This is your Contract with MVP Health Plan, Inc. (hereinafter called MVP). It is issued to the person named on the MVP Identification Card. The term of this Contract begins on the Effective Date and ends on the Contract Renewal Date referenced in the group remittance agreement between MVP and the remitting agent who is making premium payments on your behalf. This Contract will be renewed for another term on the Contract Renewal Date, unless it is nonrenewed or terminated for any of the reasons described in the Contract. The coverage under this Contract begins on the effective date shown on the Identification Card.

Please examine this Contract carefully. If you are not satisfied with this Contract, you have the right to return it and to ask MVP to cancel it. Your request must be made in writing within ten days from the date you receive this Contract. Upon cancellation of this Contract, all benefits under it shall terminate.

MVP Health Plan, Inc.
111 Liberty Street
Schenectady, NY 12305

By:  
David W. Oliker
President

Name: ____________________________________________________________

I.D. No.: _________________________________________________________

Primary Care Physician: _____________________________________________

Phone: ___________________________________________________________
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SECTION ONE - INTRODUCTION

1. MVP HEALTH PLAN is a not–for–profit corporation which has been certified by
the State of New York to provide comprehensive health care on a prepaid basis.
MVP’s service area includes Albany, Broome, Chenango, Columbia, Delaware,
Dutchess, Fulton, Greene, Hamilton, Herkimer, Lewis, Madison, Montgomery,
Oneida, Onondaga, Orange, Otsego, Putnam, Rensselaer, Saratoga, Schenectady,
Schoharie, Tioga, Ulster, Warren and Washington Counties in the State of New
York; and the State of Vermont. This service area may be expanded into
surrounding communities in the future. MVP arranges for the provision of all
professional services through agreements with independent providers and
affiliated Individual Practice Associations (IPAs), which are organizations
consisting of physicians engaged in the practice of medicine in the communities
in which MVP provides services. Under the MVP concept, your primary care
physician is responsible for coordinating and overseeing the medical services
available to you. Except in the event of a medical emergency, you must access all
care through your primary care physician. MVP will not be responsible for the
payment of other services which result when you self–refer to other than your
primary care physician, except that female members may obtain primary and
preventive obstetric or gynecological services from a qualified participating
provider of such services up to twice per calendar year, and care related to
pregnancy, without an approval or referral from their primary care physician.
Female members may also self–refer for primary and preventive obstetric and
gynecological follow–up services required as a result of such visits, or as a result
of acute gynecological conditions, if the provider discusses such services and
treatment plan with the member’s primary care physician.

In addition, MVP will not be responsible for services from non–participating
physicians, hospitals and other providers, except where authorized by MVP in
advance in writing, in the event of a medical emergency, or where otherwise
specifically provided in this Contract. All of the medical care you receive will be
provided by physicians, hospitals or other health care providers who participate
with MVP Health Plan, unless the care you require is not available through a
participating provider. If that is the case, you will be referred to an appropriate
out–of–plan provider; and must receive prior written authorization from MVP
before receiving services. You will incur no additional expense in such situations
beyond what you would pay for in–plan care. Requests for out–of–plan care must
come from your primary care physician, and must include your diagnosis and
other relevant information regarding your condition, a medical opinion as to why
your care can not be obtained in–plan, and the name of the provider to whom
you are being referred. In urgent situations such requests may be made by
telephone; and MVP will render a decision within one working day, to be
followed by written notice within three working days. MVP will be the sole
determinator of the availability, or lack thereof, of medical care within the plan.

For more complete details, please refer to the pertinent sections of this Contract.
2. Your PRIMARY CARE PHYSICIAN is a physician in a contractual agreement with MVP or an IPA affiliated with MVP whom you have chosen to provide your primary care. Except in the event of a medical emergency (see Section Seven) or where otherwise specifically provided in this Contract, you will not receive any benefits under this Contract unless you contact your primary care physician before receiving services. If you change your primary care physician, you must notify MVP prior to seeing your new choice of physician.

3. A PARTICIPATING PHYSICIAN is a physician who has entered into a contractual agreement with MVP or an IPA affiliated with MVP.

4. HOSPITAL throughout this Contract refers to an acute general hospital which provides diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care. It must be licensed to operate as an acute general hospital under applicable State and local laws.

5. PARTICIPATING HOSPITAL is a hospital which has signed a contract with MVP.

6. LEGAL RELATIONSHIP − This Contract establishes a legal relationship between you and MVP. You are entitled to receive only the benefits described in this Contract. Keep this Contract with your other important papers so that it is available for future reference.

7. USE OF THE WORDS "YOU", "YOUR" AND "YOURS" IN THIS CONTRACT − These words refer to you, the person to whom this Contract is issued and whose name appears on the MVP Identification Card. They also apply to any members of your family who are covered under this contract, unless the context unambiguously indicates otherwise.

8. PAYMENT OF PREMIUMS − You are covered under this Contract as an individual subscriber whose premiums are paid by a remitting agent.

9. PAYMENT OF COPAYMENTS − You will be responsible for making copayments for certain professional services. The amount of copayment for a particular service will be determined by the program in which you are enrolled through your employer group. Check with MVP if you are uncertain as to which program that is. A Copayment Schedule is on the last page of this Contract, listing which professional services require copayments, and the appropriate copayment under the various coplans.

Notwithstanding the foregoing, you will not be responsible for any copayments for well-child visits for members from birth to age 19, provided that the visits are made to or by the member’s primary care physician; and provided further that the visits are scheduled in accordance with the prevailing clinical standards of the American Academy of Pediatrics, as follows:
Visits at: 2 to 3 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months.
Ages 2 – 5: One visit per year.
Ages 6 – 19: One visit every 2 years.

For purposes of this section, well−child visits shall include: a medical history; physical examination; developmental assessment; anticipatory guidance; necessary and appropriate immunizations; and laboratory tests ordered at the time of the visit.

10. "MEDICALLY NECESSARY" refers to covered services that MVP determines are necessary to prevent, diagnose, correct or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with a person’s capacity for normal activity or threaten a significant medical handicap.

SECTION TWO - WHO IS COVERED

1. **Who Is Covered Under This Contract** – You, the person to whom this Contract is issued, are covered under this Contract. If you select family coverage, the following members of your family are also covered:

   A. Your wife or husband, unless you are divorced or your marriage has been annulled;

   B. Your unmarried children (defined in subsection 2, below) who are under 19 years of age and are dependent upon you for support and maintenance;

   C. Your unmarried children (defined in subsection 2, below) of any age if:

      i. The child is unable to work or support himself or herself because of mental illness, developmental disability or mental retardation, as defined in the applicable State Law, or because of physical handicap;

      ii. The child became incapacitated before reaching the age at which coverage as a dependent would otherwise have terminated under this Contract; and

      iii. You provide MVP with proof of the child’s incapacity, including certification by a physician.

MVP has the right to verify whether a child is and continues to qualify as an incapacitated child.

2. **Children Covered Under This Contract** – For purposes of subsection 1, above, “children” and "child" are defined as being related to you, the person to whom this Contract is issued, as follows:
A. Your natural child;
B. Your legally adopted child;
C. Your step child;
D. A child for whom you are the legal guardian;
E. A child for whom you are the proposed adoptive parent. This includes newly born infants from the moment of birth if the subscriber takes physical custody of the infant upon release from the hospital and files a petition with a court of proper jurisdiction within 30 days of birth; provided that no notice of revocation to the adoption has been filed pursuant to law and/or consent to the adoption has not been revoked. The initial hospital stay shall not be covered under this Contract if a natural parent of the child has insurance coverage available for care of the infant.

3. **Coverage of New Family Members:**
   A. Except as otherwise noted in this Section, if you have family coverage, a new family member, including a newborn child, will be covered from the date he or she becomes a family member, provided that you notify MVP within 30 days after such date.
   
   B. If you do not have family coverage and marry or have a child, you must change to family coverage in order to cover your spouse or child under this Contract. You must notify MVP that you want family coverage within 30 days after your marriage or the birth or adoption of your child. If you do so, your new family members will be covered as of the date of your marriage or the date your child is born or adopted.

