The National Academies of Science, Engineering and Medicine Consensus Study Report.

Abortions services are subject to the Deductible but are not subject to Copayments or Coinsurance when provided by a Participating Provider.

SECTION NINE – COVERED SKILLED NURSING FACILITY SERVICES

1. Pre-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 up to 60 days per Plan Year for non-custodial care.

- Room and board in a semiprivate room.
- Skilled nursing care.
- Therapy Services.
- Drugs, medications, supplies and equipment used in and furnished by the SNF.
- 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. Pre-Authorization is required for out of network 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 Summary of Benefits and Coverage (SBC) 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 Pre-Authorization. Please refer to your SBC.

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.

We Cover inpatient Hospice Services in a Participating Hospice or Participating Hospital and home care and outpatient services provided by the hospice, including drugs and medical supplies. We also Cover supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker services, companion care, or unskilled respite care. You must pay the Copayment, Deductible and/or Coinsurance that applies.

4. Private Duty Nursing

A. You must get Pre-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 for up to 4 visits 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. Delivery of Covered Services Using Telehealth. If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Contract that are at least as favorable as those requirements for the same service when not delivered using telehealth.

"Telehealth" means the use of electronic information and audio and video telecommunication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location. "Telehealth" also includes coverage for all medically necessary, clinically appropriate health care services delivered remotely by audio-only telephone to the same extent covered if they were provided through in-person consultation. This includes services that are covered when provided in the home by home health agencies. For a service to be considered eligible for Telehealth coverage, the interactive audio and video or audio-only telecommunications must be either real-time communication with electronic transmission of Your health information, or pre-recorded videos known as "store and forward" technology.

6. Telemedicine Program

In addition to providing Covered Services via telehealth, We cover online internet consultations between You and Providers who participate in our telemedicine programs for medical conditions that are not an Emergency Condition.

The telemedicine programs are provided pursuant to contracts with Amwell, Galileo, and UCM Digital Health and are services that provide Participants with access to a national network of Providers for medical care in connection with a wide range of conditions and cases, including some mental health disorders. A member can access these services through video and/or phone, using either desktop or mobile devices. More information can be found at **StartWithGia.com**.

SECTION ELEVEN - COVERED EMERGENCY SERVICES AND URGENTLY NEEDED CARE

1. Emergency Services. We cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

   A. **Emergency Condition.** A sudden and, at the time, unexpected onset of an illness, 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 or of an independent freestanding emergency department, as applicable, 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 or the independent freestanding emergency department, such further medical examination and treatment as are required to stabilize the patient. Emergency Services also include items and services for which benefits are provided or covered that are furnished (regardless of the department of the hospital in which such items or services are furnished) after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay which respect to the visit in which the pre-stabilization Emergency Services are furnished.

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

   D. **Pre-Authorization.** Emergency Services are not subject to Pre-Authorization requirements.

E. You, your Provider, or a member of your family must call MVP at 1-800-348-8515 within 48 hours, or as soon as reasonably possible, after receiving Emergency services.

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

G. **Your Payments.** You must pay the Cost Share listed on your Summary of Benefits and Coverage (SBC) 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 Provider 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 1-800-348-8515 within 48 hours, or as soon as reasonably possible, after receiving Urgently-Needed Care that results in an inpatient admission.

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

E. You must pay the applicable Cost Share listed on your Summary of Benefits and Coverage (SBC). 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 SBC.

SECTION TWELVE – COVERED PROFESSIONAL CARE AND SERVICES

1. After Hours Provider Services. Providers 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 Provider's regular office hours, you should call his or her office, identify yourself as an MVP Enrollee, and follow the Provider 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 Summary of Benefits and Coverage (SBC) 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. We Cover the following services for the purpose of promoting good health and early detection of disease. Unless otherwise noted, Preventive services are not subject to Cost-Sharing (Co-payments, Deductibles or Co-insurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your Member ID card or visit Our website at **mvphealthcare.com** for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

      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 Participating Provider. 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 SBC 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 Participating Provider.

iii. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer. 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. 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. For a list of Participating Providers who specialize in obstetrics or gynecology, contact the Customer Care Center at 1-888-687-6277.

iv. Family Planning and Reproductive Health Services. We Cover family planning services which consist of: FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered under the Prescription Drug Coverage section of this Certificate; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; pregnancy tests; ultrasounds; STD and STI testing; and sterilization procedures for males and females. Such services are not subject to Co-payments, Deductibles or Co-insurance when provided by a Participating Provider. Voluntary sterilization procedures for males are subject to the deductible for members in plans that are titled "MVP High Deductible" (an IRS HSA Qualified High Deductible Health Plan).

iv. Mammograms Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

(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.

