MVP HEALTH PLAN, INC.
HEALTH MAINTENANCE ORGANIZATION

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

NOTICE

THIS CERTIFICATE OF COVERAGE IS EVIDENCE OF THE BENEFITS AVAILABLE TO ELIGIBLE GROUP MEMBERS UNDER THE GROUP CONTRACT ENTERED INTO BETWEEN MVP HEALTH PLAN, INC. AND YOUR GROUP. THIS CERTIFICATE, AS WELL AS, ANY SCHEDULES, RIDERS, ENDORSEMENTS OR OTHER DOCUMENTS DISTRIBUTED, EITHER NOW OR IN THE FUTURE, IN CONJUNCTION WITH THIS CERTIFICATE, DOES NOT CONSTITUTE A CONTRACT BETWEEN YOU AND MVP.

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

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SECTION ONE – INTRODUCTION

MVP Health Plan, Inc. (MVP) is a New York State not-for-profit corporation. MVP is authorized by the New York State Department of Insurance and New York State Department of Health to issue health maintenance organization (HMO) health insurance products to qualified groups and individuals within MVP's approved Service Area.

Your Group has purchased MVP's HMO group health benefits product. Group eligible employees, who meet the eligibility requirements set forth in this document, who live, work or reside within MVP's Services Area may enroll as Subscriber's and obtain coverage for their eligible dependents under this Group Contract. For purposes of this Group Contract, MVP's Service Area includes the following counties within New York State: Albany, Broome, Cayuga, Chenango, Columbia, Cortland, Delaware, Dutchess, Fulton, Greene, Hamilton, Herkimer, Jefferson Lewis, Madison, Montgomery, Oneida, Onondaga, Orange, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Tioga, Ulster, Warren and Washington. Additional counties may be added in the future.

This document, known as a Certificate of Coverage ("Certificate"), describes the health care services (Covered Services) for which MVP provides benefits, and, explains the terms and conditions under which we will provide benefits. The benefits available for these Covered Services are set forth on the attached Schedule of Benefits ("Schedule").

1. <u>MVP Provides Benefits For Covered Services Obtained Through Our Network Of Participating Providers.</u>

   MVP will only provide benefits for Covered Services provided by an MVP Participating Provider, except in the following circumstances:

   A. Covered Emergency Care Services;

   B. Covered Non-Emergency Care Services, in circumstances where the Covered Services you require are not available through an MVP Participating Provider. In order to obtain benefits for Covered Services provided by a Non-Participating Provider, an MVP Participating Provider must submit a Pre-Service Claim, on your behalf, and you must receive prior written approval from MVP's Utilization Management Department before services are provided. (See, Section Four, "Filing a Claim for Benefits" and Section Five, "Utilization Management"). The request must include information about 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.

   C. Covered Preventive Dental Care Services For Children, as described in Section Eight of this Certificate, MVP will provide benefits for these services, when provided by a licensed dentist.

You may obtain a list of Participating Providers available with this product by reviewing your MVP Participating Provider Directory, by contacting MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277), or by visiting MVP's Internet website at www.mvphealthcare.com.

2. The Role of Your Primary Care Physician.

When you enroll as an MVP member, you and your covered Dependents must each choose a Primary Care Physician ("PCP") from MVP's Participating Provider Directory. You must notify MVP of your choice. You may choose a Family Practitioner, General Practitioner, Internist, Pediatrician or Obstetrician/Gynecologist as your PCP. You may change your PCP at any time, but you must notify MVP of your new choice before receiving any services from that PCP. Your PCP is responsible for coordinating and overseeing your health care. Except for those services listed in Subsection A immediately below, all services must be provided by your PCP or provided by MVP Participating Providers after getting a referral from your PCP to be eligible for benefits under this Certificate.

A. No Referral Needed. You do not need a PCP to provide or refer you for the following services:

i. Emergency Services.
ii. Non-Emergency Outpatient Mental Health or Alcoholism/Substance Abuse Rehabilitation Services. **You or your designee must contact MVP's Behavioral Health Access Center at 1-800-568-0458 and receive prior written approval before obtaining Non-Emergency outpatient mental health or alcoholism/substance abuse rehabilitation services.**
iii. Certain Obstetrical and Gynecological Services.
iv. Preventive Dental Care for Children.
v. Routine Vision Care.

SECTION TWO – DEFINITIONS AND COMMON TERMS

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

A. Acute Services means services to treat an Acute Condition that according to generally accepted professional standards, are expected to provide significant, measurable clinical improvement within a reasonable and medically predictable period of time.

B. Acute Condition means a condition that according to generally accepted professional standards, is expected to have significant clinical improvement within a reasonable and medically predictable period of time.

C. Adverse Determination is any determination that results in the denial, reduction or termination of a service or that fails to provide or pay for a claimed benefit (in whole or in part); including determinations based upon eligibility to receive benefits, the

Medical Necessity or the Experimental and/or Investigational nature of procedures, or failure to comply with MVP's UM procedures.

D. Ambulance Service Provider means an entity that has been issued a certificate to operate pursuant to Section 3005 of the Public Health Law or, for ambulance services located outside the State of New York, certified pursuant to comparable legislation in the state where such ambulance service provider is located.

E. Calendar Year means the twelve (12) month period beginning at 12:01 a.m. on January 1 and ending at 12:00 midnight on December 31. However, if you were not covered under this Certificate for this entire period, Calendar Year means the period from your effective date until 12:00 midnight on December 31. The Calendar Year is your Benefit Year: therefore all visit, day or other benefit limits, if any, are based on a Calendar Year period, unless expressly indicated otherwise in this Certificate.

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

G. Coinsurance means a dollar amount, expressed as a stated percentage of the Charge. It is the amount that you must pay, in addition to the premium, for Covered Services. You must pay any Coinsurance directly to the provider.

H. Contract or Group Contract refers to the agreement between MVP and your Group for which this Certificate of Coverage and Schedule of Benefits make up a part.

I. Copayment means a fixed dollar amount, which you must pay, in addition to the premium, for Covered Services. You must pay any Copayment directly to the provider.

J. Covered Services means the health care services specified in this Certificate as eligible for benefits. MVP maintains protocols to assist in determining whether a service is a Covered Service. You may request a copy of such protocols by contacting MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

K. Custodial Services means services primarily designed to help in transferring, eating, dressing, bathing, toileting, and other such related activities.

L. Deductible means a dollar amount that you must pay, in addition to the premium, before we provide benefits under this Certificate. You pay any Deductible directly to the provider.

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

N. Diagnostic Services means radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scans, bone mineral density measurements and tests, electroencephalograms, electrocardiograms, organ scans, and other medical and surgical diagnostic services.

O. Durable Medical Equipment means equipment that is primarily and customarily used only for a medical purpose. Such equipment is appropriate for use in the home, and is designed for prolonged and repeated use. It is generally not useful to a person in the absence of an illness, injury or condition. Durable Medical Equipment includes, but is not limited to wheelchairs, hospital beds, walkers, traction equipment, and respirators. Durable Medical Equipment does not include eyeglasses, hearing aids, elastic or compression stockings, arch supports, corrective shoes, wigs and other types of orthopedic equipment.

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

Q. Emergency Condition refers to 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:

i. 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.

ii. serious impairment to the person's bodily functions.

iii. serious dysfunction of any bodily organ or part of the person.

iv. serious disfigurement of the person

R. Emergency Care or Emergency Services refers to those Covered Hospital and Covered Pre-Hospital Emergency Medical Services provided to treat an Emergency Condition.

S. Group or Group Policyholder refers to the entity (e.g. employer) to which this contract has been issued.

T. Home Health Care Agency is an organization possessing a valid certificate or license issued pursuant to Article 36 of the New York State Public Health Law.

U. 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. If services are provided in New York, then the hospice organization must also be certified pursuant to Article 40 of the New York Public Health Law.

V. Hospital, means a short term, acute care, general hospital, which:

i. is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;

ii. has organized departments of medicine and major surgery;

iii. has a requirement that every patient must be under the care of physician or dentist;

iv. provides twenty-four (24) hour nursing service by or under the supervision of a registered professional nurse (R.N.);

v. has in effect a hospitalization review plan applicable to all patients which at least meets the standards set forth in Section 1861(k) of the United States Public Law 89-97 (42 USCA 1395x(k));

vi. is duly licensed by the agency responsible for licensing such hospitals in its jurisdiction; and

vii. is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place of convalescent, custodial education or rehabilitation care.

W. Member means the Subscriber or his Dependents.

X. Non-Participating Provider means a Provider who does not have an agreement with MVP to provide Covered Services to Members.

Y. Participating Provider means a Provider who has an agreement with MVP to provide Covered Services to Members.

Z. Primary Care Physician means a Participating Provider who is licensed as a Family Practitioner, General Practitioner, Internist, Pediatrician or Obstetrician/ Gynecologist and has an agreement with MVP to provide covered Primary Care Services to Members.

AA. Primary Care Services are defined as routine well care and basic health screening services described in this Certificate.

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

CC. Providers, except as otherwise indicated, are health care institutions, health care professionals, and entities that provide additional health services as follows:

i. Institutional Providers. Institutional Providers are: acute care general hospitals; ambulatory surgery centers; birth centers; skilled nursing facilities; psychiatric hospitals; home health agencies; hospices; inpatient alcoholism and/or substance abuse treatment facilities; and outpatient alcoholism and/or substance abuse treatment facilities.

ii. Professional Providers. Professional Providers are: physicians and other health care professionals who are licensed to provide the Covered Services under this Contract.

iii. Providers of additional health services. Providers of additional health services are suppliers of: Durable Medical Equipment; Prosthetic Devices; medical supplies; ambulance service; and kidney dialysis.

In all instances, MVP will only provide benefits for Covered Services provided by appropriately licensed Providers.

DD. Skilled Nursing Facility (SNF) is a nursing home as defined in Section 2801 of the New York Public Health Law or a skilled nursing facility as defined in Subchapter XVIII of the federal Social Security Act, 42 U.S.C. §1395 et. seq., also included are facilities that are certified as a skilled nursing facility by the Joint Commission of Accreditation of Hospitals.

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

FF. 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. Surgery does not include vaccination, collection of blood, drug administration, or injections.

GG. Therapeutic Services means:

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

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

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

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

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

In this Certificate, when we use the word(s) "we", "us", "our" and "the Plan" we mean MVP. When we use the word(s) "you", "your" and "yours" we mean you the Subscriber. If you have family or some type of dependent coverage, then in most cases the word you shall also include any member of your family or other dependent covered under this Certificate. Use of the word "he" in this Certificate refers to he or she.

SECTION THREE – ENROLLMENT AND COVERAGE
(All references to "You" or "Your" in this Section shall mean the Subscriber)

1. How to Enroll.

In order to be covered under this Contract, you must complete an enrollment application and be accepted by MVP. Your Group will provide you with an enrollment application form and instructions on how to enroll. Your Group will transmit your enrollment application to MVP in paper or electronic format. If on-line enrollment is available to you, you will need to complete an on-line enrollment application form and transmit the form to MVP. If you have been enrolled electronically, MVP may also send you a paper application form to sign.

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

If you meet the eligibility requirements established by your Group, then you and the following members of your family (as selected by you on your enrollment form) may be eligible for coverage:

A. Your Spouse. This includes your husband or wife, (unless divorced or unless the marriage is annulled). A former spouse is not eligible even if a court orders the enrollee to maintain coverage.