4. **Notification of Change in Family Status** – You must notify MVP of any change in your family status which affects your coverage or the coverage of your family members. For example, you must notify MVP of your divorce, the marriage of any child or a change in guardianship or support which affects your child’s coverage.

5. **Persons Not Entitled to Coverage:**
   A. Persons (other than your unmarried, dependent children, as defined in this Section) who do not reside, live or work in MVP’s service area.
   
   B. Any child born to a member’s dependent child.
SECTION THREE - HOSPITAL INPATIENT SERVICES

1. **Hospital Inpatient Care** – Except in the event of a medical emergency (see Section Seven) or where otherwise specifically provided in this Contract, you are entitled to the hospital inpatient services described below, but only if your admission is authorized in advance by MVP. 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, is covered under your Skilled Nursing Facility Care benefit (see Section Five). Many of MVP’s CoPlans do impose copayments on a per continuous confinement basis – please consult the Copayment Schedule on the last page. Your participating physician is responsible for arranging for such authorization.

2. **Covered Hospital Inpatient Services** – Except where limited elsewhere in this contract, you are entitled to all medically necessary hospital inpatient services arranged or authorized by a participating physician, except for the services described in subsection 5, below. Please note that certain infertility services are subject to a fifty percent (50%) copayment (please see Section Eight for more details). A member will be covered for a stay in a non-affiliated hospital only if MVP authorized the admission.

    A. In addition, female members are entitled to the following maternity care inpatient benefits:

        i. For vaginal deliveries, inpatient hospital coverage for the mother and newborn for a minimum of 48 hours after childbirth;

        ii. For cesarean section deliveries, inpatient hospital coverage for the mother and newborn for a minimum of 96 hours after childbirth;

        iii. The services either of a physician or a certified nurse–midwife to perform the delivery and any necessary follow-up treatment; and

        iv. If additional hospital services are determined to be medically necessary in connection with maternity care, they will be provided to you and covered under this Contract to the same extent that this Contract provides and covers such services in connection with illness or disease.

    B. In addition, members are entitled to the following breast cancer care inpatient benefits:

        i. For a mastectomy or a lymph node dissection or a lumpectomy for the treatment of breast cancer, inpatient hospital coverage for such period as is determined by the attending physician in consultation with you to be medically appropriate.
ii. For all stages of reconstruction of the breast on which the mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance, inpatient hospital coverage for such period as is determined by the attending physician in consultation with you to be medically appropriate.

3. Admission to a Hospital Before You Become Covered Under This Contract – If you are confined as an inpatient in a hospital or other facility on the date you become covered under this Contract, the confinement will be covered by MVP from your effective date of coverage under this contract only if you: (a) authorize MVP to assume full responsibility for your care while confined and; (b) use MVP participating providers. Notwithstanding the previous sentence, if you are covered by an insurer other than MVP under which your benefits continue if you are an inpatient when that policy terminates, then that insurer, and not MVP, shall be responsible until your discharge or until the benefits under that policy expire, whichever occurs first. MVP will not cover any services that would not otherwise be covered hereunder.

4. Rehabilitation Hospital Admissions – Rehabilitation hospital admissions (e.g. following stroke) not related to substance abuse will, upon prior approval of MVP, be covered for acute conditions which in the judgment of MVP are susceptible to significant clinical improvement through short-term treatment; but not to exceed 2 months duration per condition.

5. Hospital Inpatient Services Not Covered – MVP will not provide benefits for the following inpatient services:

A. Private room, unless a private room is authorized by a participating physician because it is medically necessary for your care. If you occupy a private room which was not ordered by a participating physician, you must pay the difference between the hospital’s charge for the private room and the hospital’s charge for a semi-private room.

B. Private duty nursing; except for private duty nursing which MVP determines is medically necessary for your care.

C. Whole blood, blood plasma, packed blood cells or other blood derivatives if participation in a volunteer blood replacement program is available to you. Administration and processing costs are covered.

D. Non-medical items such as telephone or television rental.

E. Medications, supplies and equipment which you take home from the
hospital.

F. Hospital expenses associated with dental surgery, unless such services are in connection with an accidental injury to sound natural teeth (see subsection 10 of Section Ten) and are approved in advance by MVP.

G. Fees or charges for services not provided, arranged or authorized by a participating physician.

SECTION FOUR - HOSPITAL OUTPATIENT SERVICES

1. **Hospital Outpatient Care** – Except in the event of a medical emergency (see Section Seven) or where otherwise specifically provided in this Contract, you are entitled to the hospital outpatient services described in subsection 2, below, only if:

   A. Your primary care physician provides the service to you or arranges or gives prior approval for you to receive the service; and

   B. The service is medically necessary for the diagnosis or treatment of your condition or ailment.

2. **Covered Hospital Outpatient Services** – Except where limited elsewhere in this contract, you are entitled to all medically necessary services in the outpatient department of a participating hospital, subject to the applicable member copayment. Certain infertility services are subject to a fifty percent (50%) copayment (please see Section Eight for more details). Medically necessary therapeutic services including, but not limited to, chemotherapy, radiation therapy and renal dialysis are covered subject to the MVP "Office Visit" copayment. Check the Copayment Schedule on the last page for applicable copayments.

3. **Preadmission Testing** – Tests performed at a hospital as a planned preliminary to admission as an inpatient for surgery in the same hospital are covered, provided that:

   A. The tests were ordered by a physician;

   B. The tests are necessary for the diagnosis and treatment of the condition;

   C. Reservations for a hospital bed and an operating room were made prior to performance of the tests;

   D. Surgery occurs within seven (7) days of such tests; and

   E. You are physically present at the hospital for the tests.
SECTION FIVE - SKILLED NURSING FACILITY CARE

1. **Skilled Nursing Facility Care** – You are entitled to skilled nursing services in a skilled nursing facility or in a hospital for up to a total of 45 days upon prior approval by MVP. You must also meet the following conditions:

   A. Your admission must be for the continuing treatment of the condition for which you were hospitalized at least three days and for which further hospitalization would otherwise be necessary; and

   B. You must require skilled nursing or skilled rehabilitation services which:

      i. Are required on a daily basis; and

      ii. Can be provided only on an inpatient basis.

2. **Skilled Nursing Facility** – A skilled nursing facility is a licensed facility which is approved for participation as a skilled nursing facility under Medicare. Also included are those that are certified as a skilled nursing facility by the Joint Commission on Accreditation of Healthcare Organizations.

3. **Custodial Care is Not Provided** – MVP will not provide benefits for any day in a skilled nursing facility which MVP determines is primarily for custodial care. Custodial care includes any service which can be learned and provided by an average individual who does not have medical training. Examples of custodial care include:

   A. Assistance in meeting activities of daily living such as feeding, dressing, and personal hygiene;

   B. Administration of oral medications, routine changing of dressing or preparation of special diets;

   C. Assistance in walking or getting out of bed; or

   D. Child care necessitated by your incapacity.

SECTION SIX - SPECIAL BENEFITS

1. **Home Care** – You are entitled to home care services by a private or public home care agency, but only if hospitalization or confinement in a skilled nursing facility would otherwise be required and such services have been arranged or authorized by a participating physician and approved by MVP in advance in writing. MVP will pay for the following:

   A. Part–time or intermittent home nursing care by or under the supervision of a
registered nurse.

B. Part-time or intermittent health aide services. Such services must consist primarily of caring for the patient and must not include custodial care, as defined in subsection 3 of Section Five.

C. Short term physical, occupational or speech therapy for acute conditions if provided by home health agency personnel; or other qualified providers if not available through home health agency personnel.

D. Medical supplies, drugs and medications prescribed by a physician and laboratory services, to the same extent as would be covered if the person were hospitalized.

2. **Ambulance Services** – MVP will pay for ambulance service when medically necessary and approved by MVP. This includes transportation to and from hospital, between hospitals and between a hospital and a skilled nursing facility. Approval may be obtained in advance or retrospectively.