We also Cover screening by ultrasound for an Enrollee for whom the results of a screening mammogram were inconclusive or who has dense breast tissue, or both.

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 forty-five (45) 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.

(c) In addition, You will not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include one or more of the following:
(1) removal of tissue or other matter;
(2) laboratory services;
(3) physician services;
(4) facility use; and
(5) anesthesia.

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. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Cost-Sharing when provided by a Participating Provider and in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

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

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

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

xi. High Deductible Health Plan (HDHP) Preventive Care. Per IRS Notice 2019-45 certain medical care services and items for chronic conditions may be covered prior to the Deductible being met as preventive care for individuals with those chronic conditions. The following services will be treated as preventive services and are not subject to a Deductible; they are subject only to the Coinsurance or Copayment listed on Your Schedule of Benefits:

- Blood pressure monitor
- Retinopathy screening
- Peak flow meter
- Glucometer
- Hemoglobin A1c testing
- International Normalized Ratio (INR) testing
- Low-density Lipoprotein (LDL) testing

A list of the preventive services covered under this paragraph is available on our website at **mvphealthcare.com** or will be mailed to you upon request. You may request the list by calling the Customer Care Center at 1-888-687-6277.

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. 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 Participating Provider.

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. We will provide benefits for Medically Necessary routine foot care. You must pay the Cost Share for prescription drugs set forth on your SBC for diabetic equipment and supplies. Diabetic treatment services are subject to your medical benefit cost share in your SBC.

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 SBC 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 Pre-Authorization.

M. 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 SBC.

N. 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 Pre-Authorization from MVP before receiving benefits. You must pay the Cost Share listed on your SBC. Anesthesia services are provided:

i. for an Enrollee 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 an Enrollee 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.

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

Benefits are only for general anesthesia and any related hospital or facility charges. Except as specifically provided in Section Twelve, 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.

O. Laboratory Services. These services must be provided by a Participating Provider.

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

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

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

S. Medical Foods. We will provide benefits for low protein modified food products, enteral formulae, medical foods, formulas or supplements administered through a feeding tube, and 100% amino acid formula prescribed by a participating provider for use under the direction of a participating physician for the medically necessary treatment of any dietary condition including. 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 SBC.

T. Craniofacial Disorders. We will provide benefits for Participating Provider services for diagnosis and treatment, including surgical and non-surgical procedures, for 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 Pre-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.

U. 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

V. 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 SBC.

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

In addition to the above items, a listing of non-covered DME items can be found on Our website at **MVP Commercial DME Non-Covered Items**. This list will be updated from time to time based solely on changes made by CMS. We recommend that you check this list prior to purchasing any DME item to ensure it is a covered item, and not on the list of Non-Covered items. Some examples of Non-Covered DME items are hot water bottles, exercise equipment, toilet rails, and tub stools. This list will be revised from time to time by Us. If you are unable to access the website or need additional information, call the number on Your MVP ID card.

W. 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, sponges, syringes, needles, diabetic test strips, lancets and glucometers for the treatment of diabetes, reagent strips, catheters, elastic support stockings, compressive garments, dressings, and bandages.

X. 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 1-888-687-6277. Transplant Services are subject to Pre-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.

Y. Clinical Trials for Cancer Patients. We will provide benefits, to the extent required by law, to cover routine costs for patients who participate in all four types (phases I-IV) of approved cancer clinical trials that are conducted under the auspices of cancer care providers. 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.

Z. 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.

AA. Prosthetics.

1. External Prosthetic Devices.

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

- We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.
- Eyeglasses and contact lenses are not Covered under this section of the Contract and are only Covered under the Pediatric Vision Care section of this Contract.
- We do not Cover shoe inserts.
- We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.
- Coverage is for the most appropriate model that is Medically Necessary to meet Your medical needs.
- We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

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

Coverage also includes repair and replacement due to normal growth or normal wear and tear. Coverage is for standard equipment only.