B. Your Children. This includes your unmarried natural or legally adopted children including children in a waiting period prior to the finalization of adoption; unmarried stepchildren who reside in your home; unmarried stepchildren who do not reside in your home but who are chiefly dependent upon you for support; and, other unmarried children, who permanently reside in your home, are chiefly dependent upon you for support, and for whom you have assumed legal responsibility (as evidenced by having been granted legal custody, appointed as legal guardian, or other court order). **Foster children and grandchildren are not included in MVP's definition of children.** In addition to the above requirements, ONLY children who meet the requirements set forth below may be eligible for dependent child coverage:

i. Your unmarried children who are under the age of nineteen (19) and are chiefly dependent upon you for support and maintenance. Coverage shall last until the end of the month in which the child turns nineteen (19).

ii. Your unmarried children who are unable to work to support themselves because of mental illness, developmental disability, mental retardation, all as defined in the New York State Mental Hygiene Law, or physical handicap. To be eligible, the child's disability (described above) must have started before the date coverage would otherwise have terminated under this Certificate. Both the disability, and when it started, must be certified by a physician and the certification must be submitted to MVP within sixty (60) days of the dependent child reaching the limiting age. For disabled dependents who were not covered by MVP at the time the disability commenced, MVP will evaluate to determine whether the above standard has been met and whether such disability commenced prior to the date coverage would have otherwise terminated under this Certificate. MVP shall accept determinations of total disability under the above standard made by other group health insurance plans, provided that there has not been a break in coverage before the requested enrollment with MVP. Notwithstanding the above, MVP will periodically review prior determinations of total disability made by MVP or other health plans to determine if there has been a change in the dependent's medical condition whereby the child would no longer satisfy the requirements of a disabled dependent, as defined above. Coverage under this Subpart will end for any such dependent child over the age at which coverage would have terminated by virtue of reaching the limiting age, who marries, or becomes able to earn a living.

iii. A child for whom you have been ordered to provide dependent health insurance coverage pursuant to a qualified medical support order, as set forth in 29 USCA Section 1169, and who has not yet reached the limiting age for child coverage as set forth in Subsection "i" immediately above or who satisfies the requirements of Subsection "ii" immediately above.

3. <u>When Does Coverage Begin Under This Certificate.</u>

A. Upon acceptance of your enrollment application by MVP, you and your eligible Dependents are covered pursuant to the terms and conditions of this Certificate effective on the date designated by your Group.

B. If you file an enrollment application with us before becoming eligible for coverage, then your coverage will start on the date you become eligible.

C. If you marry after the start of coverage, then coverage for your spouse may start on the date of your marriage, provided that you notify your Group that your want to add your spouse and you and your spouse complete and return an enrollment application and requested documentation, and any required premium to your Group within thirty

(30) days after the marriage. If you fail to do so within thirty (30) days, coverage for your spouse will not start until the next open enrollment period for your Group, unless you meet the requirements for special enrollment described below.

D. If you already have Family Coverage (other than "Spouse Only" or "One Dependent"), then your newborn child will be covered from the date of birth, provided that you notify your Group of your intent to add such newborn to your coverage and you complete and return an enrollment application, any requested documentation, and any required premium to your Group within thirty (30) days of the birth. If you do not have Family Coverage, then your newborn born child may still be covered from date of birth, if you notify your Group of your intent to add this child to your coverage and you compete and return an enrollment application, any requested documentation, and any required premium to your Group within thirty (30) days from date of birth.

E. If you have Family Coverage (other than "Spouse Only" or "One Dependent") or switch to such coverage, pursuant to Subsection "D" above, we will cover your adoptive child or child that has been placed with you for adoption as follows:

i. We will cover your non-newborn adoptive child from the date of adoption provided that you notify your Group of your intent to add this child to your coverage and you complete and return an enrollment application, any requested documentation, and any required premium to your Group within thirty (30) days from the date of adoption.

ii. We will cover a child that has been placed with you for adoption and for whom you have assumed and retain a legal obligation to support, provided that you notify your Group of your intent to add this child to your coverage and you complete and return an enrollment application, any requested documentation, and any required premium to your Group within thirty (30) days from the placement for adoption.

iii. We will cover your proposed adopted newborn child from the date of birth provided that you notify your Group of your intent to add this child to your coverage and you complete and return an enrollment application, any requested documentation, and any required premium to your Group within thirty (30) days from the date of birth, and subject to the following conditions, as applicable:

(a) You take physical custody of the infant as soon as the infant is released from the hospital after birth;

(b) You file a petition pursuant to Section 115-c of the New York State Domestic Relations Law within thirty (30) days of the infant's birth;

(c) And, provided further that no notice of revocation of the adoption has been filed pursuant to Section 115-b of the New York State Domestic Relations Law and consent to the adoption has not been revoked.

Notwithstanding the foregoing, if we pay Benefits to cover an adopted newborn and the notice of the adoption is revoked, or one of the natural parents revokes consent, we shall be entitled to recover from you any sums paid by us for care of the adopted newborn.

F. To add a child, for whom a court has ordered you to provide dependent health insurance coverage pursuant to a qualified medical support order, to your coverage, you must mail us a copy of the order, by first class mail, postage prepaid. If the child is otherwise eligible for coverage and the order meets the definition of a qualified medical support order, as set forth in 29 USCA Section 1169, we will process the child's enrollment within ten (10) days from the date you mailed the order to us. You must pay us any required premium for coverage to be effective.

4. Open Enrollment.

You may enroll or add eligible Dependents for any reason during your Group's open enrollment period. If we receive and accept your enrollment application during the open enrollment period your coverage shall commence on your Group's next effective date for new enrollees. If you do not enroll either yourself or an eligible Dependent during your Group's open enrollment period, then you will be required to wait until the next open enrollment period as established by your Group to enroll, unless you or your Dependents meet the conditions for special enrollment described below.

5. Special Enrollment.

If you do not initially enroll or enroll during an open enrollment period, then you will in most instances be required to wait until the next open enrollment period before you may enroll (either for yourself or your dependents) for coverage with MVP, unless you or your Dependents qualify for a special enrollment period. To qualify for special enrollment period each of the following conditions must be met:

A. You and/or the Dependent[s] you seek to enroll must have been covered under a group health plan or had other health insurance coverage at the time coverage was previously offered.

B. You must have stated in writing that other coverage was the reason for declining enrollment at the time it was offered. This condition, however, must only be met if the plan sponsor for your Group required that this statement be made in writing and provided you with notice of this requirement (and the consequences of such requirement) at the time coverage was offered.

C. Coverage was provided in accordance with the continuation coverage required by state or federal law and was exhausted; or coverage under the other group health plan or health insurance contract was terminated because you and/or the dependent[s] that you seek to enroll have lost eligibility for one or more of the following reasons:

i. Termination of employment;

ii. Death of the spouse;

iii. Legal separation, divorce or annulment;

iv. Reduction in the number of hours worked; OR

v. The employer or other group ceased its contribution toward the premium for the other plan or contract; AND

D. You and/or your eligible Dependents apply for coverage within thirty (30) days after the loss of coverage or termination for any of the reasons set forth in Subsection "C" immediately above.

When enrolling pursuant to this Section 5, coverage under this Contract will commence as of the first date of loss of coverage following the qualifying event, provided we receive timely premium payment on your behalf from your Group.

6. Your Obligation To Provide Us With Information.

You must immediately notify us of any event that affects your coverage by submitting changes through the process designated by your Group. Such events include, but are not limited to, divorce or annulment, change in status of dependent that affects the eligibility requirements described in this Section, Medicare eligibility or coverage under another policy. You must also provide us with information, upon our request, regarding your initial and continuing eligibility status. This information should be provided within thirty (30) days of our request. The failure to respond promptly to requests for information may delay your enrollment or otherwise adversely impact your coverage under this Certificate.

SECTION FOUR – FILING A CLAIM FOR BENEFITS

1. What Is A Claim.

A "Claim" is any request for benefits made by you, your designee, or your Participating Provider pursuant to the requirements described in this Section. In most instances, as discussed below, your MVP Participating Provider will submit a Claim to MVP on your behalf, and, you will not be required to take any action. However, since this Contract allows you to directly access certain services without the need for a referral from your PCP, in some circumstances, you will be required to file a Claim or provide notice directly to MVP. These circumstances are described in detail in Subsections "3" and "4" below.

2. Different Types of Claims.

MVP recognizes four (4) different types of Claims in this Certificate.

A. Urgent Care Claims. An Urgent Care Claim refers to any Claim for medical care or treatment with respect to which the application of the time periods for making Non-Urgent Care determinations: (1) could seriously jeopardize the life or health of the

Member or the ability of the Member to regain maximum function, as determined by MVP (this determination will be made by MVP applying the prudent layperson standard); (2) in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot adequately be managed without the care or treatment that is the subject of the Claim; (3) any Claim that a physician with knowledge of the Member's medical condition determines is a Claim involving Urgent Care.

B. Pre-Service Claims. This involves Utilization Management (See, Section Five, "Utilization Management") determinations regarding health care services that require prior approval or pre-certification before benefits or services will be covered.

C. Concurrent Care Claims/Review. This involves our review of continued or extended health care services, or additional services when you are undergoing a course of continued treatment prescribed by your health care provider.

D. Post Service Claims. This involves Utilization Management determinations relating to services, which have already been provided.

3. The Filing of a Claim for Benefits: By Your Participating Provider (On Your Behalf).

When you obtain Covered Services from a Participating Provider under this Certificate, your Participating Provider will, in most instances, automatically file a Claim for benefits on your behalf. In such cases, MVP will make any required benefit payment directly to your Participating Provider (no assignment of benefits is required on your part) and you will only be responsible to that Participating Provider for your applicable cost share (e.g. Copayment, Coinsurance and/or Deductible). MVP has established policies and protocols to be followed by your Participating Provider with respect to the filing of Claims (e.g. Pre-Certification). If the Participating Provider fails to follow these policies and protocols, MVP will not reimburse the Provider for the services rendered. However, your Participating Provider may not bill you for amounts that would have otherwise been covered under this Certificate, but for, your Participating Provider's failure to comply with MVP's policies and protocols.

4. The Filing of a Claim for Benefits: By You or Your Designee.

In some circumstances, you or a designee appointed by you (hereinafter collectively "you") may be required to file a Claim for benefits or provide notice directly to MVP.

A. Concurrent Care Notice Requirements. MVP requests that you notify us, as soon as reasonably possible, any time you are admitted to a Non-Participating Hospital after an Emergency Care admission or to any Hospital related to a maternity care stay. This notice (referred to as a Concurrent Care Notice) will in most instances allow us to conduct Concurrent Review of the inpatient services you are receiving and provide you with determination regarding coverage in the most timely manner possible. If you fail to notify us of the admission or, if MVP is otherwise unable to conduct concurrent review of these services, MVP will conduct a Post Service

review of the services received. You may provide us with Concurrent Notice by calling MVP Utilization Management Department at 1-800-568-0458.

B. How To File A Post Service Claim. If you are required to make payment directly to a Provider after you have received Covered Services (e.g. Child Preventive Dental Services), then you must submit a Post Service Claim to MVP to receive your full benefit. To file a Post Service Claim directly with MVP, you must mail a completed MVP Claim Form (or a written note indicating your name, MVP ID number, and that the claim is being submitted for reimbursement) along with the bill from your Provider to:

MVP Health Plan, Inc.
P.O. Box 763
Schenectady, New York 12301-0763

MVP will only make benefit payments for Post Service Claims received from you within one-hundred and eighty (180) days from your receipt of the bill for the Covered Services or if MVP is deemed the "secondary plan" within one-hundred and eighty (180) days after you have received a final statement from the "primary plan", whichever is later (See, Section Twelve, Coordination of Benefits, for definition of "secondary plan" and "primary plan"). Notwithstanding, MVP shall not deny or reduce any Claim if it shall be shown not to have been reasonably possible for you to submit such Claim within the above mentioned timeframe and the claim was submitted as soon as reasonably possible.

SECTION FIVE - UTILIZATION MANAGEMENT

1. What Is Utilization Management (UM).

UM is the process used by MVP to determine if a Claim submitted for benefits is covered under this Certificate. A UM determination is the decision made at the conclusion of this process. All UM determinations that pertain to clinical matters shall be made by an appropriately licensed health care practitioner.

2. What Is An Adverse Determination.

An Adverse Determination is any determination that results in the denial, reduction or termination of a service or that fails to provide or pay for a claimed benefit (in whole or in part); including determinations based upon eligibility to receive benefits, the Medical Necessity or the Experimental and/or Investigational nature of procedures, or failure to comply with MVP's UM procedures. Any written Adverse Determination Notice sent to you by MVP, shall be deemed delivered as of the date it is mailed to you at the address provided on your Enrollment Application or at the last address provided to MVP pursuant to our policies and procedures.