3. **Hospice Care** – You are entitled to hospice care, for up to 210 days of coverage beginning with the first day on which care is provided, for home hospice care or inpatient hospice services as provided by a certified hospice program. This coverage shall include home care and outpatient services provided by the hospice, including drugs and medical supplies related to the hospice care. Coverage shall also be provided for up to five visits for bereavement counseling service to the family, either before or after the death.

**SECTION SEVEN - EMERGENCY CARE**

1. MVP defines a medical emergency as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

   A. Placing the health of the afflicted person in serious jeopardy, or in the case of a behavioral condition placing the health of the person or others in serious jeopardy;

   B. Serious impairment to the person’s bodily functions;

   C. Serious dysfunction of any bodily organ or part of the person; or

   D. Serious disfigurement of the person.

While emergency care does not require prior approval, if you receive such care under circumstances that do not qualify as a medical emergency, as defined above, you will be responsible for all associated costs.
Follow-up care to an emergency must, whenever possible, be coordinated by your primary care physician.

2. **Emergency Care Within the Service Area** – In the event of a medical emergency within MVP’s service area, you are entitled to medically necessary emergency care at a hospital emergency room. You, or someone on your behalf, should try to notify MVP within 48 hours, or else as soon as reasonably possible, after receiving the emergency care, so that MVP can help coordinate any necessary follow-up care. You will be responsible for a copayment for each emergency room visit. Check the Copayment Schedule on the last page to determine your copayment. When hospitalization immediately follows as a result of the medical emergency, the emergency room copayment is waived, but the hospital inpatient copayment must be paid, if applicable.

3. **Emergency Care Outside the Service Area** – In the event of a medical emergency outside MVP’s service area, you are entitled to medically necessary emergency care in a hospital or from a physician outside the service area, subject to the following conditions:

   A. You were unable to receive such care from a participating physician or a hospital within the service area.

   B. MVP’s obligation to provide coverage for such care stops when you can safely be taken to a hospital within MVP’s service area. MVP shall have sole discretion to determine if you can travel or be transported.

   C. You, or someone on your behalf, should try to notify MVP within 48 hours, or else as soon as reasonably possible, after receiving emergency care outside the service area, so that MVP can help coordinate any necessary follow-up care. No copayments for outpatient hospital services shall be required when the medical emergency happens outside the service area.

4. When you make visits to the emergency room in non-emergency situations you shall be liable for the entire charge for the visit including all associated charges such as, but not limited to, x-ray, laboratory services and medication expenses. MVP reserves the right to retrospectively determine if the visit was made under circumstances that qualified as a medical emergency.

**SECTION EIGHT - PROFESSIONAL CARE AND SERVICES COVERED**

1. **Professional Care** – Except in the event of a medical emergency (see Section Seven) or where otherwise specifically provided in this Contract, you are entitled to the professional services described in subsection "2", below, only if:

   A. Your primary care physician provides the service to you or arranges or gives
prior approval for you to receive the service; and

B. The service is medically necessary for the diagnosis or treatment of your condition or ailment.

2. **Professional Services Covered** – You are entitled to the following professional services. Check the Copayment Schedule on the last page for applicable copayments:

A. Office visits including immunizations and injections and pre–natal and post–natal care for mother and child. Female members may obtain primary and preventive obstetric or gynecological services from a qualified participating provider of such services up to twice per calendar year; and care related to pregnancy; without an approval or referral from their primary care physician. Female members may also self–refer for primary and preventive obstetric and gynecological follow–up services required as a result of such visits, or as a result of acute gynecological conditions, if the provider discusses such services and treatment plan with the member’s primary care physician.

Regarding maternity care, female members are responsible for making a copayment for the first maternity care office visit only. Also, female members are entitled to the following professional services, in addition to the inpatient hospital services described in Section Three of this Contract:

i. Parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments.

ii. If you opt to be discharged from the hospital earlier than the time periods set forth in subsection 2.A of Section Three of this Contract, you are entitled to at least one home care visit. You must request this home care visit from your physician within 48 hours of a vaginal delivery, or within 96 hours of a cesarean section delivery. If such request is timely made, MVP will provide this home care visit within 24 hours after discharge from the hospital or from the time of the mother’s request, whichever is later. This home visit will be provided to you without charge (no copayment) and shall be in addition to any home care coverage to which you may otherwise be entitled under this Contract.

iii. If additional medical or surgical services are determined to be medically necessary in connection with maternity care, they will be provided to you and covered under this Contract to the same extent that this Contract provides and covers such services in connection with illness or disease.

The provisions in this subsection do not apply to coverage for perinatal
complications, which are covered under the regular terms of the Contract.

B. Periodic health evaluations as determined by age and sex or as medically necessary.

C. Well baby care.

D. Eye examinations and hearing tests as medically necessary, subject to the exclusions in subsection 18 of Section Ten of this Contract. In addition, routine eye examinations will be covered once every two calendar years, when provided by a participating provider.

E. Consultations; and second surgical opinions for non–emergency surgery only.

F. Surgical care.

G. Casts and dressings.

H. Anesthesia.

I. Laboratory services.

J. X–ray services.

K. Radiation therapy services.

L. Short–term physical, speech or occupational therapy for acute conditions which, in the judgment of MVP, are subject to significant clinical improvement through relatively short–term therapy; not to exceed two months per acute condition per calendar year.

M. Obstetrical care for you and members of your family covered by this Contract.

N. House calls by a physician to your home (if a regular part of the physician’s practice). House calls are limited to the MVP Service Area, and a $10.00 copayment will be charged for each visit.

O. Referral to medical social services, but not the cost of such services.

P. Health education and nutritional counseling, with MVP’s prior approval.

Q. Medical treatment and referral for abuse of or addiction to alcohol or drugs, as follows: up to 60 outpatient visits per person per calendar year as medically necessary for diagnosis and treatment of alcohol abuse or substance abuse. Up to 20 of these visits may be used for family therapy, even if the covered person in need of treatment is not receiving treatment. This also includes medical detoxification for alcohol or drug abuse.

R. Upon prior written approval by MVP, non–experimental infertility services
are covered, with appropriate documentation of medical necessity, as follows:

1. Basic infertility services (i.e. infertility services provided for the initial evaluation and testing for infertility). All basic infertility services are subject to the applicable copayment on the last page of this Contract except for semen analysis, post-coital examinations and hysterosalpingograms, which are each subject to a 50% member copayment.

2. Advanced infertility services (i.e. infertility services provided in addition to basic infertility services). In order for such services to be covered, you must obtain a referral to an appropriate specialist and both parties must have already received basic infertility services. Coverage for each advanced infertility service is subject to a 50% member copayment. Covered services include:

   i. Tubal surgery;
   
   ii. Laporoscopy;
   
   iii. Administration of HCG and Progesterone injections;
   
   iv. Up to six (6) cycles of artificial insemination. Coverage does not include any fees related to donor sperm;
   
   v. Administration of the injectable agents Menotropins and Urofollitropins. For primary infertility (i.e. a female Member has not conceived after one year of unprotected intercourse), administration includes the cost of the drug itself for the first three (3) cycles only. For secondary infertility (i.e. the mother has successfully given birth in the past) and artificial insemination, the cost of the drug itself is not covered, and the administration is limited to a maximum of three (3) cycles. For primary and secondary infertility, each cycle shall consist of either Menotropins or Urofollitropins; at no time shall one cycle consist of both Menotropins and Urofollitropins;
   
   vi. Administration of Serophene (Clomid). For primary infertility, administration includes the cost of the drug itself for the first six (6) cycles only. For secondary infertility and artificial insemination, the cost of the drug itself is not covered, and the administration is limited to a maximum of six (6) cycles; and
   
   vii. Varicocele surgery.

3. The following infertility services are not covered:

   i. GIFT;
   
   ii. ZIFT;
iii. In-vitro fertilization;
iv. Reversals of vasectomies or tubal ligations;
v. External pump for the administration of infertility drugs;
vi. Sperm banking;

vii. Gender selection;

viii. The cost of the injectable agents Menotropins and Urofollitropins for secondary infertility; and

ix. Any infertility service provided to a non-MVP member including, but not limited to, a spouse that is not an MVP member.