BB. 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 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.

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

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.

CC. Tobacco Cessation Services. We will cover the cost of at least two (2) tobacco cessation attempts 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.

DD. Weight Loss Services. We will provide Benefits for any Medically Necessary Covered Services or care set forth in your Contract, 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 1-888-687-6277.

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

EE. Infertility Treatment. We cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Infertility is determined by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older; or the inability of an individual to establish a clinical pregnancy due to sexual orientation or gender identity. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

a. Basic Infertility Services. Basic infertility services will be provided to a member who is an appropriate candidate for infertility treatment. In order to determine eligibility, we will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of Vermont.

   Basic infertility services include:

   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultrasound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

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

b. Additional Infertility Services. If the basic infertility services do not result in increased fertility, we cover Additional Infertility Services.

   Additional Infertility Services include:

   - Ovulation induction and monitoring;
   - Pelvic ultrasound;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

c. Exclusions and Limitations. We will not provide benefits for any services for or related to artificial means to induce pregnancy, including but not limited to artificial insemination or Intrauterine 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, cloning, and gender selection.

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 SBC for your Cost Share obligations.

ii. Eyewear. We will provide Benefits for one (1) pair of prescription eyeglasses OR for prescription contact lenses. See your SBC for any applicable cost-sharing. 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 iii 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) Nonprescription 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 in your SBC, 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. Hearing Aid Exam and Devices.

Exam. We will provide benefits for an annual hearing exam for prescribing, fitting, or determining the need for hearing aids and for hearing therapy or training. A hearing aid exam is subject to the specialist visit cost share.

External Hearing Aids. We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered Services include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years. External hearing aids are subject to the durable medical equipment cost share.

Cochlear Implants. We cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Contract, unless more than one is Medically Necessary. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions. Cochlear implants are internal prosthetic devices. Pre-Authorization is required.

HH. Routine Foot Care. We cover Medically Necessary routine foot care.

II. Acupuncture Coverage.

We will provide benefits for acupuncture with a maximum allowance of $500. This allowance is subject to the deductible. The Member may use any licensed provider. If a Member has met their deductible, services will be reimbursed up to $500 in the same manner they are billed. If a Member has not met their deductible, MVP will apply the $500 allowance directly to the deductible and out-of-pocket maximum (OOPM) until the deductible is met. Once the $500 allowance is met, the benefit is exhausted and no further acupuncture services will be covered.

JJ. 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 to the end of the year the member turns 21. Please refer to the SBC 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. 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,

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

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; alveoloplasty; 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 limited 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 consist of necessary treatment and procedures required for the correction of malocclusion.

Pre-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.

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.

Prescription drug means any human drug required by federal law or regulation to be dispensed only by a prescription, including finished dosage forms and active ingredients subject to Section 503(b) of the Federal Food, Drug and Cosmetic Act.

B. **Medically Appropriate Off-label Use of a Drug** means the use of a Covered Drug, pursuant to a valid prescription by a health care provider, for other than the particular condition(s) for which approval was given by the U.S. Food and Drug Administration in circumstances in which the medically appropriate off-label use is reasonably calculated to restore or maintain the member's health, prevent deterioration of or palliate the member's condition, prevent the reasonably likely onset of a health problem or detect an incipient problem; and that is informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition.

C. **Experimental or Investigational Drugs** 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.

D. **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 1-888-687-6277 or by viewing the list online at **mvphealthcare.com**.

E. **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.

F. **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 Summary of Benefits and Coverage (SBC) 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.

Insulin Drugs. Your total out-of-pocket responsibility for prescription insulin medications will not be more than $100 per 30-day supply, regardless of the amount, type, or number of insulin medications being prescribed. This Out-of-Pocket Maximum will apply even if you have not met your deductible.

- Qualified High Deductible Health Plan (HDHP),
  If you are in a HDHP, you will pay the full cost of your Prescription Drugs until either of the following occurs:

  If you have met the HDHP Medical Deductible with either all medical expenses or a combination of medical expenses and Prescription Drug expenses; then you will pay any applicable copayment, coinsurance or other cost sharing amount for Prescription Drugs until you have met your HDHP Medical Out of Pocket Maximum or you have met your Annual Out of Pocket Maximum Expense for Prescription Drugs, whichever occurs first.