3. When Will MVP Make UM Determinations.

MVP shall make all UM determinations within the following timeframes:

A. UM Determinations For Urgent Care Claims. MVP will make all UM determinations with respect to Urgent Care Claims within the following timeframes:

i. If we have all necessary information at the time the Urgent Care Claim is received, MVP will make a decision within seventy-two (72) hours after receipt of the Claim.

ii. If we do not have all necessary information at the time the Urgent Care Claim is received, we will notify you within twenty-four (24) hours of receiving the Urgent Care Claim of any missing information. You will then have forty-eight (48) hours from receipt of this notice to provide us with the missing information. In such cases we will make a decision within forty-eight (48) hours after: (i) our receipt of the missing information or (ii) the expiration of time to provide us with the missing information, whichever is earlier.

iii. We will notify you of our decision either verbally or in writing within the timeframe, set forth above. If verbal notification is used, we will also notify you in writing within the earlier of three (3) days after the verbal notification or three (3) business days of receipt of all necessary information. MVP's failure to notify you within the above timeframe may be considered an Adverse Determination, which may be appealed directly to MVP's Level One Expedited Appeal process.

B. UM Determinations For Pre-Service Claims. MVP will make all UM determinations relating to Pre-Service Claims within the following timeframes:

i. If we have all necessary information at the time the Pre-Service Claim is received, MVP will make a decision within three (3) business days after receipt of the Claim.

ii. If we do not have all necessary information at the time the Pre-Service Claim is received, we will notify you and your health care provider within fifteen (15) days after receiving the Pre-Service Claim of any missing information. You will then have forty-five (45) days after receipt of this notice to provide the missing information. In such cases, we will make a decision: (a) within three (3) business days of our receipt of the missing information; or (b) within fifteen (15) days of the expiration of time to provide us with the missing information, whichever is earlier.

iii. We will notify you and your health care provider of our decision both verbally and in writing within the timeframe, set forth above. MVP's failure to notify you within the above timeframe may be considered an

Adverse Determination, which may be appealed directly to MVP's Level One Standard Appeal process.

C. UM Determinations For Concurrent Care Claims. MVP will make all UM determinations relating to Concurrent Care Claims within the following timeframes:

i. Any UM Determination related to an extended course of treatment that involves an Urgent Care matter, shall be made within twenty-four (24) hours after receipt of the Concurrent Care Claim. If the Concurrent Care Claim does not involve Urgent Care matter, then UM Determination shall be made within one (1) business day after receipt of all necessary information or within the timeframe to make a Pre-Service UM Determination, whichever is earlier.

ii. Any Adverse Determination that results in a reduction or denial of a course of treatment before the end of the period of time or number of treatments that have been previously approved, shall be made at a time sufficiently in advance of such reduction or denial to allow you to commence an Expedited Level One Appeal (see "Expedited Level One Appeals" below) and to obtain a determination from such promptly commenced Expedited Level One Appeal before such benefit is reduced or denied

iii. We will notify you and your health care provider of our decision both verbally and in writing within the timeframe, set forth above. MVP's failure to notify you within the above timeframe may be considered an Adverse Determination, which may be appealed directly to MVP's Level One Expedited Appeal process.

D. UM Determinations For Post Service Claims. MVP will make UM determinations relating to Post-Service Claims within the following timeframes:

i. If we have all necessary information at the time the Post Service Claim is received, MVP will make a decision within thirty (30) days after receipt of the Claim.

ii. If we do not have all necessary information at the time the Post Service Claim is received, we will notify you within thirty (30) days of receiving the Post Service Claim of any missing information that is needed to make a determination. You will then have forty-five (45) days after receipt of this notice to provide us with the missing information. In such cases, we will make a decision: (a) within fifteen (15) days of our receipt of the missing information; or, if missing information is not provided, (b) within fifteen (15) days of the expiration of the time to provide such missing information.

iii. We will notify you in writing of our decision within the timeframe set forth above. MVP's failure to notify you within the above timeframe may

be considered an Adverse Determination, which may be appealed directly to MVP's Level One Standard Appeal process.

SECTION SIX – INPATIENT HOSPITAL SERVICES
(See Also, Section One, Subsection 2A, Regarding Inpatient Hospital Services)

1. Inpatient Hospital Services.

We will provide benefits for the inpatient Hospital services described below. Coverage is subject to all conditions, exclusions and limitations set forth in this Certificate. Except for Emergency Care Services or services provided on prior written approval from MVP, MVP will only provide benefits for Covered Services provided to you in a Participating Hospital. Inpatient Hospital services include the following:

A. bed and board, including special diet and nutritional therapy. Benefits will be paid for a semi-private room or ward of a Hospital, unless a private room is found to be Medically Necessary.

B. general, special and critical care nursing service, but not private duty nursing service.

C. services, supplies, and equipment related to surgical operations; recovery facilities; anesthesia; and facilities for intensive or special care.

D. oxygen and other inhalation therapeutic services and supplies.

E. drugs and medications, which are listed and approved for use by the Food and Drug Administration (FDA).

F. sera; biologicals; vaccines; intravenous preparations; dressings; casts; and materials for diagnostic studies.

G. services, supplies and equipment related to the administration of blood, blood products, and blood derivatives.

H. services, supplies, and equipment related to physical and occupational therapy and rehabilitation.

I. services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to: laboratory; pathology; cardiographic; endoscopic; radiologic; and electroencephalo-graphic studies and examinations.

J. social, psychological, and pastoral services.

K. services, supplies and equipment related to radiation and nuclear therapy.

L. services, supplies, and equipment related to emergency medical care.

M cancer chemotherapy (including medications) provided in the Hospital.

Inpatient Hospital services do not include: medication, supplies and equipment, which the Member takes home from the Hospital; whole blood, blood plasma, packed blood cells or other blood derivatives if participation in a volunteer blood replacement program is available to the Member; and, non-medical items such as telephone or television rental.

2. Inpatient Services Available for Specific Covered Services.

A. Breast Cancer Care. We will provide benefits for the inpatient services described in Subsection "1" above, in connection with an inpatient stay following a mastectomy, lymph node dissection or lumpectomy for the treatment of breast cancer and for physical complications of mastectomy, including lymphedemas. We will also provide benefits for these inpatient services, when provided in connection with an inpatient stay following all stages of 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.

B. Maternity Care. We will provide benefits for the inpatient services described in Subsection "1" above, in connection with the following maternity care inpatient services:

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

ii. For cesarean section deliveries, inpatient hospital coverage for the mother and newborn for a minimum of ninety-six (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 inpatient services in connection with maternity care are determined to be Medically Necessary, we will provide benefits to the Covered Member for such services to the same extent that this Contract provides benefits for such services in connection with illness or disease.

C. Mental Health Care. We will provide benefits for the inpatient services described in Subsection "1" above, to treat mental health care conditions for up to a maximum of thirty (30) inpatient days per Member per Calendar Year only when such services are Acute Services. MVP will only provide benefits for inpatient services provided at a Participating Hospital. We will not provide benefits for care in a residential treatment facility. Mental health care conditions do not include motor disorders, communication disorders, mental retardation, pervasive developmental disorders, and dementia. Please note that for "Partial

Hospitalization Programs" and/or "Intensive Outpatient Treatment Programs" two (2) days of participation in a Partial Hospitalization Program and/or four (4) days of participation in an Intensive Outpatient Treatment Program will count as one (1) full day toward this thirty (30) day benefit maximum and the inpatient Copayment listed on your Schedule of Benefits shall apply.

For purposes of this Subsection, Hospital shall mean the inpatient services unit of a psychiatric center under the jurisdiction of the Office of Mental Health or other psychiatric in-patient facility in the Department, a psychiatric in-patient facility maintained by a political subdivision of the State for the care or treatment of the mentally ill, a ward, wing, unit, or other part of a hospital, as defined in Article 28 of the Public Health Law, operated as part of such hospital for the purpose of providing services for the mentally ill pursuant to an operating certificate issued by the Commissioner of Mental Health, or other facility providing an operating certificate by the Commissioner.

D. Alcohol Abuse and/or Substance (Drug) Abuse and Dependence. We will provide benefits for active treatment for detoxification needed because of alcohol abuse/dependence or substance abuse/dependence for up to a maximum of seven (7) days per Member per Calendar Year. MVP will only provide benefits for inpatient services obtained at a Participating Hospital. For purposes of this Subsection, Hospital shall mean an appropriately certified Participating facility, certified by the New York State Office of Substance Abuse Services as a medically supervised substance abuse program. Outside New York State, care must be received in a facility whose substance abuse treatment program has been approved by the Joint Commission of Accreditation of Health Care Organizations.

E. Physical Rehabilitation Care. We will provide benefits for up to a maximum of sixty (60) inpatient days per Member per Calendar Year for the inpatient services described in Subsection "1" above, for physical rehabilitation, not related to substance abuse (e.g. following a stroke), only when such services are Acute Services.

F. 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 benefit.

G. End of Life Care. We will provide benefits for acute inpatient services described in Subsection "1" above, when provided at a Participating acute care facility licensed pursuant to Article 28 of the Public Health Law and specializing in the treatment of terminally ill individuals, when the following conditions have been met:

i. The Member has been diagnosed with advanced cancer with no hope of reversal of primary disease and with fewer than sixty (60) days to live;

ii. The Member's treating physician, in consultation with the medical director for the acute care facility determines that the Member's care would most appropriately be provided by the facility;

iii. MVP must be provided, prior to admission or as soon as reasonably possible, with a written certification from the Member's treating physician that the criteria set forth in Subpart's (i) and (ii) has been satisfied.

If MVP believes that the above conditions for End of Life Care Services have not been met, then we will initiate an External Appeal subject to the requirements of the New York State Insurance Law. Pending resolution by the New York State External Appeal Agent, we will provide benefits for the requested services in accordance with the terms of this Certificate.

H. Infertility Services. MVP shall not exclude coverage for inpatient services solely because the medical condition relates to infertility.

I. Bariatric Surgery. We will provide benefits for bariatric surgery only when such surgery is performed at a Hospital participating in MVP's Bariatric Surgery Network. You may obtain a description of this Network by calling the MVP Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

SECTION SEVEN – OUTPATIENT SERVICES

1. Outpatient Services.

We will provide benefits for the outpatient services described below. Coverage is subject to all conditions, exclusions and limitations set forth in this Certificate. Except for Emergency Care Services or on prior written approval from MVP, Covered Services must be provided to you: in the outpatient department of a Participating Hospital; at a Participating free-standing facility; or at a Participating Provider's office. **Some Covered Services are listed both in Section Seven "Outpatient Services" and Section Ten "Professional Care and Services" in this Certificate. This is to indicate that we will provide benefits when these services are obtained in multiple outpatient settings (e.g. Participating Hospital, Participating free-standing facility, or Participating Provider's office) and does not mean that benefits will be provided for additional visits or services if Covered Services are obtained at different outpatient settings.**

A. Emergency and Urgent Care Services. We will provide benefits for Emergency Care services provided at a Participating or Non-Participating Hospital emergency room and Urgent Care Services provided at a Participating urgent care facility. (See Section Nine, "Emergency and Urgent Care Services")

B. Pre-admission/Pre-Surgical Testing. We will provide benefits for pre-admission testing performed on an outpatient basis, when performed at the Hospital where the surgery is scheduled to take place, and the following requirements are satisfied:

i. The tests were ordered by a Participating physician;

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

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

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

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

C. Outpatient Surgery. We will provide benefits for outpatient surgery.

D. Cervical Cancer Screening. We will provide benefits for an annual cervical cytology screening for females eighteen (18) years of age or older. This includes benefits for an annual pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

E. Mammography Screening. We will provide benefits for mammography screening for occult breast cancer, subject to the following limits:

i. upon the recommendation of a Participating physician, at any age if a Member has a prior history of breast cancer or if you have a first degree relative with a prior history of breast cancer;

ii. a single baseline mammogram if you are thirty-five (35) to thirty-nine (39) years of age;

iii. an annual mammogram if you are age forty (40) or older.

F. Therapy Services (PT/OT/ST). We will provide benefits for up to a combined thirty (30) visits per Member per Calendar Year for Therapy Services only when such services are Acute Services and are provided under the direction of a Participating physician in a Participating Hospital or facility or in a Participating Provider's office as described in Section Ten.

G. Therapeutic Services (radiation therapy, chemotherapy, infusion therapy and inhalation therapy). We will provide benefits for Therapeutic Services, including charges for medications, provided in connection with outpatient Therapeutic Services. MVP will only provide benefits for medications that are required to be provided by and administered in the Hospital or at the facility as part of the treatment or by prescription filled by the Hospital pharmacy.