S. Procurement, repair or replacement of durable medical equipment such as crutches, braces and wheelchairs, if medically necessary and authorized by a participating physician. Check the Copayment Schedule on the last page for applicable copayments. The option of whether to rent or purchase authorized durable medical equipment is at the sole discretion of MVP.

T. Allergy tests and treatment.

U. Chemotherapy.

V. Visits by a participating provider when you are a registered bed patient in a hospital or skilled nursing facility.

W. Psychiatric care provided by a participating provider for acute conditions which in the judgment of MVP are susceptible to significant improvement through short-term treatment.

i. You are entitled to up to 30 inpatient hospital days per calendar year including up to 20 inpatient physician visits per calendar year. Intensive outpatient hospital days may be substituted for inpatient days at the discretion of MVP. Check the Copayment Schedule on the last page for applicable copayments.

ii. You are entitled to up to 20 acute outpatient psychiatric care visits per calendar year for the purpose of receiving short-term evaluative or crisis intervention psychiatric care. Group therapy sessions may be substituted at the discretion of MVP.

iii. You shall not be entitled to psychotherapy for chronic conditions which in the judgment of MVP are not susceptible to significant clinical improvement through short-term therapy.

X. Mammography screening for breast cancer, subject to the following limits:
i. Upon the recommendation of a physician, at any age if you have a prior history of breast cancer or if your mother, sister or daughter has a prior history of breast cancer;

ii. A single baseline mammogram if you are 35–39 years of age;

iii. Once every two years, or more frequently upon the recommendation of a physician, if you are 40–49 years of age; and

iv. Annually if you are 50 years of age or older.

Y. Mastectomy or lymph node dissection or lumpectomy for the treatment of breast cancer; all stages of reconstruction of the breast on which the mastectomy was performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance.

Z. Second medical opinions in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of a course of treatment for cancer. To receive coverage for a second medical opinion from a non-participating physician or cancer specialty care center in connection with the diagnosis and treatment of cancer, a referral or approval must be obtained from your primary care physician.

AA. Cervical cytology screening. MVP will pay for an annual cervical cytology screening for cervical cancer and its precursor for women 18 years of age and older.

BB. Diabetes treatment services. Notwithstanding any statement in this Contract to the contrary, MVP will pay for services required for the treatment of diabetes including test strips for glucose monitors; urine testing strips; insulin; syringes and related supplies that are medically necessary for the treatment of diabetes. There will be a copayment for each item of 20% or your regular office visit copayment, whichever is less; limited to a 31-day supply per dispensing. Coverage will also be provided for diabetes education for proper self-management and treatment, limited to visits medically necessary upon diagnosis of diabetes; or where a physician diagnoses a significant change in a patient’s condition which necessitates changes in self-management. Coverage for education will include home visits when medically necessary. You will be responsible for your regular office visit copayment for each educational visit.

CC. Preventive dental care for children, as follows:

i. For MVP members under 19 years of age, the following dental services are covered when recommended, approved and certified as necessary and reasonable by a dentist:

   a. One initial oral examination per child;
b. Periodic oral examinations, once every six months;

c. Bitewing x-rays, once every six months;

d. Full mouth x-rays and panoramic x-rays, once every 36 months;

e. Routine cleaning, scaling and polishing of teeth, once every six months;

f. Fluoride treatments, once every six months;

g. Pulp vitality testing, as needed;

h. Diagnostics casts, as needed;

i. Sealants, once per tooth per child up to age 16;

j. Space maintainers and recementation thereof, as needed;

k. Intra-oral and periapical x-rays, as needed.

ii. A $10 copayment per visit, per child is required. You may see the dental provider of your choice (except in those instances excluded below) to receive benefits. Your provider may require you to pay for the services at the time rendered in which case you should submit the claim to MVP and you will be reimbursed in full, less the $10 copayment. You may obtain a claim form by calling the MVP Member Services Department at 1-888-MVP-MBRS. Claim forms should be mailed to: Dental Benefit Providers 7200 Wisconsin Avenue, Suite 800, Bethesda, Maryland 20814.

Claims should be filed as soon as reasonably possible, but in any event no later than one year after the service is performed. Claims filed later than one year from the date of service will not be covered.

iii. The following services are excluded from coverage:

a. Services which are not listed in the Schedule of Dental Services;

b. Services provided by a member of the child’s immediate family or household;

c. Services which are not approved by the Council of Dental Therapeutics of the American Dental Association;

d. Services rendered by a medical department, clinic or similar facility of the child’s employer, labor union, mutual benefit association or other similar group;

e. Services for which benefits will be paid under a worker’s
compensation or similar law;

f. Charges for dental appointments which are not kept;

g. Charges incurred after a child’s MVP coverage ends;

h. Coverage of hospitalization for any dental procedures;

i. Coverage for experimental procedures, implantation or pharmacological regimens, drugs obtainable with or without a prescription, prescribed by a dentist.

DD. Donor costs for the following non-experimental transplant procedures, when approved in advance by MVP:

i. Organ/body part transplants for:
   a. Kidney;
   b. Cornea; and
   c. Liver.

ii. Bone marrow transplants for:
   a. Aplastic anemia;
   b. Leukemia;
   c. Severe combined immunodeficiency disease; and
   d. Wiskott–Aldrich syndrome.

The cost of outpatient drugs associated with the above procedures will not be covered.

EE. Chiropractic care, which is defined as detecting or correcting by manual or mechanical means structural imbalance, distortion, or subluxations in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

FF. Medically necessary therapeutic services, including but not limited to, chemotherapy, radiation therapy and renal dialysis provided on an outpatient basis at a hospital, physician’s office or other outpatient facility. Each such outpatient visit, whether provided at a hospital, physician office, or other outpatient facility, is subject to MVP’s "Office Visit" copayment. Check the Copayment Schedule on the last page for applicable copayments.
GG. Services for Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and other behavioral problems and learning disorders for diagnostic purposes only. Such services require prior approval by MVP and must be provided by a participating provider. Coverage is limited to three (3) visits and is subject to the applicable copayment listed in the Copayment Schedule on the last page.

SECTION NINE - LIMITATIONS ON INPATIENT CARE BENEFITS

Benefits covering inpatient confinement or confinement in hospitals or skilled nursing facilities are limited as follows:

1. The days of confinement shall be consecutive. You may not select the day or days for which MVP will pay benefits;

2. MVP is responsible for the day you are admitted. MVP is not responsible for the day you are discharged. If you are admitted and discharged on the same day, MVP will pay for that day;

3. MVP will not provide hospital, skilled nursing facility or professional care after the date MVP determines that your hospitalization or confinement in that facility is no longer medically necessary;

4. If you are discharged from a hospital or a skilled nursing facility and you do not vacate your room by the official discharge time, you will be responsible for any additional charges; and

5. If you receive services not included in this Contract, you will be responsible to make payment directly to the health practitioners who provided the services.

SECTION TEN - EXCLUSIONS

(Note: You should also check the Sections of this Contract pertaining to services and benefits for additional limitations on coverage.)

1. **Authorized Care** – MVP will not pay for any services, professional or otherwise, which were not medically necessary and which were not provided, arranged or authorized by your primary care physician or with appropriate authorization by MVP, except in the event of a medical emergency (see Section Seven) or where otherwise specifically provided in this Contract.

2. **Government Hospital** – MVP will not pay for care otherwise covered under this Contract that is provided in any hospital or other institution which is owned, operated or maintained by the Veterans Administration, the federal government or a state government, except in the event of a medical emergency, as defined in
Section Seven, which occurs in close proximity to such hospital. In such event, MVP will cover the cost of medically necessary emergency care only for as long as MVP determines that it is not possible for you to be transferred to another hospital.

3. **Worker’s Compensation**  – If payment is available to you and required under a Worker’s Compensation Law or similar legislation for any injury, condition or disease, you must first claim the benefits you are entitled to receive under such law. To the extent that the cost of care for such injury, condition or disease is not covered under such law to the same extent that this Contract provides, MVP will pay the difference.