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

- 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 SBC.
- Any differences in the cost of the brand prescription drug and the cost of the generic drug when applicable.

G. **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.

H. **Brand/Generic Difference**. If you have a covered prescription filled with a brand name drug, as defined by MediSpan® and there is a generic equivalent drug for that brand name drug, and you have not obtained an exemption based on the medical necessity for the brand name drug, you must pay the generic drug cost share, plus the difference in cost between the generic and the brand name drug, not to exceed the cost of the drug. The amount you pay for the difference between generic and brand will not apply to any maximum benefit, out of pocket maximum or deductible.

I. **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 **mvphealthcare.com** for a list of VBID Drugs. See your SBC for your Cost Share for VBID Drugs. VBID prescription coverage may not be available with your plan. Please refer to your SBC.

J. **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 1-888-687-6277 or by contacting us online at **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 Pre-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 1-888-687-6277. You can also view the list online. Go to **mvphealthcare.com** and follow the instructions.

3. Benefits Available. Prescription drugs other than contraceptives are covered up to a thirty (30) day supply ("Standard Supply"). You may get two vacation supplies per Benefit Year. This means that you may get up to an additional 30 day supply for vacation periods two times per Benefit Year. You must pay the applicable multiple payments for a vacation supply. Prescription contraceptive drugs and devices approved by the FDA are covered subject to any applicable Cost Share as per HRSA guidelines, and may be covered up to a 12 month supply.

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 SBC. For any prescription drugs that you get at an MVP Participating Retail Pharmacy which are also included on MVP's Mail Order Pharmacy Benefit List, MVP will provide coverage for up to a 90-day supply per dispensing by the Participating Retail Pharmacy, subject to the same Allowable Charge and Cost Share requirements as detailed in the Mail Order

Pharmacy Benefit below. Note that mail order prescriptions may not be available at all MVP Participating Retail Pharmacies.

Mail Order Pharmacy Benefit. For covered prescription drugs listed on MVP's 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 SBC. 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 1-888-687-6277 or by contacting us online at **mvphealthcare.com** and following the instructions.

How to Use the Mail Order Program Through CVS/Caremark 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 1-888-687-6277. You may also visit MVP's web site at **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 **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 1-888-687-6277. You may also visit MVP's web site at **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.

B. 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 by tier as set forth in the Formulary.

How to Use the Specialty Pharmacy Vendor Program.

a. 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 **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 1-888-687-6277. You may also visit MVP's web site at **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.

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 Pre-Authorization by calling MVP's Customer Care Center at 1-888-687-6277. You may also visit MVP's web site at **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. Pre-Authorization Requirements. In some cases, MVP may require that your prescribing provider satisfy MVP Pre Authorization Requirements before a prescription is filled at the pharmacy. Drugs that must be Pre-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 Pre-Authorization for a minimum of six (6) months. All compounded prescriptions over $100 require Pre-Authorization. Compounds containing non-FDA approved drugs may also require Pre-Authorization. Please refer to Section Six – Utilization Management for additional information regarding Pre-Authorization requests.

A. Changes to Pre-Authorization Requirements or Quantity Limits. MVP lets Providers know, in writing, when we change Pre-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 Pre-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 Pre-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. Pre-Authorization and prescription drug override requests can be submitted via fax to 1-800-376-6373, or submitted online at **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.

D. In cases where MVP requires step therapy protocols for coverage, MVP will:

(i) Not require failure on the same medication on more than one occasion for insured who are continuously enrolled in the plan.

(ii) Grant an exception to its step therapy protocols upon request within 24 hours for urgent request or 2 business days for nonurgent requests if and one of the following apply:

(a) the prescription drug required under the step-therapy protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(b) the prescription drug required under the step-therapy protocol is expected to be ineffective based on the insured's known clinical history, condition, and prescription drug regimen;

(c) the insured has already tried the prescription drugs on the protocol, or other prescription drugs in the same pharmacologic class or with the same mechanism of action, which have been discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, regardless of whether the insured was covered at the time on

a plan offered by the current insurer or its pharmacy benefit manager;

(d) the insured is stable on a prescription drug selected by the insured's treating health care professional for the medical condition under consideration; or

(e) the step-therapy protocol or a prescription drug required under the protocol is not in the patient's best interests because it will:

1. pose a barrier to adherence;
2. likely worsen a comorbid condition; or
3. likely decrease the insured's ability to achieve or maintain reasonable functional ability.