H. Laboratory Services. We will provide benefits for laboratory services.

I. Diagnostic Services (including Bone Mineral Density Measurements or Tests). We will provide benefits for Diagnostic Services. For bone mineral density measurements or tests, we will provide benefits for Members who meet the criteria established under the Federal Medicare Program or the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, benefits shall also be provided to:

i. Members previously diagnosed as having osteoporosis or having a family history of osteoporosis;

ii. Members with symptoms or conditions indicative of the presence of osteoporosis, or the significant risk of osteoporosis; or

iii. Members on a prescribed drug regimen posing a significant risk of osteoporosis; or

iv. Members with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

v. Members of such age, gender and/or other physiological characteristics, which pose a significant risk of osteoporosis.

J. Prostate Cancer Screenings. We will provide benefits for diagnostic screening for prostate cancer, subject to the following limits:

i. Standard diagnostic testing including, a digital rectal examination and a prostate specific antigen test at any age for men having a prior history of prostate cancer; and

ii. An annual standard diagnostic examination including, a digital rectal examination and a prostate specific antigen test for men age fifty (50) and over who are not symptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.

K. Alcoholism and Substance Abuse Rehabilitation. We will provide benefits for the outpatient treatment of alcohol and substance dependency for up to sixty (60) outpatient visits per Member per Calendar Year. We will not provide benefits for day treatment. Of the sixty (60) visits, up to twenty (20) visits may be used for family counseling, provided the family members receiving therapy are Members; and no more than twenty (20) family visits are used by all family members combined. These family counseling visits are eligible for Coverage even if the person in need of treatment has not yet begun that treatment. Benefits for family counseling are limited to one (1) visit per day. Coverage is limited to facilities certified by the Office of Alcoholism and Substance Abuse Services or licensed by such Office as outpatient clinics or medically supervised ambulatory substance abuse programs. Please note that for "Intensive Outpatient Treatment Programs", one (1) day of participation in such a Program will count as one (1) outpatient visit under this Subsection.

L. Mental Health Care. We will provide benefits for the diagnosis and treatment of mental health care conditions for up to twenty (20) outpatient visits per Member per Calendar Year only when such services are Acute Services. We will not provide benefits for continuous day treatment. Coverage is limited to: facilities operated by the Office of Mental Health; a facility issued an operating certificate by the Commissioner of Mental Health pursuant to the provisions of Article 31 of Mental Hygiene Law; or a psychiatrist, psychologist, or duly certified social worker who are certified pursuant to the requirements of Section 4303(n) of the New York State Insurance law or comparable legislation outside of the State of New York. Mental health care conditions do not include the following motor disorders, communication disorders, mental retardation, pervasive developmental disorders, and dementia. Please note that for "Partial Hospitalization Programs" and/or "Intensive Outpatient Treatment Programs" two (2) days of participation in a

Partial Hospitalization Program and/or four (4) days of participation in an Intensive Outpatient Treatment Program will count as one (1) full day toward your thirty (30) day Inpatient Mental Health benefit maximum and the inpatient Copayment listed on your Schedule of Benefits shall apply.

M. Dialysis Services. We will provide benefits for hemodialysis or peritoneal dialysis, as follows:

i. Dialysis treatment on a walk-in basis if the program is approved by the appropriate governmental authorities.

ii. For home treatment, we cover the reasonable rental cost of equipment as determined by us, plus all appropriate and necessary supplies required for home dialysis treatment when ordered by your Participating physician. Coverage will not include any furniture, electrical or other fixtures or plumbing needed to perform the dialysis treatments at home.

iii. For these home and facility based Services to be covered, the treatments must be provided, supervised or arranged by the Participating physician and the Member must be a registered patient of an MVP approved kidney disease treatment center.

iv. The benefits for ambulatory and home dialysis have no time limit, and continue while enrollment is in good standing until the Member becomes eligible for Medicare.

N. Cardiac Rehabilitation Care. We will provide benefits for up to thirty six (36) visits per Calendar Year only when such services are Acute Services and are provided under the direction of a Participating physician in a Participating Hospital or facility.

SECTION EIGHT – ADDITIONAL COVERED SERVICES

1. Skilled Nursing Facility (SNF) Care.

We will provide benefits for up to a total of sixty (60) days of coverage per Member per Calendar Year for the SNF services described below: Coverage is subject to all conditions, exclusions and limitations set forth in this Subsection and, in this Certificate.

A. SNF Services For Which We Pay Benefits. We will provide benefits for the following SNF Services:

i. room and board in a semiprivate room.

ii. skilled nursing care.

iii. Therapy Services.

iv. drugs, medications, supplies and equipment used in and furnished by the SNF.

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

B. Conditions on Coverage. In addition to all other conditions, exclusions and limitations in this Certificate, we will only provide benefits for SNF services, if the following conditions are met:

i. you must be under the care of a Participating physician;

ii. the SNF services must be provided in a Participating SNF;

iii. you must have been in a Hospital for at least three (3) days immediately preceding admittance to the SNF;

iv. further hospitalization would otherwise be necessary; and

v. SNF services are Medically Necessary to treat your condition.

Additionally, we will provide benefits for the day you are admitted. We will not provide benefits for the day you are discharged. If you are admitted and discharged on the same day, we will provide benefits for that day.

2. Home Health Care.

We will provide benefits for up to sixty (60) visits per Member per Calendar Year for the home health care services described below. Coverage is subject to all conditions, exclusions and limitations set forth in this Subsection, and, in this Certificate.

A. Home Health Care Services For Which We Pay Benefits. We will provide benefits for the following home health care Services:

i. part time or intermittent SNF services by or under the supervision of a registered nurse.

ii. part time or intermittent home health aide services, provided that such services consist primarily of caring for the patient and do not include Custodial Services.

iii. Therapy Services, if provided by Home Health Care Agency personnel.

iv. Medical supplies, drugs and medications prescribed by a Participating Physician, and laboratory services by or on behalf of a certified Home Health Care Agency or licensed Home Care Services Agency to the extent such items would be covered or provided under this Certificate if the Member had been hospitalized or confined in a Skilled Nursing Facility as defined in Subchapter XVIII of the Social Security Act, 42 U.S.C. Section 1395.

B. Conditions on Coverage. In addition to all other conditions, exclusions and limitations in this Certificate, we will only provide benefits for home health care services, if the following conditions are met:

i. the services are supervised by a Participating physician under a written treatment plan;

ii. all services are provided by a Participating Home Health Care Agency and their personnel;

iii. without the provision of these services you would need to be admitted to a Hospital or SNF.

3. Hospice.

We will provide benefits for up to a total of two hundred and ten (210) days of coverage, per the Member's lifetime, for the Hospice services described below. Coverage is subject to all conditions, exclusions and limitations set forth in this Subsection, and, in this Certificate.

A. Hospice Services For Which We Pay Benefits. We will provide benefits for the Hospice Services listed below:

i. Home Care and outpatient services otherwise covered under this Certificate provided by the Hospice, including drugs and medical supplies.

ii. five visits for bereavement counseling for your family either before or after your death.

B. Conditions on Coverage. In addition to all other conditions, exclusions and limitations under this Certificate, we will only provide benefits for Hospice Services, if the following conditions are met:

i. All services are obtained from a Participating Hospice;

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

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

4. Non-Emergency Ambulance Transport Services. (See, Section Nine, "Emergency and Urgent Care Services" for a description of Emergency Ambulance Services)

We will provide benefits for Non-Emergency ambulance services, when provided by an Ambulance Service Provider, that are Medically Necessary to take you to and from a Hospital, between Hospitals and between a Hospital and a SNF.

5. Supplies and Equipment for the Treatment of Diabetes.

We will provide benefits for supplies and equipment for the treatment of diabetes, described below, subject to all conditions, exclusions and limitations set forth in this Subsection and in this Certificate.

A. Supplies and Equipment For Which We Pay Benefits. We will provide benefits for a thirty-one (31) day supply per dispensing for the following items:

i. blood glucose monitors.

ii. blood glucose monitors for the visually impaired.

iii. data management systems.

iv. test strips for glucose monitors and visual reading.

v. urine testing strips.

vi. insulin and injection aids.

vii. cartridges for the visually impaired.

viii. syringes.

ix. insulin pumps and appurtenances thereto.

x. insulin infusion devices.

xi. oral agents for controlling blood sugar.

xii. other items of equipment and supplies as may be required by the New York State Department of Health.

Benefits will also be provided for diabetes education for proper self-management and treatment, which shall include information on proper diets.

B. Conditions on Coverage. In addition to all other conditions, exclusions and limitations under this Certificate, we will only provide benefits for the services described Subsection 5A, immediately above, if the following conditions are met:

i. for the items described in Subsection 5A, Subparts "i-xii", the items must be prescribed by a Participating Provider, who is licensed to prescribe such items pursuant to Title 8 of the New York State Education Law, and obtained through a Participating Provider, or other Provider upon prior approval from MVP.

ii. for diabetes education for proper self management and treatment, benefits shall be limited to visits that are Medically Necessary upon the diagnosis of diabetes, where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in the patient's self management, or where reeducation or refresher education is necessary. Coverage for education will also include home visits when Medically Necessary. Such education may be provided by a Participating Provider or other licensed health care provider legally authorized to prescribe under Title 8 of the New York Education Law, or their staff; as part of an office visit for diabetes diagnosis or treatment; or by a Participating: certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician; upon the referral of a Participating physician or other Participating licensed health care provider legally authorized to prescribe under Title 8 of the New York

Education Law, provided that education provided by a Participating: certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician shall be limited to group settings wherever practicable.

6. Durable Medical Equipment, External Prosthetic Devices and Ostomy Supplies.

We will provide benefits for Durable Medical Equipment, external prosthetic devices and ostomy supplies, described below, subject to all conditions, exclusions and limitations set forth in this Subsection and in this Certificate.

A. Durable Medical Equipment, External Prosthetic Devices and Ostomy Supplies For Which We Pay Benefits. Benefits are available for procurement, repair or replacement of durable medical equipment, such as crutches and wheelchairs, if medically necessary and approved in advance by MVP. (The option of whether to rent or purchase authorized durable medical equipment is solely within MVP's discretion.) External prosthetic devices, such as artificial limbs and medical appliances (including ostomy supplies), that replace all or part of a body organ or that replace all or some of the functions of a permanently inoperative and/or malfunctioning body organ are covered when prescribed by a licensed Participating physician. Coverage includes repair and/or replacement of external prosthetic devices, which are otherwise covered. Custom prosthetics will not be covered if a standard device exists, unless a custom device is medically necessary. This Coverage does not include eyeglasses, hearing aids, elastic stockings, arch supports, corrective shoes, wigs, other orthopedic equipment and duplicate items.

B. Conditions on Coverage. In addition to all other conditions, exclusions and limitations set forth in this Certificate, MVP will only provide benefits for Medically Necessary items that have been prior approved by MVP. All items must be obtained from an MVP Participating Provider/vendor or other vendor authorized in advance by MVP.

7. Preventive Dental Care For Children To Age 19. We will provide benefits for the Dental Services, described below, subject to all conditions, exclusions and limitations set forth in this Subsection and in this Certificate.

A. Preventive Dental Services For Which We Pay Benefits.

i. One (1) initial oral examination per child;

ii. periodic oral examinations once every six (6) months;

iii. bitewing x-rays, once every six (6) months;

iv. full mouth x-rays and panoramic x-rays, once every thirty six (36) months;

v. routine cleaning, scaling and polishing of teeth, once every six (6) months;

vi. fluoride treatments, once every six (6) months;

vii. pulp vitality testing, as needed;

viii. diagnostics casts as needed;

ix. sealants, once per tooth per child up to age sixteen (16);

x. space maintainers and recementation thereof, as needed;

xi. intra-oral and periapical x-rays, as needed.

B. Conditions On Coverage. In addition to all other conditions, exclusions and limitations set forth in this Certificate, MVP will only provide benefits for the Preventive Dental Services, described above, for Covered Members to age nineteen (19), when such services have been recommended by a licensed [Participating] dentist. You may [must] obtain services from a licensed [Participating] dentist [of your choice]. [To obtain benefits you or your designee must submit a Post Service Claim to MVP. (See, Section Four, Subsection 3C "The Filing of a Post Service Claim")]

C. Other Dental Services. (See, Section Eleven, "Exclusions")

8. Transplant Services/Donor Costs.

A. Transplant Services. We will provide Benefits for covered transplant services only when such services are approved by MVP and obtained through MVP's Network of Participating Transplant Providers. For a description of this Network, contact MVP's Member Services department at 1-888-MVP-MBRS (1-888-687-6277).