4. **Admission to a Hospital Before You Become Covered Under This Contract**  – If you are confined as an inpatient in a hospital or other facility on the date you become covered under this Contract, services will only be covered to the extent described in subsection 3 of Section Three.

5. **Custodial Care**  – MVP will not pay for services rendered for bed rest, custodial care (as defined in subsection 3 of Section Five) or personal convenience.

6. **Cosmetic Surgery**  – MVP will not pay for any services in connection with cosmetic surgery which is primarily intended to improve your appearance. MVP will, however, pay for services in connection with breast reconstruction surgery after a mastectomy, or reconstructive surgery when such services are incidental to or follow surgery resulting from trauma, infection or other diseases of the part of the body involved. MVP will also pay for reconstructive surgery because of congenital disease or anomaly of a child covered under this Contract which has resulted in a functional defect.

7. **No Fault Automobile Insurance**  – MVP will not pay for any services which are covered by mandatory automobile no-fault benefits or applied to the no-fault deductible.

8. **Free Care**  – MVP will not pay for any care if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion will also apply if the care would have been furnished to you without charge if you were not covered under this Contract or under any other insurance.

9. **Government Programs**  – With the exception of services available to you under Medicaid, MVP will not pay for any service which is available to you under any federal, state or local government program, including Medicare to the extent it is a primary plan (see subsection 2.A of Section Fifteen). MVP will not pay for services covered under other programs even if you do not claim the benefits you are entitled to under them.

10. **Dental Care, except as specifically noted in this subsection and in subsection 2. CC of Section Eight**  – MVP will not pay for any dental care and treatment you receive (including, but not limited to, orthodontia), except for treatment
otherwise covered under this Contract which is medically necessary to diagnose, correct or cure any accidental injury to sound natural teeth, and which occurs within 12 months of the accident and is approved by MVP in advance, except in cases of emergency. In addition, MVP will not pay for any hospital services, either inpatient or outpatient, in connection with such dental care and treatment, except where in the judgment of your primary care physician a hazardous concurrent medical condition requires hospitalization, either inpatient or outpatient, and MVP approves in advance. Coverage for treatment of temporomandibular joint (TMJ) disease or dysfunction is excluded where MVP determines that such disease or dysfunction is dental in nature.

11. **Unnecessary Care** – MVP will not pay for any service or care under this Contract which MVP determines, in its sole judgment, is not or was not medically necessary. Examples of unnecessary care are physical examinations or immunizations or vaccinations for employment, educational, insurance or travel purposes.

12. **Chronic Mental Illness** – MVP will not pay for the treatment of chronic mental illness which in MVP’s judgment is not susceptible to significant improvement through short-term treatment.

13. **Prescription Drugs** – MVP will not provide benefits for prescription drugs except for those that are administered to you in the course of covered outpatient or inpatient treatment in a hospital or through home care or hospice benefits or for immunizations.

14. **Injuries or Sickness Due to War** – MVP will not pay for any injuries or sickness resulting from war or any act of war (declared or undeclared), for which facilities for care are reasonably available, if any government plan provides for or covers that injury or sickness.

15. **Routine or Palliative Foot Care** – MVP will not pay for routine or palliative foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, MVP will pay for non-routine foot care which MVP determines to be medically necessary.

16. **Non-emergency Health Services Outside MVP’s Service Area** – MVP will not pay for non-emergency health services rendered outside the service area, unless MVP approves such health services in writing, in advance.

17. **Experimental or Investigational Procedures** – MVP will not cover any treatment, procedure, drug or device, or any hospitalization in connection with same, if it is experimental or investigational, unless MVP determines that:

   A. The proposed treatment has demonstrated promise in treating the underlying condition through a nationally recognized clinical trial; and

   B. An expert panel, chosen by MVP, with quality assurance and technology
assessment expertise has reviewed the proposed treatment and deemed it appropriate.

If, in accordance with Section Seventeen of this Contract, an External Appeal Agent overturns MVP’s denial of such services, then MVP shall cover the experimental or investigational treatment. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, MVP will only cover the costs of services required to provide treatment to you according to the design of the trial. MVP shall not be responsible for the cost of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Contract for non-experimental or non-investigational treatments provided in such clinical trial.

18. **Other** – MVP will not provide benefits for the following:

A. External prosthetic devices, such as artificial limbs and medical appliances, and wigs;

B. Long-term physical therapy and rehabilitation.

C. Foot orthotic devices such as orthopedic shoes; arch supports; shoe inserts; or elastic support stockings.

D. Disposable Medical Supplies such as syringes; bandages; or needles.

E. Personal comfort items.

F. Ambulance services, including air ambulance, unless determined by MVP to be medically necessary.

G. Ophthalmic services for correction or accommodation of a vision disorder, or the expense of fitting or purchasing eyeglasses or contact lenses; except as provided in subsection 2.D of Section Eight.

H. Travel costs, other than for medically necessary ambulance services, even if ordered by a participating physician.

I. Reversals of vasectomies or tubal ligations.

J. Hearing aids, including procedures for prescribing and fitting the aids.

K. Transsexual operations, including any service, procedure or medication associated with such operations.

L. Donor costs for transplants, including the cost of medications associated with such transplants, except as provided in subsection 2.DD of Section Eight.

M. Cost for which you are responsible if you fail to keep an appointment with a physician or other provider.
N. Cost of medical care and treatment resulting from a court order, unless such treatment is determined by MVP to be medically necessary and is obtained in accordance with MVP protocols regarding such treatment.

O. Cost of bills submitted to MVP more than one year after the date of service, except in cases where MVP is the secondary payor.

P. Any artificial means to induce pregnancy, including in vitro fertilization and the GIFT program; except to the extent services are specifically described as being covered in this contract.

Q. Cost of whole blood, blood plasma, packed blood cells or other blood derivatives if participation in a volunteer blood replacement program is available to you. However, autologous blood donations are covered when medically necessary.

R. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column, except when provided by a duly licensed chiropractor in connection with covered chiropractic care as provided in Section Eight, Paragraph 2.EE.

S. Anything except the items of care enumerated in this Contract.

SECTION ELEVEN - PREMIUMS

1. **Amount of Premiums** – The premiums quoted by MVP for this Contract are based on premium rates that have been approved by, and are on file with, the New York State Department of Insurance.

2. **Change in Premiums** – Subject to Department of Insurance approval, MVP may change the premiums for this Contract, provided that MVP gives you written notice at least 30 days before the change takes effect.

3. **Payment of Premiums, Grace Periods and Lateness Penalty Charges** – All premiums for this Contract are due in advance. However, MVP allows you a 30 day grace period for the payment of all premiums, except the first premium. This means that, except for the first premium, if you make your payment to MVP in full within 30 days of the date the payment was due, MVP will continue coverage under this Contract for the entire period covered by your payment. If MVP does not receive your payment within the 30−day grace period, then MVP may terminate your coverage under this Contract in accordance with Section Twelve of this Contract. Premiums still due at the end of the grace period shall be subject to a lateness penalty charge of 1.5% of the total premium amount due.
calculated for each 30 day period or portion thereof that the amount due remains unpaid. If this Contract is terminated for any reason, you will continue to be held liable for all premium payments due and unpaid before the termination, including, but not limited to, premium payments for any time this Contract is in force during the grace period. You will not become covered under this Contract until the first premium has been paid to MVP.

SECTION TWELVE - TERMINATION OF COVERAGE

Described below are reasons why this Contract may terminate, or coverage under this Contract may terminate, and the rules which govern such termination.

1. **Automatic Termination of Coverage** – A member’s coverage will automatically be terminated in the event of the following:

   A. Discontinuance of Your Group Membership – This Contract will automatically terminate on the date to which your premium has been paid if you are no longer a member of the group. For example, if your employment in the group terminates on May 15 and your premium has been paid to June 1, this Contract will terminate on June 1. See subsection 2 of Section Thirteen regarding how you can continue MVP coverage.