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

E. 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 Pre 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 Pre-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.

F. 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.

G. 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.

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

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

Expedited Review of a Formulary Exception. If you are suffering from a health condition that may seriously jeopardize your health, life or ability to regain maximum function or if you are undergoing a current course of treatment using a non-Formulary Prescription Drug, you may request an expedited review of a Formulary Exception. The request should include a statement from your prescribing Health Care Professional that harm could reasonably come to you if the requested drug is not provided within the timeframes for our standard

Formulary exception process. We will make a decision and notify you or your designee and the prescribing Health Care Professional no later than 24 hours after Our receipt of your request. If we approve the request, we will cover the Prescription Drug while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function or for the duration of your current course of treatment using the non-Formulary Prescription Drug.

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). 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.

O. Drugs entering the market between 1938 and 1962 that were approved for safety but not effectiveness is called "DESI" drugs. DESI drugs are not covered.

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

A. **STEP ONE**: Have your provider write a prescription and complete any required Pre-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 Pre-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 Pre-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 1-888-687-6277 or by visiting MVP's website at **mvphealthcare.com**. 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 Pre-Authorization request for Pharmacy Benefits. Generally, Pre-Authorization requests for Pharmacy Benefits will be considered urgent. To request Pre-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 Pre-Authorization request within the timeframe set forth in your Contract.

10. How to file an Urgent Pre-Authorization request for Pharmacy Benefits. To file an Urgent Pre-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 1-888-687-6277. Nothing in this Subsection shall limit MVP's ability to terminate your coverage under your Contract for any of the reasons set forth in your Group Contract or Contract.

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.

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

   A. Services Starting Before Coverage Begins. 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 Summary of Benefits and Coverage (SBC).

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

L. 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, Section Twelve, paragraph 2(AA))2, and Section Twenty One, paragraph F. 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.

M. 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.

N. 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.

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

P. Dental Services. Except as specifically provided, 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.

Q. 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.

R. 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.

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

T. 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, to cover routine costs for patients who participate in approved cancer clinical trials. See Section Thirteen, paragraph 1.A., and also the Exclusions in Section Thirteen.

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

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

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.

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

GG. 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.

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

II. 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.

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

KK. Vision Examinations, Therapies and Supplies. Except as provided in Section Twelve, paragraph 2(FF), we will not provide benefits for any services related to eye examinations for prescribing, fitting, or determining the need for eyeglasses, lenses, frames, or contact lenses, for vision 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 care.

LL. 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 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 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:

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

(b) 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.

A. You may terminate your coverage at any time by giving us fourteen (14) days' prior written notice.

B. If you demonstrate to Vermont Health Connect (VHC) you attempted to terminate coverage but experienced a technical error, you may request retroactive termination within 60 days of discovering the technical error. The termination date will be no sooner than 14 days after the date you previously contacted VHC to terminate the enrollment.

C. If you demonstrate enrollment in a qualified health plan through VHC was unintentional, inadvertent or erroneous and was the result of the error or misconduct of an officer, employee, or agent of VHC or the Department of Health and Human Services, or an entity providing enrollment assistance, you must request retroactive termination within 60 days of discovering the enrollment. The cancellation or termination date will be the original coverage effective date or a later date if determined appropriate by VHC depending on the circumstances.

D. If you demonstrate to VHC that you were enrolled in a qualified health plan without your knowledge or consent by a third party, including third parties who have no connection with VHC, and request cancellation within 60 days of discovery of the enrollment. The cancellation date or termination date will be the original coverage effective date or a later date if determined appropriate by VHC depending on the circumstances.

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.

   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 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 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 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 covered by Medicare, you must notify MVP in writing and Medicare then becomes your Primary Plan. We will reduce our benefits by the amount Medicare paid for the services or care.

2. 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. 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.

4. 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 attorney's 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 1-888-687-6277 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 1-800-919-7787 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. 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 Contract. 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. Not available to individual plan members. This applies to group coverage only. 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.