B. Donor Costs Available With Covered Transplant Procedures. We will provide benefits for actual donor costs, described below, incurred by an authorized donor in connection with a covered transplant procedure. Benefits are only available when the recipient of the transplant is a Member under this Certificate and is receiving a covered transplant procedure.

i. Donor Costs For Which We Pay Benefits. We will provide benefits for medical services (otherwise Covered under this Certificate) performed in connection with a covered transplant procedure, as well as, medical services that arise as a result of complications from such covered transplant procedure that are performed within three (3) months from the date of the transplant. We will not provide benefits for any expenses incurred for travel, food and lodging for either the recipient or donor or costs related to searches or screenings of a donor.

ii. Conditions On Coverage. We will only provide benefits for donor costs, if:

(a) Transplant recipient is a Covered Member under this Certificate;

(b) The Transplant recipient is receiving covered transplant services;

(c) The donor has met all criteria established by MVP's Transplant Provider; and

(d) All medical services must be described as Covered Services in this Certificate and obtained from MVP's Participating Transplant Provider or other Provider upon prior approval from MVP.

SECTION NINE - EMERGENCY AND URGENT CARE SERVICES

1. Emergency Services. We will provide benefits for Pre-Hospital Emergency Medical Services, Emergency Care Air Ambulance Transport and, Hospital services necessary to treat an Emergency Condition, whether such services are provided by a Participating or Non-Participating Provider.

   A. Pre-Hospital Emergency Medical Services means the prompt evaluation and treatment of an Emergency Condition and/or non-air-borne transportation of the Member to a Hospital, when services are provided by an Ambulance Service Provider.

   B. Emergency Care Air Ambulance Transport means the air borne transportation of the Member to a Hospital that is Medically Necessary as a result of the Member's Emergency Medical Condition. Benefits will only be provided for services that are provided by an Ambulance Services Provider that has been certified to provide air transport, and, where the Member's medical condition makes ground transport medically inappropriate.

   C. Hospital Services. MVP will provide benefits for Hospital services (e.g. Emergency Room Services) necessary to treat your Emergency Condition. If Hospital services are provided by a Non-Participating Hospital, then we will only provide Benefits if you were unable to receive such care from a Participating Hospital and only for Hospital services that are necessary to screen and stabilize the Emergency Condition, so that you can be safely transported to a Participating Provider. If you are admitted to the Hospital after you have received Emergency Services, then you, your designee or your Provider must call MVP at 1-888-MVP-MBRS (1-888-687-6277), as soon as reasonably possible.

2. Urgent Care Services. We will provide benefits for Medically Necessary Covered Services provided by a Participating Urgent Care Facility to treat your Urgent Care Condition. An Urgent Care Condition means an accidental injury, illness or condition that does not meet the definition of an Emergency Condition but for which services cannot be delayed until you are able to seek care through your PCP.

SECTION TEN – PROFESSIONAL CARE AND SERVICES

1. Professional Services.

   We will provide benefits for the following professional services, when provided at the office of a Participating Professional Provider or where applicable at a Participating Hospital or Participating free-standing facility. **Some Covered Services are listed both in Section Seven "Outpatient Services" and Section Ten "Professional Care and Services" in this**

Certificate. This is to indicate that we will provide benefits when these services are obtained in multiple outpatient settings (e.g. Participating Hospital, Participating free-standing facility, or Participating Provider's office) and does not mean that additional visits or services are available if services are obtained at different outpatient settings.

A. Preventive Care Services.

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

ii. Periodic Health Evaluations. We will provide benefits for adult (age 19 or older) physical or health evaluations, when provided by your PCP.

iii. Primary and/or Preventive Gynecological Services. Female Members may obtain up to two (2) gynecological examinations per Member per Calendar Year. We will provide benefits for additional gynecological services if Medically Necessary. These benefits will be provided without requiring a referral from your PCP. However, the Participating Provider must discuss the services and treatment plan with your PCP and provide your PCP with all relevant and necessary medical information relating to your treatment.

iv. Mammography Screenings. We will provide benefits for mammography screening for occult breast cancer, subject to the following limits:

(a) upon the recommendation of a physician, at any age if a Member has a prior history of breast cancer or if you have a first degree relative with a prior history of breast cancer;

(b) a single baseline mammogram if you are thirty-five (35) to thirty-nine (39) years of age;

(c) an annual mammogram if you are age forty (40) or older.

v. Cervical Cancer Screenings. We will provide benefits for annual cervical cytology screening for females eighteen (18) years of age or older. This

includes benefits for an annual pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

vi. Prostate Cancer Screenings. 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 at any age for men having a prior history of prostate cancer; and

(b) An annual standard diagnostic examination including, a digital rectal examination and a prostate specific antigen test for men age fifty (50) and over who are not symptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.

B. Maternity Care. We will provide benefits for the following professional services related to maternity care:

i. Pre-natal and post-natal care (no PCP referral is required for this care);

ii. Parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments. If the Member opts to be discharged from the Hospital after childbirth earlier than the time periods set forth in Section Six, Subsection 2B, then such Member shall be entitled to at least one (1) home care visit. This home care visit must be requested by the Member or the Member's Participating Physician within forty-eight (48) hours of a vaginal delivery, or within ninety-six (96) hours of a cesarean section delivery. If such request is timely made, MVP will provide this home care visit within twenty-four (24) hours after discharge from the Hospital or from the time of the request, whichever is later. This home visit shall be covered in full and shall be in addition to any other home care coverage available with this Certificate.

iii. If additional professional services in connection with maternity care are determined to be Medically Necessary, we will provide benefits to the Covered Member for such services to the same extent that this Contract provides benefits for such services in connection with illness or disease.

C. Office or Home Visits. We will provide benefits for the examination, diagnosis, and treatment of an injury, illness or condition, and laboratory services provided at the time of such visit.

D. 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.

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

F. Second Surgical Opinions. We will provide benefits for a second surgical opinion to be performed by a Participating Provider, when your Participating Provider has made a recommendation on the need for covered elective surgery. We will also provide benefits for a second medical opinion by an appropriate Participating or Non-Participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, 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.

G. Treatment of Mental Health Conditions. We will provide benefits for the diagnosis and treatment of mental health care conditions for up to twenty (20) outpatient visits, per Calendar Year.

H. Treatment of Alcohol or Substance Dependency. We will provide benefits for the outpatient treatment of alcohol and substance dependency for up to sixty (60) outpatient visits per Member per Calendar Year. Of the sixty (60) visits, up to twenty (20) visits may be used for family counseling, provided the family members receiving therapy are Members; and no more than twenty (20) family visits are used by all family members combined. These family counseling visits are eligible for Coverage even if the person in need of treatment has not yet begun that treatment. Benefits for family counseling are limited to one (1) visit per day.

I. Chiropractic Treatment. We will provide benefits for chiropractic services, when provided by a Participating licensed chiropractic physician. Chiropractic Services are 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.

J. Allergy Tests and Treatment. We will provide benefits for diagnosis and treatment of allergies.

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. We will not provide benefits for medical services for uncovered inpatient services.

L. Surgery. We will provide benefits for surgery and surgical care.

M. Breast Cancer Care. We will provide benefits for mastectomy and treatment of physical complications of mastectomy such as lymphedema, lymph node dissection, or lumpectomy for the treatment of breast cancer. Following a covered mastectomy, we will provide benefits for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined appropriate by your provider, in consultation with you. We will also provide benefits for breast prostheses (See also, Section Eight, Subsection 6).

N. Anesthesia Services. We will provide benefits for anesthesia services provided in connection with Covered Services.

O. Laboratory Services.

P. Diagnostic Services. (including Bone Mineral Density Measurements or Tests). We will provide benefits for Diagnostic Services. For bone mineral density measurements or tests, we will provide benefits for Members who meet the criteria established under the Federal Medicare Program or the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, benefits shall also be provided to:

i. Members previously diagnosed as having osteoporosis or having a family history of osteoporosis;

ii. Members with symptoms or conditions indicative of the presence of osteoporosis, or the significant risk of osteoporosis; or

iii. Members on a prescribed drug regimen posing a significant risk of osteoporosis; or

iv. Members with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

v. Members of such age, gender and/or other physiological characteristics, which pose a significant risk of osteoporosis.

Q. Therapeutic Services (radiation therapy, chemotherapy, infusion therapy and inhalation therapy).

R. Casts and Dressings.

S. Therapy Services (PT/OT/ST). We will provide benefits for up to a combined thirty (30) visits per Member per Calendar Year for Therapy Services, when such services are Acute Services and are provided under the direction of a Participating physician by a Participating Hospital or a Participating facility or in a Participating Provider's office as described in Section Seven.

T. Vision Exams. We will provide benefits for vision exam once every two (2) Calendar Years. A vision exam means an eye care exam for prescribing, fitting or

determining your need for eyeglasses or contact lenses. The examination must be provided by a Participating optometrist or ophthalmologist.

U. Infertility Services. Benefits are available for surgical or medical procedures, necessary to correct malformation, disease or dysfunction resulting in infertility. These benefits are not subject to paragraphs (i) and (ii) below.

Benefits are also available for diagnostic tests and procedures that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments. Diagnostic tests and procedures include, but are not limited to, hysterosalpingrogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound. In addition to all other terms, conditions and exclusions set forth in your Contract, coverage for the infertility services set forth above is subject to the following conditions:

i. Diagnosis and treatment of infertility must be prescribed as part of a Participating physician's overall plan of care and must be consistent with the guidelines established by MVP. MVP's guidelines shall be consistent with regulations established or hereafter adopted by the New York State Department of Insurance.

ii. Coverage shall only be available for Members between twenty-one (21) and forty-four (44) years of age.

iii. Coverage shall not include benefits for the diagnosis and treatment of infertility in connection with:

a. In-Vitro Fertilization

b. Gamete Intrafallopian Tube Transfers

c. Zygote Intrafallopian Tube Transfers

d. The reversal of elective sterilization

e. Sex change procedures

f. Cloning

g. Medical or surgical services that are deemed to be experimental

h. Gender Selection

i. Sperm Banking

j. Surrogate Services

SECTION ELEVEN – EXCLUSIONS

In addition to any exclusions and limitations described in other sections of this Certificate, MVP will not provide benefits for the following:

1. Services Provided By Non-Participating Provider.

Except for Covered Emergency Care Services and Child Preventive Dental Services (as defined in Section Eight, Subsection Seven of this Certificate), or upon prior written approval from MVP, we will only provide benefits for Covered Services provided by a Participating Provider.

2. Non-Medically Necessary Services.

No Benefits will be provided for services, which in MVP's judgment are not Medically Necessary. Services will be deemed Medically Necessary only if:

A. they are recommended by your treating Professional Provider; and

B. they are determined by MVP's Medical Director or physician designee to meet the following criteria:

i. the services are appropriate and consistent with the diagnosis and treatment of your medical condition;

ii. the services are not primarily for your convenience, the convenience of your family, or your provider;

iii. the services are required for the direct care and treatment or management of that condition;

iv. the services are provided in accordance with general standards of good medical practice, as evidenced by, reports in peer reviewed medical literature; reports and guidelines as published by nationally recognized health care organizations that include supporting scientific data; and any other relevant information brought to our attention; and

v. the services are rendered in the most efficient and economical way and at the most economical level of care, which can safely be provided to you.

3. Non-Covered Services.

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

4. Services Starting Before Coverage Begins.

We will not provide benefits for any services received:

A. Prior to the Effective Date; or

B. On or after the effective date if the service is covered under any other health benefits contract, program or plan.

5. Services not Provided By, or Received Pursuant to a Referral From Your PCP.

Except as specifically provided, we will not provide benefits for any services not provided by your PCP or for any service received without a referral from your PCP.

6. Admission to a Hospital Before You Become Covered under this Contract.

If you are covered by an insurer other than MVP, and 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.

7. Alternative Services.

We will not provide benefits for alternative or complementary health services, products, remedies, treatments and therapies including, but not limited to caffeine cessation therapy, osteopathic manipulation, acupuncture, biofeedback, massage therapy, hypnosis and hypnotherapy, naturopathy, homeopathy, play therapy, primal therapy, chelation therapy, carbon dioxide therapy, rolfing, psychodrama, psychoanalysis, megavitamin therapy, purging, bioenergetic therapy, aroma therapy, hair analysis, thermograms, thermography, swimming therapy, horseback riding therapy and herbal and other associated remedies.