   B. On Your Death – This Contract will automatically terminate on the date of your death, unless you have family coverage. If you have family coverage, this Contract automatically terminates as of the date to which the premium was paid. See subsection 2 of Section Thirteen regarding how your dependents can continue MVP coverage.

   C. Termination of Your Marriage – If you become divorced or your marriage is annulled, the coverage of your wife or husband under this Contract will automatically terminate on the date of the divorce or annulment. See subsection 2 of Section Thirteen regarding how your wife or husband can continue MVP coverage.

   D. Termination of Coverage of a Child – The coverage of your child under this Contract will automatically terminate on the date the child ceases to be eligible for such coverage under Section Two. See subsection 2 of Section Thirteen regarding how your child can continue MVP coverage.

2. **Your Option to Terminate This Contract** – You may terminate this Contract at any time by giving MVP at least one month’s prior written notice. If you terminate this Contract in this manner, MVP will refund any unearned portion of the premiums for the Contract which have been paid.

3. **MVP’s Option to Terminate This Contract** – MVP may terminate this Contract for one of the following reasons:
A. Default in Payment of Premiums – This Contract may be terminated by MVP, upon written notice, if any premium payment required to be made on your behalf by a remitting agent or your group is not received by the date the payment is due, subject to a 30-day grace period. If you are totally disabled on the date your coverage terminates, however, you will continue to receive payment for your care, as described in subsection 5, below. See subsection 2 of Section Thirteen regarding your right to a new contract after termination. If your group fails to pay the premium and this Contract terminates, your group must notify you of the termination.

B. Fraud or Intentional Misrepresentation – MVP may terminate this Contract if you have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Contract.

C. Discontinuance of Entire Class of Contract – MVP may terminate this Contract if it decides to discontinue the entire class of contract to which this Contract belongs (in other words, if MVP terminates the same contract held by everyone else). MVP will give you at least 5 months’ prior written notice that this Contract will be terminated in this manner.

D. Relocation Outside the MVP Service Area – MVP may terminate this Contract if you no longer live, reside or work in the service area.

E. Other Reasons Acceptable to the Superintendent of Insurance – MVP may terminate this Contract for any other reason which is acceptable to the Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996 or by applicable federal regulations and rules, as amended. If this Contract is terminated in this manner, MVP will give you at least one month’s prior written notice, which shall include the reason for the termination.

4. Notice of Termination – MVP will give you and your group at least one month’s prior written notice of any termination or refusal to renew, except as otherwise provided in subsections 1 and 3, above.

5. Benefits After Termination for Totally Disabled Persons – If you are, in MVP’s sole judgment, totally disabled on the date this Contract terminates, and you have received service or care for that specific totally disabling condition while you were covered under this Contract, MVP will continue its coverage for such condition only, during an uninterrupted period of total disability. Coverage will
continue until a date you are, in MVP’s sole judgment, no longer totally disabled, or twelve months from the date of termination, whichever comes first.

If you have family coverage and the totally disabled person is a covered family member, these benefits after termination are extended only to that family member. Other family members covered under this Contract will be excluded from coverage on the date the Contract terminates.

SECTION THIRTEEN - POST-TERMINATION CONTINUATION OF COVERAGE; CONVERSION TO A NEW CONTRACT

If this Contract terminates, or your coverage under this Contract terminates, you may be able to temporarily continue group coverage in some circumstances or to continue coverage by purchasing a new contract available to non-group subscribers.

1. **Continuation of Coverage:**

   A. Under Federal COBRA Law – Most employer sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write your employer or us to find out if you are entitled to temporary continuation of coverage under COBRA.

   B. Under New York Law – If you are not eligible for temporary continuation under federal law as set forth above, you may be eligible for temporary continuation of coverage under New York law. If you are covered under this Contract through a group, and your eligibility for such coverage ends because of termination of employment or membership in the group eligible for coverage, you may be entitled under New York law, without evidence of insurability, to continue coverage for you and your eligible dependents, subject to the terms of the Group Contract and this Contract. Such coverage will not be available for:

   i. A member who is covered, becomes covered or could be covered by Medicare; or

   ii. A member who is covered, becomes covered or could be covered as an employee, member or dependent by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group which does not contain any exclusion or limit with respect to pre-existing conditions. The conversion contract available under subsection 2, below, is not considered an arrangement under which the Member could be covered for purposes of this section.

   C. Written Request for Continuation:
i. A member who wishes to continue coverage must request continuation in writing within 60 days after the latter of:

a. The date of termination; or

b. The date the member is given notice by the Group of the right to continue coverage.

ii. In addition to submitting the above written request for continuation, a member who wishes to continue coverage and who is determined under the applicable provisions of the Social Security Act to have been disabled at the time of termination of employment or membership or at any time during the first 60 days of continuation of coverage must notify the Group of such determination within 60 days after it is made.

D. Payment of Premium – A member who elects to continue must pay any applicable premium to the Group, but no more frequently than monthly in advance. The applicable premium may be no more than 102% of the group rate for the benefits being continued. The Group must remit such premium to us. The premium payment must be made within 60 days of the date benefits would otherwise terminate.

E. Termination of Continuation Coverage – Continuation of benefits shall terminate at the first of the following to occur:

i. 18 months after the date the Member’s benefits under the contract would otherwise have terminated because of termination of employment or membership; or

ii. The end of the period for which premium payments were made, if the Group or the Member fails to make timely payment of a required premium payment; or

iii. In the case of an eligible dependent, 36 months after the person’s benefits would have terminated by reason of:

   a. death of the member;

   b. divorce or legal separation of the member from his/her spouse;

   c. the member becoming entitled to benefits under Medicare; or

   d. a dependent child ceasing to meet the definition of a dependent child; or

iv. In the case of a member who is determined under the Social Security Act to have been disabled at the time of termination of employment or membership or at any time during the first 60 days of continuation of coverage, 29 months after the date the member’s benefits would have
terminated; except that if the member is no longer disabled, the continuation shall terminate on the later of: (1) the date 18 months after the member’s coverage terminated; or (2) the first day of the month at least 31 days after the date of the final determination under the Social Security Act that the member is no longer disabled; or

v. The date on which the Group Contract between MVP and the group is terminated. However, in such event, if coverage is replaced by similar coverage under another Group Contract:

a. The member shall have the right to become covered under the other Group Contract for the balance of the period that the member would have remained covered under the prior Group Contract had it not terminated;

b. The minimum level of benefits provided by the other Group Contract shall be the applicable level of benefits of the prior Group Contract, reduced by any benefits payable under the prior Group Contract; and

c. 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 New Contract:** When coverage terminates under Section Twelve of this Contract, the member shall have the right to convert to another contract, in accordance with the following rules:

A. "Eligible Individual" Under Federal Law – Under the Health Insurance Portability and Accountability Act of 1996, an "eligible individual" whose coverage under a Group Contract has terminated is entitled to convert coverage to a direct payment contract under which no pre-existing condition exclusion period may be imposed on him or her. (Note that if an eligible individual elects family coverage, such an exclusion period may be imposed, where applicable, on covered family members who are not themselves eligible individuals, to the same extent that such an exclusion period has been imposed under this Contract.) An "eligible individual" is defined as someone:

i. Who has creditable prior health insurance coverage totaling 18 months or more, with no breaks in actual or pending coverage greater than 63 days;

ii. Whose coverage under the Group Contract was not terminated because of nonpayment of premiums, fraud or intentional representation;

iii. Who is not eligible for coverage under another group health plan, Medicare or Medicaid; and
iv. Who, if offered the option of continuation coverage under federal COBRA law or state law, elected and subsequently exhausted such coverage.

B. "Non-Eligible Individual" — If the member does not qualify as an "eligible individual" as set forth above, the member may be eligible under other applicable law to convert coverage to a direct payment contract, without evidence of insurability. However, a pre-existing condition exclusion period may be imposed, where applicable, to the same extent that such an exclusion period has been imposed under this Contract. This conversion privilege will be available to the member if coverage under this Contract has been terminated for any of the following reasons:

i. A subscriber has ceased membership in the Group;

ii. The member no longer qualifies as a covered family member under this Contract (for example, the member is over 19 years of age and does not qualify for extended coverage, or the member is a spouse who is divorced or legally separated from the subscriber, or the subscriber has died); or

iii. This Contract has terminated, for any reason, unless the group has replaced this Contract with similar and continuous coverage for the group, whether insured or self-insured.