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 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., 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 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 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. <u>First-Level Non-Urgent, Pre-Service Grievance - Timeframe for Completion and Notification</u>:

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 receive MVP's response to the Voluntary Second Level Grievance. Paragraphs 11-16 are not applicable to enrollees 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. (Paragraphs 11-16 are not applicable to enrollees in individual health plans. If you are in an individual health plan, please proceed directly to paragraph 17.)

A. 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 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. 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 to deny, reduce, or terminate coverage or to deny payment for a health care service. 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; treatment of a pre-existing condition; an adverse determination related to surprise medical billing 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 appeals review requirements described in your Contract, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in your Contract.

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 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. 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.

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 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.

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 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.

E. 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).

F 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 Summary of Benefits and Coverage (SBC).

If you would like more information on WHCRA benefits, you may call the Customer Care Center at 1-888-687-6277.

4. 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.

5. 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.

6. 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.

7. 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.

8. Payment of Claims. We will pay the claim within 30 days of receipt if all required information to make a payment determination is present. If we request additional information, We will pay the claim within 30 days of receipt of all requested information. Member claims forms are available at this link: MVP Claim Reimbursement Request (**mvphealthcare.com)**. Online member claim forms are available at **mvphealthcare.com**. To submit a claim form online, sign into your online account and select Medical Claim Reimbursement.

9. 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.

10. 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.

11. 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.

12. 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. Please refer to Section Four – Access to Providers, to find out when and how you may continue receiving services from a non-participating provider.

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. When You are in our Service Area**,** you should not usually have to travel more than 30 minutes from home or work for:
- Routine office-based medical provider treatment
- 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 1-888-687-6277.
2. Information about your coverage.	2. This is in your **Contract and Riders.**
3. Information on Pre-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.**

You have a right to this information.	You can find this information here.
5. Enrollee responsibility to pay premiums, Coinsurance, Copayments, and Deductibles.	5. This is in your **Contract, Riders**, and your **Summary of Benefits and Coverage (SBC)**.
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 1-888-687-6277 **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. Waiting and travel time standards.	13. This is in your **Contract**.
14. How providers are paid and that they can see non-MVP patients.	14. This is in your **Contract**.
15. The services offered by the Vermont Department of Financial Regulation.	15. This is in your **Contract**.
16. Access to Enrollee medical records and procedures to keep medical records private.	16. Call **MVP's Customer Care Center** at 1-888-687-6277 for more information.

You have a right to this information.	You can find this information here.
17. Access to Prescription Drug Formulary	17. This is in your **Contract**. You can also Call **MVP's Customer Care Center** at 1-888-687-6277 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 1-888-687-6277 for help.

26. Quality Improvement (QI)
The scope of the QI Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to MVP members including medical, behavioral health, dental, and vision care as applicable to MVP's benefit package. MVP wants you to have access to and receive good health care. In addition, MVP wants you to be happy with the services you receive. Many of MVP's structured quality improvement committees have both MVP member and external provider participation to help make decisions about the QI program.

The main goals of the Program are:
- To measure and improve Enrollee satisfaction.
- To ensure Providers meet MVP and regulatory standards.
- To offer Enrollees both health and case management 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 and availability of medical care and services and, the quality of service outcomes.

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

At least twenty percent (20%) 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 1-518-991-3609, email mailto:SchQIGroup@mvphealthcare.com, or write to this address:

Quality Department, MVP Health Care, 625 State St., Schenectady, NY 12305

MVP reviews all ideas.

IMPORTANT TELEPHONE NUMBERS

MVP Customer Care Center	1-888-687-6277
TTY (for the hearing impaired)	711
MVP After Hours	1-888-687-6277
Little Footprints (8:30 a.m. to 5:00 p.m. Mon.-Fri.) (for Enrollees with pregnancy problems)	1-866-942-7966
MVP Asthma Care Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.)	1-866-942-7966
MVP Diabetes Care Program (8:30 a.m. to 5:00 p.m. Mon.- Fri.)	1-866-942-7966
MVP Cardiac Care Program (8:30 a.m. to 5:00 p.m. Mon. - Fri.)	1-866-942-7966
MVP Low Back Pain Program (8:30 a.m. to 5:00 p.m. Mon. - Fri.)	1-866-942-7966
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
Vermont Health Connect	1-855-899-9600