8. Blood Products.

We will not provide benefits for Whole blood, blood plasma, packed blood cells or other blood derivatives if participation in a volunteer blood replacement program is available to the Member. Autologous blood donations are covered when Medically Necessary.

9. Certification Examinations.

Except as specifically provided, we will not provide Benefits for any services related to routine physical examination and/or testing to certify health status. This includes, but is not limited to, examinations required for school, employment, insurance, marriage, divorce, adoption, custody, medical research, licensing, travel, camp or sports.

10. Communication Devices.

Except as otherwise provided, we will not provide benefits for the purchase, rental, repair, replacement or maintenance of devices for speaking, listening, or otherwise communicating. This includes, but is not limited to telecommunication devices for the deaf (TDDs) and teletype machines (TYYs), and services for evaluation, fitting, or modification of such devices.

11. Cosmetic Surgery, Services or other Items.

We will not provide benefits for any Non-Medically Necessary services that are primarily intended to improve your appearance. MVP will, however, provide benefits for otherwise Covered 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 provide benefits for otherwise Covered Services provided in connection with other types of reconstructive surgery, when such services are incidental to or follows surgery because of congenital disease or anomaly of a Covered Dependent Child, which has resulted in a functional defect.

12. Court Ordered Services.

We will not provide benefits for the costs for medical services resulting from a court order or an administrative order, such as by the Department of Motor Vehicles, unless such services are determined to be Medically Necessary, are obtained in accordance with the terms and conditions set forth in this Certificate and involve services provided for under this Certificate. Such services include, but are not limited to custodial evaluations, special medical reports not directly related to treatment and reports prepared in connection with legal actions.

13. Coverage Outside the United States.

Except for Emergency Services, we will not provide benefits for services accessed outside the United States, its possessions or the countries of Canada and Mexico.

14. Custodial Services.

We will not provide benefits for Custodial Services.

15. Dental Services.

We will not provide benefits for any service related to dental care or treatment, except for:

A. Preventive Dental Care for Children (as described in Section Eight, Subsection Seven in this Certificate);

B. Dental Care or treatment due to accidental injury to sound natural teeth provided within twelve (12) months of the accident or when a claim is made within twelve (12) months of the accident establishing that it is Medically Necessary for the care or treatment to be provided more than twelve (12) months from the date of accident. Notwithstanding the foregoing, in all cases, the Member must be a Covered Member at the time services are provided; and

C. Dental Care or treatment necessary due to congenital disease or anomaly.

16. Disposable Medical Supplies.

Except as noted for in Section Eight, Subsection Five, we will not provide Benefits for disposable medical supplies.

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

18. Experimental or Investigational Treatments.

We will not provide benefits for any treatment, procedure, drug or device, or any hospitalization in connection with same, if it is determined by MVP to be experimental or investigational. However, MVP shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with Section Fifteen of this Contract. If the External Appeal Agent approves 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 costs 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.

19. Family Services.

We will not provide benefits for services provided by a member of your immediate family. This applies even if charges are billed.

20. Foot Care.

We will not provide benefits for routine foot care, including corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, thickened toenails and onuchomycosis.

21. Free Services.

We will not provide benefits for any services provided to you without charge or services that would normally be provided without charge. This applies even if charges are billed.

22. Government Benefits.

We will not provide benefits for any services for which payments are provided under Medicare, or any other federal, state, county or municipal law, except when required by state or federal law. 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 benefits under this Certificate.

The above exclusion is not applicable under the following circumstances.

A. The government program is Medicaid.

B. You, the Subscriber, are entitled to payments for Medicare by reason of your age, and the following conditions are met:

   i. You are an active employee (working actively and not retired) of your Group.

   ii. Your employer maintains or participates in an employer group health plan that is required by law to have this Certificate pay benefits before Medicare.

C. You, the Subscriber, are entitled to payments under Medicare by reason of disability (other than end stage renal disease), and the following conditions are met:

   i. You are an active employee (working actively and not retired) of your Group.

   ii. Your employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Certificate pay its benefits before Medicare.

D. You are entitled to Medicare by reason of end stage renal disease, and there is a waiting period before Medicare becomes effective. We will not reduce this Contract's benefits, and we will provide benefits before Medicare pays, during the waiting period. We will also provide benefits before Medicare pays, during the coordination period with Medicare. After the coordination period, Medicare will make its payments before we provide benefits under this Contract (this means that Medicare is the Primary Plan after this waiting period).

23. Government Hospital.

We will not provide benefits for services you receive in any hospital, facility or other 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, when provided to a veteran for non-service connected disability.

24. Home Modifications and/or Fixtures.

We will not provide benefits for the purchase, rental, repair, replacement or maintenance of home modifications and fixtures, including but not limited to 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 fixtures. This Exclusion does not limit benefits available for those items of Durable Medical Equipment (DME) described in Section Eight, Subsection 6 of this Certificate.

25. Missed Appointments

We will not provide benefits for the costs for which a Member is responsible for failure to keep an appointment with a Provider.

26. No-Fault Automobile Insurance.

We will not provide benefits for any services for which benefits are recovered or recoverable under the mandatory portion of a No-fault automobile insurance policy. This exclusion also applies if, after receiving no-fault benefits, you must repay then because you recovered money from a party who caused or was involved with your injury.

27. Non-Acute Hospital Care.

We will not provide benefits for the portion of a hospital stay that is primarily custodial or for convalescent or sanitarium-type care.

28. Orthodontia Services.

We will not provide benefits for orthodontia and orthodontia services.

29. Orthotic Devices for Feet.

We will not provide benefits for orthotic devices for the feet, such as orthopedic shoes and arch supports.

30. Personal or Comfort Items.

We will not provide Benefits for massage services, spa services, and other provider services, central or unit air conditioners, air or water purifiers, waterbeds, massage equipment, radio, telephone, telephone service, telephones, cellular phones, computers, computer hardware and software, Internet service, television, beauty and barber services, hypoallergenic bedding, mattresses, waterbeds, dehumidifiers, humidifiers, hygiene equipment, saunas, whirlpool baths, exercise or physical fitness equipment, emergency alert systems and

equipment, heat appliances, and business or vehicle modifications, or for services for evaluation, fitting or modification of such items.

31. Prescription Drugs.

We will not provide benefits for prescription drugs or devices, except for those that are administered to you in the course of Covered outpatient or inpatient services in a Hospital; administered during a Covered Home Care or Hospice services; allergy shots provided in a Participating Physicians office; or for otherwise covered immunizations.

32. Prohibited Referrals.

We will not provide benefits for the cost of referrals to radiology facilities, pharmacies or laboratories, which are prohibited under N.Y. Pub. Health Law § 238-a(1).

33. Reversal of Elective Sterilization.

We will not provide benefits for reversals of elective vasectomies or tubal ligations.

34. Self-Help Education and Training.

Except as specifically provided, we will not provide benefits for self-diagnosis, self-treatment or self-help training.

35. Self-Inflicted and/or Criminal Behavior.

We will not provide benefits for any intentionally self-inflicted injury or for any 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.

36. Support Therapies.

Except as specifically provided in this Certificate, we will not provide benefits for support therapies including, but not limited to, marriage counseling, pastoral or religious counseling, compulsive gambling, assertiveness training, music or art therapy or recreational therapy.

37. Travel and Transportation Costs.

We will not provide benefits for travel costs and related expenses such as meals and lodging, except for Covered Ambulance Services.

38. Vision and Hearing Examinations, Therapies and Supplies.

Except as described in Section 10, Subsection 1(T), we will not provide benefits for eyeglasses, contact lenses, hearing aids or hearing aid evaluations; including the costs for prescriptions or fitting thereof.

39. Workers' Compensation.

We will not provide benefits for any services for which benefits are provided under any state or federal workers' compensation, employer's liability or occupational disease law. This exclusion also applies if, after receiving workers' compensation, you must repay them because you recovered money from a party who caused or was involved with your injury.

40. War, Services in the Armed Forces and Aviation.

We will not provide benefits for any injuries or sickness resulting from war or any act of war (declared or undeclared). We will not provide benefits for injuries or sickness arising out of service in the Armed Forces or units auxiliary thereto. We will also not provide benefits for injuries or sickness resulting from aviation, other than as a fare-paying passenger on a scheduled or chartered flight operated by a scheduled airline.

SECTION TWELVE – COORDINATION OF BENEFITS

1. Applicability.

This Section applies only to those Members who have health care coverage with another "Plan." When that is the case and a Member receives services, we will coordinate benefits with any payment made under the other Plan. One Plan will pay its full benefit as the primary plan and the other will pay secondary benefits, if necessary, to cover some or all of his remaining expenses. This prevents duplicate payments and overpayments.

2. Definitions.

For purposes of this Section ONLY, the following terms shall be defined as follows:

A. "THIS PLAN" is the Group Contract/Certificate issued by MVP of which this Section is a part.

B. "Plan" is another health benefits program not issued by MVP with which we will coordinate benefits. The term "Plan" includes:

i. Health benefits insurance and group, blanket or group remittance health benefits insurance coverage, whether insured, self-insured, or self-funded. This includes HMO and other prepaid coverage. This does not include blanket school accident coverage or coverage's issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the policyholder (the school or organization) pays the premium.

ii. Medical benefits coverage in a group and/or individual mandatory automobile "no-fault" and traditional mandatory automobile "no-fault" type contracts.

iii. Hospital, medical, surgical and pharmaceutical benefits coverage of Medicare or a governmental plan offered, required or provided by law, except Medicaid. It also does not include any plan whose benefits are by law excess to any private insurance program or other non-governmental program.

3. Rules to Determine Payment.

The first of the rules listed below (A-F), which applies shall determine which Plan shall be primary:

A. If the other Plan does not have a provision similar to this one, then it shall be primary.

B. If the Insured Person receiving the benefits is the person belonging to the group through which, or to which THIS PLAN was issued and he is only covered as a dependent under the other Plan, THIS PLAN will be primary.

C. If a dependent child is covered under the Plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan, which covered the parent longer, shall be primary. For purposes of determining whose birthday falls earlier in the year, only the month and date are considered. If the other plan does not have this "birthday" rule but instead has a rule based on the gender of the parent and as a result the plans do not agree on which is primary, then the father's plan shall be primary.

D. If a dependent child is covered by both parents' plans, and the parents are separated or divorced, and there is no court decree, which establishes financial responsibility for the child's health care expenses:

i. The plan of the parent who has custody (the custodial parent) shall be primary;

ii. If the custodial parent has remarried, and the child is also covered as a dependent under the stepparent’s plan, the custodial parent's plan shall pay first, the stepparent's plan second and non-custodial parent's plan third.

E. If a dependent child is covered under both parents plan, and there is a decree, which specifies the parent whom is responsible for the child's health care expenses, and that parent's Plan has actual knowledge of the decree, then that parent's plan shall be primary.

F. The plan covering the Insured Person as an active employee or the dependent of an active employee shall be primary. The plan covering the Insured Person as an inactive employee or the dependent of an inactive employee shall be secondary. If the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

G. If none of the above rules determines which Plan shall be primary, the Plan that has covered the Insured Person for the longest period of time shall be primary.

H. Notwithstanding the foregoing, for any person age 65 or older who is a Medicare eligible actively at work employee or spouse of an employee, the benefits of this Certificate will be considered primary to the benefits provided by Medicare, except as set forth in applicable law.

4. Effects of Coordination.

When THIS PLAN is secondary, the benefits of THIS PLAN will be reduced by the amount paid or provided by the primary Plan(s) for the same item of service. The amount THIS PLAN will pay or provide will not be more than the amount it would pay or provide if it were primary.

5. Payments to other Plans.

We may repay to any other Plan the amount it paid for your expenses and, which we decide we should have paid. These payments are the same as benefits paid to you and they satisfy our obligation to you under THIS Plan.

6. Our Right to Recover Overpayment.

In some cases we may have made payment even though you had coverage, which was primary, under another Plan. Under these circumstances, you agree to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover any overpayment from the other Plan and the Insured Person agrees to sign all documents necessary to help us recover any overpayment.

7. Coordination with "Always Excess," "Always Secondary" or Non-Complying" Plans.

We will coordinate benefits with Plans, which provide benefits, which are always excess or always secondary or use an order of benefit determination rules inconsistent with those described above ("non-complying Plans") in the following manner:

A. If THIS Plan is primary, we will pay or provide benefits first;

B. If THIS Plan is secondary, we will still pay or provide Benefits first, but the amount paid or Benefits provided will be limited to what we will pay or provide if we were secondary; and

C. If we request information from a non-complying Plan and do not receive it within thirty (30) days of our request, we can calculate the amount we should pay or provide on the assumption that the non-complying Plan and THIS Plan provide identical benefits. When the information is received, we will make the necessary adjustments.