C. Notice and Application Requirements — Within 15 days of the termination of a member’s coverage, the group must advise the member in writing of his or her conversion privilege under this Contract. The member must apply for conversion within 45 days after coverage would terminate. If the group provides notice to the member more than 15 days but not more than 90 days after the date of termination, the member will have 45 days after receiving the notice to apply for conversion. If no notice is given, the right to conversion will expire at the end of 90 days from the date of termination.

D. Process for Effectuating Conversion Coverage — To convert from this Contract and maintain coverage, a member must do two things: apply for a new direct payment contract and pay MVP the charge for the new contract within the time frames indicated in subsection C, above. If this is done, the new contract takes effect as soon as coverage under this Contract ends.

E. Circumstances Under Which Conversion is Not Available — MVP is not required to convert a member to a direct payment contract upon termination of coverage under this Contract if the person would then be overinsured or have duplication of benefits according to standards approved by the Superintendent of Insurance that define overinsurance and duplication of benefits.
SECTION FOURTEEN - EFFECT OF MEDICARE

1. If you are entitled to Medicare coverage, you must enroll for coverage under Part A and Part B of Medicare in order to be eligible for coverage pursuant to this Contract. Even if you do not enroll for Medicare Parts A and B, the amount that Medicare would have paid will be subtracted from plan benefits.

2. When you become entitled to Medicare coverage, you must notify MVP in writing.

3. The benefits of this Contract are not intended to duplicate Medicare benefits. To the extent that the benefits of this Contract are also covered by Medicare, MVP will provide those benefits, but will, for purposes of payment, coordinate benefits with Medicare in accordance with Section Fifteen. Medicare is considered to be a Primary Plan within the meaning of Section Fifteen, except in those circumstances described in subsection 2.A of Section Fifteen.

SECTION FIFTEEN - COORDINATION OF BENEFITS

This Section applies only to group subscribers and members of their families covered under this Contract who are also covered by another group health plan. A group health plan means Medicare and a health insurance contract or policy which is issued through, or to, groups such as employers, unions or associations. A self−insured employer or union plan or program is considered to be a group health plan.

1. When You Have Other Health Benefits – You may be covered by two or more group health insurance plans which provide similar benefits. If so, and you receive a service which is covered at least in part by any of the plans involved, MVP will coordinate its 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 the cost of the services received. The benefits of the Secondary Plan will be reduced to cover only those expenses which were not covered by the Primary Plan.

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

   A. Medicare is considered to be a Primary Plan, except: (i) for active employees or their spouses; (ii) if you are entitled to Medicare because you have end stage renal disease, (ESRD), Medicare is secondary for the first eighteen months after you have been determined eligible for ESRD benefits; or (iii) if you are disabled, (except ESRD beneficiaries) and your employer and you
agree you may be covered as a current employee or an eligible dependent of a current employee.

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

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

D. 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 parent’s 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.

E. There are special rules for a child of separated or divorced parents:
   i. The plan of the parent with custody will be the primary plan.
   ii. The plan of the spouse of the parent with custody is primary over the plan of the parent without custody.
   iii. The plan of the parent not having custody will be primary if no coverage is available under i. or ii. above.
   iv. Notwithstanding i., ii. or iii. above, if a court decree imposes responsibility for the provision of health care on one of the parents, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, then the plan of that parent will be primary. This does not apply during any period that benefits are actually paid or provided before such entity has actual knowledge.

F. A plan which covers you as an active employee, or as that employee’s dependent, is primary; a plan which covers you as a laid off or retired employee, or as that employee’s dependent, is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on which plan is primary, this section is ignored.

G. 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 claim under both contracts or policies.
3. **When MVP is the Secondary Plan** – In the event that MVP is considered to be the secondary payor to that of another group health plan, MVP reserves the right to: (1) request that you submit claim to the other plan; (2) recover any claim payment that you received from that plan to the extent such payment is for services actually received from or paid by that plan; (3) bill the plan for health services provided or paid for by MVP.

4. **Recovery of Overpayment** – If MVP provides benefits greater than it should have under this provision, MVP has the right to recover the overpayment from you or from any other person, insurance company, or organization which may have gained from MVP's 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 MVP to recover its 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 MVP, 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 copayments.

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.

5. **Copayments When You Are Enrolled in Two MVP Plans** – If you are covered under MVP as a subscriber and also as a dependent under a separate MVP plan, you are responsible for the copayment under the primary plan only, unless the secondary plan copayment is lower, in which case the secondary plan’s copayment shall apply.

**SECTION SIXTEEN - SUBROGATION & DUTY OF COOPERATION**

This section applies when another party is, or may be considered, liable for your injury, sickness or other condition (including insurance carriers who are so liable) and MVP has provided or paid for benefits.

A. MVP is subrogated to all of your rights against any party liable for your injury or illness or for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the reasonable value of the medical benefits paid for or provided by MVP to you. MVP may assert this right independently of you.

B. MVP is entitled to reimbursement for medical, surgical and hospital benefits
MVP has paid from any settlement, judgment, verdict or insurance proceeds you receive for your injury, sickness or other condition; provided that, such settlement, judgment, verdict or insurance proceeds specifically identify the amount of expenses incurred by MVP in paying for or providing such benefits.

C. You shall in good faith cooperate with MVP and its agents in order to protect MVP’s subrogation rights specified above. Such cooperation shall include, but not be limited to, the following:

i. Providing MVP or its agents with any relevant information requested by them; and

ii. Signing and delivering such documents as MVP or its agents reasonably request to secure MVP’s subrogation claim.

Failure to cooperate in accordance with this subsection shall render you responsible for reimbursing MVP for the benefits paid or provided by MVP for your treatment.

D. The costs of legal representation of MVP in matters related to subrogation shall be borne solely by MVP. The costs of your legal representation shall be borne solely by you.

SECTION SEVENTEEN - COMPLAINTS AND APPEALS

1. You agree that any complaint or appeal regarding this Contract shall be submitted for resolution in accordance with the Member Appeals Procedure established by MVP. This includes complaints or appeals regarding utilization review decisions (i.e. decisions based on medical necessity) and non-medical necessity issues. A description of MVP’s Member Appeals Procedure is contained in the MVP Member Handbook. Please contact the Member Services Department and/or consult the MVP Member Handbook for more complete details on MVP’s appeal procedures.

2. **Right to External Appeal.** An external appeal is an appeal conducted by an organization certified by the New York State Department of Health and Department of Insurance to review denials of coverage. These independent review organizations are referred to as "External Appeal Agents".

   A. You may request an external appeal if you satisfy the following criteria:

      i. The denied service is otherwise covered under this Contract; and

      ii. You received a final adverse determination through the first level of MVP’s appeal process, or you and MVP agree to waive any internal appeals. An adverse determination is a utilization review determination
made by MVP that a covered service is not medically necessary.

If coverage for a service is denied based on the experimental or investigational nature of the service, then the following additional conditions must also be satisfied in order for you to be entitled to an external appeal.

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

ii. Your attending physician certifies that your life-threatening or disabling condition or disease is (a) one for which standard health services are ineffective or medically inappropriate, or (b) one for which there does not exist a more beneficial standard service or procedure covered by MVP; or (c) one for which there exists a clinical trial, as defined by law;

iii. Your attending physician recommends either (a) a service or procedure that, based on two (2) documents from the available medical and scientific evidence, is likely to be more beneficial than any covered service, or (b) a clinical trial for which you are eligible. Only certain documents will be considered in support of this recommendation. Your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable. Also, only certain clinical trials can be considered;

iv. The service or procedure recommended by your attending physician would otherwise be covered except for MVP’s determination that the service or procedure is experimental or investigational; and

v. Your attending physician is a licensed, board certified, or board eligible physician qualified to practice in the area of practice appropriate to treat your life-threatening or disabling condition or disease.