SECTION THIRTEEN–THIRD PARTY LIABILITY AND RIGHTS TO REPAYMENT

1. Right to Subrogation. In the event that a Member suffers an injury or illness for which another party may be responsible, such as someone injuring the Member in an accident, and we pay benefits as a result of that injury or illness, we will be subrogated and succeed to the Member's right of recovery against the party responsible for the Member's illness or injury to the extent of the benefits we have paid. This means that we have a right independent of the Member to proceed against the party responsible for the Member's injury or illness and to recover the benefits we have paid.

2. Duty to Cooperate with Us. Under certain circumstances, we are entitled to be reimbursed for the benefits that we have paid from a settlement or a judgment received by the Member from the party responsible for the Member's illness or injury. This and other penalties, which apply under certain circumstances, are noted below. Those circumstances are:

   A. The settlement or judgment the Member receives from the party responsible for the Member's illness or injury specifically identifies or allocates monetary sums directly attributable to expenses for which we have paid benefits; or

   B. The Member fails to cooperate with us in a proceeding against the party responsible for the Member's illness or injury to recover the benefits we have paid. We will pay all expenses associated with a legal action instituted by our initiative.

   The penalty for failing to cooperate with Subpart "2" immediately above is that the Member will be responsible to repay to us the amount of the benefits we have paid. We agree to invoke Subpart "2" only when the Member's illness or injury caused by third party results in our expenditure on the Member's behalf of an amount exceeding $500.00 under this Certificate.

SECTION FOURTEEN – INTERNAL APPEALS

1. Internal Appeals

   An "internal appeal" is an appeal submitted directly to MVP. You or a designee appointed by you may submit an Internal Appeal of any Adverse UM Determination.

   In all cases, you have the right to designate a representative for the purpose of initiating an Internal Appeal. To appoint a designee, you should contact MVP's Member Services

Department at 1-888-MVP-MBRS (1-888-687-6277) and follow the instructions provided.

You shall be afforded the opportunity to submit written comments, documents, records, and other information relating to your Internal Appeal. Moreover, upon request and free of charge you shall be allowed reasonable access to, and copies of all documents, records and other information relevant to your Internal Appeal.

Internal Appeals that pertain to clinical matters shall be reviewed by an appropriate licensed health care practitioner with appropriate training and experience in the field of medicine involved in your Internal Appeal.

Internal Appeals shall be reviewed by persons who were not involved in the UM determination process and who are not subordinate to those who made the prior UM determination. No deference shall be given to the determination made at the prior level of review.

Any written Adverse Determination Notice sent to you shall be deemed delivered as of the date it is sent by mail to you by MVP at the address provided on your Enrollment Application or at the last address provided to MVP pursuant to our policies and procedures.

You may submit your request for an Internal Appeal verbally or in writing by either calling MVP at 1-888-MVP-MBRS (1-888-687-6277) or writing to MVP Health Plan, Inc., at 625 State Street, Schenectady, New York 12305.

There are two (2) levels of Internal Appeal.

A. Level One Appeals - Mandatory Internal Appeals. Level One Appeals are "mandatory appeals." This means that you must commence and complete a Level One Internal Appeal (unless jointly waived in writing by you and MVP) before you may seek any other internal or external remedy, including External Review by the State of New York or civil action.

   MVP has two types of Level One Appeals:

   i. Expedited Level One Appeals. You may request an Expedited Level One Appeal if you are appealing an Adverse UM Determination related to Urgent Care or Concurrent Care Claims. You must submit your request for an Expedited Level One Appeal within one-hundred and eighty (180) days after your receipt of the Adverse Determination Notice.

      (a) MVP will make a decision within forty-eight (48) hours after receipt of the Expedited Level One Appeal.

      (b) We will notify you of our decision verbally and in writing within the timeframe set forth above. If MVP fails to notify you within the above timeframe, then this may be considered satisfaction of

your Mandatory Internal Appeal requirements. Additionally, if MVP fails to notify you within the above timeframe, we will reverse any Adverse UM Determination that was based upon Medical Necessity and/or because a service is deemed Experimental or Investigational

(c) Receipt of an Adverse Determination Notice from an Expedited Level One Appeal or expiration of MVP's time to make a decision regarding a properly commenced Expedited Level One Appeal shall satisfy your Mandatory Internal Appeal requirements.

(d) In the event you receive an Adverse Determination Notice following your Expedited Level One Appeal, you may, **in addition to any other legal remedy available to you**:

(i) Proceed directly to New York State External Review, if the Adverse Determination Notice is based upon Medical Necessity and/or because a service is Experimental or Investigational. In this case, the Adverse Determination Notice from MVP's Expedited Level One Appeal shall be deemed the Final Adverse Determination Notice for the purpose of initiating an NYS External Appeal;

(ii) Commence a MVP Standard Level One Appeal. In this case, if you timely commence a Standard Level One Appeal the time to file a NYS External Appeal shall be stayed until you receive a Final Adverse Determination Notice from your Standard Level One Appeal;

(iii) Commence a "voluntary" Expedited Level Two Appeal. Please be advised that commencing an Expedited Level Two Appeal does not stay your time to file a NYS External Appeal. In this case, the time to file a NYS External Appeal would run from your receipt of a Final Adverse Determination Notice from the Expedited Level One Appeal.

ii. Standard Level One Appeals. You may request a Standard Level One Appeal if you are appealing an Adverse UM Determination related to Pre-Service or Post Service Claims. Additionally, you may elect to commence a Standard Level One Appeal following an Adverse Determination from an Expedited Level One Appeal. You must request a Standard Level One Appeal within one hundred and eighty (180) days after your receipt of a written Adverse UM Determination Notice or a written Adverse Determination Notice from an Expedited Level One Appeal.

(a) MVP will make a decision regarding a Standard Level One Appeal within fifteen (15) days after receipt of the Appeal.

(b) We will notify you of our decision in writing within the timeframe set forth above. If MVP fails to notify you within the above

timeframe, then this may be considered satisfaction of your Mandatory Internal Appeal requirements. Additionally, if MVP fails to notify you within the above timeframe, we will reverse any Adverse UM Determination that was based upon Medical Necessity and/or because a service is deemed Experimental or Investigational.

(c) In the event you receive an Adverse Determination Notice following your Standard Level One Appeal, you may, **in addition to any other legal remedy available to you**:

(i) Proceed directly to New York State External Review, if the Adverse Determination Notice (denial) is based upon Medical Necessity and/or because a service is Experimental or Investigational. In this case, the Adverse Determination Notice from MVP's Standard Level One Appeal shall be deemed the Final Adverse Determination Notice for the purpose of initiating an NYS External Appeal;

(ii) Commence a "voluntary" Standard Level Two Appeal. Please be advised that commencing a Standard Level Two Appeal does not stay your time to file a NYS External Appeal. In this case, the time to file a NYS External Appeal would run from your receipt of a Final Adverse Determination" Notice from the Standard Level One Appeal.

B. Level Two Appeals - Voluntary Internal Appeals. Level Two Appeals are "voluntary appeals." This means that you are not required to commence a Level Two Appeal in order to pursue any other external remedy that may be available to you. Notwithstanding, if you are dissatisfied with the results of the Level One Appeal, MVP provides for a voluntary second level of Internal Appeal.

You may submit your request for a Level Two Appeal in the same manner as a Level One Appeal.

Your decision as to whether or not to submit a Claim to Level Two Appeal will have no effect on your rights to any other benefits under this Contract.

Level Two Appeals are reviewed by persons who are not subordinate to persons who conducted the Level One Appeal.

For those appealing an Adverse Determination from a Level One Appeal based on Medical Necessity or because a service is deemed Experimental or Investigational, please be advised that initiating a Level Two Appeal does not stay the time period to file an External Appeal with the State of New York. Notwithstanding, MVP shall stay any other statute of limitation or other defense based on timeliness during the time that any Level Two Appeal is pending.

MVP has two (2) types of Level Two Appeals:

i. Expedited Level Two Appeals. Expedited Level Two Appeals are only available if you have received an Adverse Determination from an Expedited Level One Appeal. You must submit your request for an Expedited Level One Appeal within one-hundred and eighty (180) days after your receipt of a written Adverse Determination Notice from Expedited Level One Appeal. MVP will review and respond to Expedited Level Two Appeals within the following timeframes:

   (a) MVP will make a decision regarding the Expedited Level Two Appeal within forty-eight (48) hours after its receipt.

   (b) We will notify you of our decision in writing within the timeframe set forth above.

ii. Standard Level Two Appeals. Standard Level Two Appeals are only available following an Adverse Determination from Standard Level One Appeal. You must submit your request for a Standard Level Two Appeal within one-hundred and eighty (180) days after your receipt of a written Adverse Determination from Standard Level One Appeal. MVP will respond to Standard Level Two Appeals within the following timeframes:

   (a) MVP will make a decision regarding the Standard Level Two Appeal within fifteen (15) days after its receipt.

   (b) We will notify you of our decision in writing within the timeframe set forth above.

SECTION FIFTEEN – EXTERNAL APPEALS

1. Your Right to External Appeal.

Under certain circumstances, you have a right to an external appeal of a denial of benefits. Specifically, if MVP has denied benefits on the basis that the health care service is not Medically Necessary or is an Experimental or Investigational treatment, you or a representative appointed by you may appeal that decision to an External Appeal Agent. An External Appeal Agent is an independent entity certified by the State of New York to conduct such appeals.

2. Your Right to Appeal a Determination that a Health Care Service is Not Medically Necessary.

If MVP has denied benefits on the basis that the health care service is not Medically Necessary, you may appeal to an External Appeal Agent if you can satisfy the following two (2) criteria:

A. The service, procedure or treatment must otherwise be a Covered Service under this Contract; and

B. You must have received a Final Adverse Determination through MVP's internal appeal process and MVP must have upheld the denial or you and MVP must agree in writing to waive any internal appeal.

3. Your Right to Appeal a Determination that a Health Care Service is Experimental or Investigational.

If you have been denied benefits on the basis that the health care service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

A. The service must otherwise be a Covered Service under this Contract; and

B. You must have received a Final Adverse Determination through MVP's internal appeal process and MVP must have upheld the denial or you and MVP must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life threatening or disabling condition or disease. A "life-threatening condition or disease" is one in 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, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

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

In addition, your physician must have recommended one of the following:

A. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (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); or

B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this Section, your physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

4. The External Appeal Process

If, through MVP's internal appeal process, you have received a Final Adverse Determination upholding a denial of benefits on the basis that the health care service is not Medically Necessary or is an Experimental or Investigational treatment, you have forty-five (45) days from receipt of such notice to file a written request for an external appeal. If you and MVP have agreed in writing to waive any internal appeal, then you have forty-five (45) days from receipt of such waiver to file a written request for an external appeal. MVP will provide an external appeal application with the Final Adverse Determination issued through MVP's internal appeal process or our written waiver of the internal appeal process.

You may also request an external appeal application from New York State by contacting:

1. New York State Department of Insurance at 1-800-400-8882, or its website at www.ins.state.ny.us; or

2. New York State Department of Health at (518) 486-6074, or its website at www.health.state.ny.us.

You must submit the completed application to State Department of Insurance at the address indicated on the application. If you can satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with this request. If the External Appeal Agent determines that the information submitted represents a material change from the information on which MVP based its denial, the External Appeal Agent will share this information with MVP in order to allow us the opportunity to exercise our right to reconsider our decision. If we choose to exercise this right, we will amend or confirm our prior decision within three (3) business days. Please note that in the case of an expedited external appeal (described below), MVP does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or MVP. If the External Appeal Agent requests additional information, it will have five (5) business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the health care service that has been denied poses an imminent or serious threat to your health, then you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and MVP by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns MVP's decision that the health care service is not Medically Necessary or approves coverage of an Experimental or Investigational treatment, MVP will provide coverage subject to the other terms and conditions of this Contract. Please note that if the External Appeal Agent approves coverage of an Experimental or Investigational treatment that is part of a clinical trial, MVP will only provide coverage for the costs of health care services required to provide treatment to you according to the design of the trial. MVP shall not be responsible for the costs 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.