B. Requests for an external appeal must be made to the New York State Insurance Department. It is your responsibility to initiate the external appeal process. If the requested service has already been provided to you, your physician may request an external appeal on your behalf if you have consented to this in writing. An external appeal must be requested in writing within forty-five (45) days of notice from MVP of the final adverse
determination at the first level of appeal. Likewise, if you and MVP agree to waive the applicable internal appeals process, you have forty-five (45) days from receipt of the waiver notice to file a written request for an external appeal. Under New York State Law, MVP has no authority to grant an extension to this deadline. MVP will provide an application for external appeal with its final adverse determination letter issued through the first level of MVP’s internal appeal process or its written waiver of internal appeals. Applications are also available from the New York State Departments of Insurance and Health. You must submit the completed application to the New York State Department of Insurance. If you satisfy the criteria for an external appeal, then the State will forward your request to an External Appeal Agent.

C. You may submit additional information regarding your external appeal. If the External Appeal Agent determines that the additional information materially changes the information upon which MVP made its decision, then MVP reserves the right to reconsider its decision. If MVP chooses to exercise this right, then MVP shall have three (3) business days to reconsider your appeal. MVP does not have a right to reconsider its decision in the case of an expedited appeal.

D. The External Appeal Agent will make a determination within thirty (30) days of its receipt of the request for an external appeal. The External Appeal Agent may request additional information from you and/or your healthcare provider and shall have up to five (5) additional business days, if necessary, to make a determination. The External Appeal Agent shall notify you in writing of its decision within two (2) business days of rendering a determination.

E. If your attending physician certifies that a delay in providing the service would result in an imminent or serious threat to your health, then you may request an expedited appeal. In that case, the External Appeal Agent will make a determination within three (3) days of receipt of your request. The External Appeal Agent will notify you of its decision immediately by telephone or facsimile. The External Appeal Agent will also notify you of the decision in writing.

F. If the External Appeal Agent overturns MVP’s decision, then MVP will provide coverage subject to the other terms and conditions of this Contract. If the External Appeal Agent approves coverage of experimental or investigational treatment that is part of a clinical trial, MVP will only cover the costs of services required to provide treatment according to the design of the trial. MVP shall not be responsible for costs of investigational drugs or devices, the costs of non–health care services, the costs of managing research, or costs which are not covered under this Contract for non–experimental or non–investigational treatments provided in such clinical trial.
G. The External Appeal Agent’s decision is binding on you and MVP. The External Appeal Agent’s decision is admissible in any court proceeding.

H. MVP will impose a fee of fifty dollars ($50.00) for an external appeal which shall be refunded to you in the event that the final adverse determination is overturned by the External Appeal Agent. MVP will waive this fee if MVP determines that paying the fee would pose a hardship to you.

3. **Review by Department of Health or Department of Insurance** – Any time during this process, you may request a review by the New York State Department of Health or Department of Insurance. However, it is recommended that you await the decision of the complaint and appeals process before doing so.

### SECTION EIGHTEEN - GENERAL PROVISIONS

1. **No Assignment** – You may not assign any benefits or payments due under this Contract to any person, corporation or other organization. Any assignment by you shall be void. Assignment means the transfer to another person or organization of your right to the services provided under this Contract. It also includes your right to collect from MVP for those services.

2. **Notice** – All notices to the parties to this Contract shall be in writing. Notice given by MVP to you will be mailed to you at your address as it appears in MVP’s records. However, if you are covered in a group, notice mailed by MVP to the address of the employer or other organization which sends your premiums to MVP shall be deemed notice given to you.

   Notice given by you to MVP should be mailed to MVP’s principal office at 111 Liberty Street, Schenectady, New York 12305.

3. **Your Medical Records** – It may be necessary for MVP to obtain your medical records and information from hospitals, skilled nursing facilities, physicians or other practitioners who treat you. By signing this Contract or accessing care pursuant to this Contract, you thereby give MVP authorization to obtain and use such records and information. Such records will be treated and protected as confidential to the full extent required under applicable state and federal law. MVP shall have the right under this Contract to deny services or care or to refuse to provide reimbursement for services or care to any member who withdraws or denies such authorization.

4. **Changes To This Contract** – MVP may make changes to this Contract on the Contract Renewal Date (indicated on the first page of this Contract) if the appropriate government entity or entities require or approve them. MVP will give you at least 30 days’ prior written notice of any change.

5. **Who Receives Payment Under This Contract** – Payment for covered services provided by a physician affiliated with a participating IPA, in a participating
hospital, or with any other provider with whom MVP contracts will be made by MVP directly to such physician or hospital. If you receive covered services from any other provider of care, MVP reserves the right to pay either you or the provider.

6. **Legal Action** – You must start any lawsuit against MVP under this Contract within 2 years from the date you received the service for which you want MVP to pay. However, before you bring a lawsuit against MVP, you must submit a claim to MVP and allow at least 90 days for the review of the claim.

7. **MVP’s Relationship to Affiliated IPAs** – IPAs affiliated with MVP are independent organizations and related to MVP by contract only. The physicians in such IPAs are not MVP’s employees or agents. They maintain a physician–patient relationship with you and are solely responsible for the professional services they provide. MVP is not responsible for any acts or omissions of such physicians and such IPAs.

8. **Construction of this Contract** – MVP, in its sole discretion, shall have the authority to determine eligibility for benefits and to construe the terms of this contract.

9. **Suspension of Coverage** –

   A. If you are a member of a reserve component of the Armed Forces of the United States, including the National Guard, in accordance with the criteria set forth in this subsection, you may, upon written request, have your coverage suspended during a period of active duty as described below. MVP will refund any unused premium during the period of suspension. You will be entitled to resume coverage upon written application and payment of the required premium within sixty (60) days after the date of termination of the period of active duty, with no limits or conditions imposed as a result of such period of active duty, except as described in this subsection. Coverage will be retroactive to the date of termination of the period of active duty. Such right to resume coverage shall be in addition to other existing rights granted pursuant to New York and federal laws and shall not be deemed to qualify or limit such rights in any way. There will be no exclusion or waiting periods in connection with the resumption of coverage, unless:

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

   ii. Any waiting period or exclusion described in this Contract was not completed prior to the suspension. In no event shall the sum of the waiting or exclusion period imposed prior to and subsequent to the period of suspension exceed the length of the waiting period in the exclusion originally imposed.
B. This subsection applies 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 four (4) years of active duty, and you either:

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

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

10. **No Vesting of Benefits** – There is no vesting of benefits or services under this Contract. This means that absent regulatory or contractual provisions to the contrary, as of the effective date of a reduction, modification or change in MVP benefits or services, you are entitled to receive only the level and type of benefits and services that are in effect as of that date, regardless of whether you previously had been receiving a higher level or type of MVP benefits and services.
**MVP HEALTH PLAN-CO-PAYMENT SCHEDULE**

Consult MVP Subscriber Contract for coverage details

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<tr>
<th>Service</th>
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<td>Durable Medical Equipment</td>
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¹When these services are provided in the course of a regular physician visit, only one Co-Payment will be charged per appointment.

²Limited to one per member per calendar year; maximum of 3 per family per calendar year; applicable to all inpatient admissions in and out of the area including maternity, mental health and detoxification; not applicable to newborns or to hospital outpatient services. The coplan you are enrolled under on the date you are admitted will determine your copayment level for inpatient hospitalization.
<table>
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<tr>
<th>Co-Plan 10</th>
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</tbody>
</table>
| 40.00 or 50% | 40.00 or 50% | 45.00 or 50% | 45.00 or 50% |}

$^3$Whichever is less.

$^4$No copayments are required for certain office visits for well child care, as described in paragraph 9 of Section One of the Contract. For maternity care, a copayment is required for the first office visit only, as described in paragraph 2.A of Section Eight of the Contract.

$^*Copayments in any calendar year may not, in the aggregate, exceed 200% of your total annual premium. You may contact MVP to determine your annual premium cost.