The External Appeal Agent's decision is binding on both you and MVP. The External Appeal Agent's decision is admissible in any court proceeding.

MVP will charge Members a fee of fifty dollars ($50.00) for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. MVP will also waive the fee if we determine that paying the fee would pose an undue hardship. If the External Appeal Agent overturns the denial of benefits, the fee shall be refunded to you.

5. Your Responsibilities.

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested health care service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you consent to this in writing.

Under New York State law, your completed request for appeal must be filed within forty-five (45) days of either the date upon which you receive written notification from MVP that it has upheld a denial of Coverage or the date upon which you receive a written waiver of any internal appeal. MVP has no authority to grant an extension of this deadline.

SECTION SIXTEEN - TERMINATION OF COVERAGE

1. Generally.

Described below are the reasons why your coverage under this Contract may terminate. All terminations are effective at 12:01 a.m., on the date specified.

2. Termination of the Group Contract.

The Group Contract will continue for a period of one (1) year from the first Effective Date of Coverage and will automatically be renewed for one (1) additional year thereafter at each renewal date unless the Group Contract is terminated as set forth below.

A. At the option of your Group. At anytime for any reason during the Contract Year if your Group provides MVP with thirty (30) days advance written notice of their intent to terminate. Your coverage and the coverage of your Eligible Dependents with MVP will automatically terminate as of the date the group contract terminates. Your Group is responsible for notifying you of its decision to terminate its coverage with MVP.

B. At the option of MVP. For any of the following reasons:

i. Your Group has failed to timely pay premiums required under the Group Contract. In this case, your coverage and the coverage of your Eligible Dependents will end on the date to which the premium has been paid;

ii. Your Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Group Contract. In this case, your coverage and the coverage of your Eligible Dependents will terminate on the date that we provide your Group with notice of the termination;

iii. Your Group has failed to comply with a material term relating to the employer contribution and group participation rules as set forth in the Group Contract and as permitted under Section 4235 of the Insurance Law. In this case, your coverage and the coverage of your Eligible Dependents will terminate on the date that we provide you with notice of such event;

iv. If we discontinue the entire class of contracts to which this Group Contract belongs. In this case, your coverage and the coverage of your Eligible Dependents will terminate no sooner than ninety (90) days from the date that we provide you with notice of our intent to discontinue this Group Contract;

v. If we withdraw from the applicable market through which you obtained coverage under this Group Contract, and we cease offering any products in that market. In this case, your coverage and the coverage of your Eligible Dependents will terminate six (6) months from the date we provide you with notice of such termination;

vi. Your Group ceases to meet the requirements for a Group under Section 4235 of the Insurance Law or, if applicable, a participating employer, labor union, association or other entity ceases membership or participation in your Group. In this case, your coverage and the coverage of your Eligible Dependents will terminate on the date your group ceases to meet the requirements of a Group or the date that membership or participation (as described above) ceases;

vii. Your Group relocates outside MVP's Service Area. MVP may also terminate the Group Contract if there are no longer any Subscribers who live, work or reside within MVP's Service Area or in an area where MVP is authorized to do business; or

viii. If your Group purchased a Point of Service (POS) Contract along with an HMO Contract, and your Group's POS Contract is terminated, then this Contract shall automatically be terminated.

3. Termination Of Your Coverage Under This Contract

In the following instances, the Group Contract will continue in force, but the Member's coverage will be terminated.

A. Upon your Election. Coverage for you and your Eligible Dependents shall terminate on the date to which premium has been paid;

B. The Subscriber is no longer an eligible member of Group. Coverage shall terminate for you and your Eligible Dependents on the date to which premiums have been paid;

C. The Member commits Fraud or makes an Intentional Misrepresentation in applying for Coverage or in Filing a Claim with MVP. Coverage will terminate thirty (30) days from the date in which we provide notice to the Member of our decision to terminate pursuant to this Subpart. If the individual who committed the Fraud or made the Intentional Misrepresentation was the Subscriber, then coverage for the Subscriber's Eligible Dependents shall also terminate thirty (30) days from the date of notice to the Subscriber of our decision to terminate pursuant to this Subpart;

D. On Your Death. Coverage under this Certificate will automatically terminate on the date of your death. If you are covered as the Dependent of the Subscriber, then your coverage shall also terminate automatically upon your death or the death of the Subscriber;

E. Termination of Marriage. If you are the Subscriber under this Certificate with Dependent coverage and you become divorced or your marriage is annulled, the coverage of your Dependent wife or husband will end automatically on the date the decree is actually filed. In such case, you should immediately notify your Group of the change in your marital status;

F. Termination of Coverage of a Child. Coverage of your Dependent Child under this Certificate will automatically terminate on the date the child no longer qualifies as a Dependent Child as set forth in Section Three of this Certificate.

SECTION SEVENTEEN – POST TERMINATION OF COVERAGE ISSUES

1. Extension of Benefits For Total Disability.

A. Total Disability or Totally Disabled, for purposes of this Section shall mean, a condition when, by reason of accidental injury or illness, a working Member is not able to perform the tasks of any employment. If a non-working Member, he is

unable, due to accidental injury or illness, to engage in the normal activities of a person of the same sex and age.

B. If you are, in MVP's Medical Director's or his/her designee's sole discretion, Totally Disabled while covered by this Certificate, Coverage for that specific disabling condition will be continued, upon termination of Coverage, during a continuous period of Total Disability. Coverage shall continue for the lesser of:

i. the period for which the Member is, in MVP's Medical Director's or his/her designee's sole discretion, Totally Disabled;

ii. twelve (12) months from the date that the Member's Coverage is terminated; or

iii. until the Member is covered by other insurance or group health plan, which provides coverage for the disabling condition, whichever occurs first.

2. Continuation of Coverage under Federal 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 employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Members should call or write their Group or us to find out if they are entitled to temporary continuation of coverage under COBRA.

If you are not eligible for temporary continuation coverage under COBRA, then you may still be eligible for temporary continuation coverage under New York Law.

3. Continuation of Coverage under New York State Law.

If you have lost coverage under this Certificate because of termination of employment or membership in the class or classes eligible for Coverage, you may be eligible for Continuation Coverage for yourself and, if you have Dependent Coverage, your Eligible Dependents subject to the following conditions:

A. You are not entitled to Medicare; and you are not covered under or eligible for other group coverage, which does not exclude or limit coverage for pre-existing conditions.

B. You have requested Continuation Coverage within sixty (60) days after the later of: (i) the date of termination or (ii) the date you are given notice of your right to Continuation Coverage by your Group. If you seek Continuation Coverage as set forth in Subpart "D, (iv)" immediately below, you must notify and submit a completed application to MVP within sixty (60) days after termination that you were disabled under the Social Security Act at the time of termination of your employment or membership.

C. You must pay the premium (not more frequently than monthly) when due. The first payment is due within sixty (60) days after the date coverage would otherwise terminate. The premium cannot exceed one-hundred and two (102) percent of the Group's rate.

D. Coverage will terminate at the earliest of the following:

i. The date eighteen (18) months after your Coverage would have terminated because of termination of employment or membership.

ii. If you fail to make a timely payment, the date to which, premiums were paid.

iii. If you are an Eligible Dependent, the date thirty-six (36) months after Coverage would have terminated due to: death of the subscriber; divorce or legal separation; the subscriber's eligibility for Medicare; your failure to meet the definition of a "dependent child" as defined in this Contract.

iv. The date twenty-nine (29) months after your Coverage would have otherwise terminated because of employment or membership if you are determined to have been disabled under the Social Security Act at the time of termination of employment or membership. However, if you are no longer disabled, Coverage will terminate the later of: eighteen (18) months after your Coverage would have terminated because of termination of employment or membership or the first day of the month that begins more than thirty-one (31) days after the determination that you are no longer disabled.

v. The date your Group no longer provides coverage to any of its employees or members.

4. Your Right To A Conversion Contract.

If your coverage under this Certificate ends, you may be entitled to purchase a direct pay statutory conversion product, subject to the conditions set forth below.

A. Eligibility. You may be eligible to convert to an individual direct pay contract, if:

i. You have lost eligibility for coverage because of termination of employment or membership in the class or classes eligible for coverage under the policy;

ii. You are an Eligible Dependent and have lost eligibility due to: the death of the Subscriber; divorce or annulment of the marriage from the Subscriber; or attaining the limiting age of coverage.

B. We do not have to offer you the right to conversion coverage if:

i. The Group Contract from which you seek conversion has been replaced with similar and continuous coverage whether on an insured or self insured basis; or

ii. You have or have available to you other health benefits coverage that would result in over-insurance or duplication of benefits according to the standards

on file with and approved by the New York State Superintendent of Insurance; or

iii. You have not been insured under the Group Contract from which you seek conversion for at least three (3) months (not applicable to Eligible Dependents who are entitled to conversion coverage pursuant to Section Seventeen, Subsection 4A(ii)); or

iv. You are covered by Medicare, by reason of age. Moreover, the converted policy may provide for termination of coverage thereunder on any person when he is or could be covered by Medicare, by reason of age; or

v. For such other reasons, including, but not limited to, prior termination of your Group Contract based upon acts of fraud or intentional misrepresentation, as the Superintendent of Insurance shall approve.

C. Notice: You must apply for conversion coverage within forty-five (45) days after coverage under this Certificate would otherwise terminate. If a notice is sent more than fifteen (15) days but less than ninety (90) days after the date of termination, you will have forty-five (45) days after receiving the notice to apply for conversion coverage. If no notice is given, the right to conversion expires at the end of ninety (90) days from the date of termination.

D. How to convert from this Contract. To convert this Group Contract and maintain coverage, you must do two things: complete an application for a new direct payment contract, and pay us the premium for the new contract within forty-five (45) days after Coverage ends, except if the time is extended under Subpart "C" above. If this is done, the new contract takes effect as soon as coverage under this Group Contract ends.

SECTION EIGHTEEN – FURTHER TERMS OF THIS CERTIFICATE

1. Assignment. You cannot assign your right to receive benefits or to bring legal action against us to any person, corporation or other organization. Any such assignment shall be voidable by MVP.

2. Notices. Any notice 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. Your Medical Records And Health Information. 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 complaints/appeals 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 complete an enrollment application with MVP and/or access services for which you seek benefits under this Certificate, you authorize MVP and each provider

who provides such services to use your *protected health information* for its *treatment, payment and health care operations* and for purposes otherwise permitted by applicable state and federal law (text set forth in *italics* above, shall be defined in a manner consistent with the provisions set forth in 45 CFR Parts 160 and 164).

4. Changes to this Certificate. At the time of Coverage renewal (your Group's Anniversary Date), MVP may modify the Coverage offered under this Certificate. There is no vesting of benefits for Covered Services under this Certificate. This means that absent regulatory or contractual provisions to the contrary, as of the Effective Date of a reduction, modification or change in this Certificate, you are entitled to receive only the level and type of benefits and Covered Services that are in effect as of that date, regardless of whether you previously had been receiving a higher level or type of benefit or Covered Services. Any modification, amendment, or change to this Certificate, shall be made in writing and signed by our Chief Executive Officer or Chief Financial Officer. MVP shall not be bound to any promise, verbal or written, regarding coverage under this Certificate made by any party other than our Chief Executive Officer or Chief Financial Officer.

5. Who Receives Payment Under this Certificate. Payments for Covered Services provided by a Participating Provider will be made by us directly to the Participating Provider. When Covered Services are provided by a Non-Participating Provider, either in an Emergency Care situation or upon prior approval from MVP, we may at our discretion make payment either to you or the Non-Participating Provider who performed the services.

6. Legal Action. No legal action may be maintained against us prior to exhaustion of the Level One Internal Appeal Process described in Section Fourteen of this Certificate (unless jointly waived in writing by you and MVP). You must commence any civil lawsuit against us within two (2) years from the latter of: (A) the Final Adverse Determination rendered by MVP for all benefit claims or (B) the date of the alleged actionable event. Service of 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.

7. Venue for Legal Action. You must start any lawsuit against us in a court in New York. 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.

8. MVP's Relationship with Participating Providers. MVP and Participating Providers have an independent contract relationship. Providers are not agents or employees of MVP and MVP is not an agent or employee of any provider. This Certificate does not require any particular provider to accept you as a patient and we do not guarantee such acceptance by any particular provider. Participating and Non-Participating Providers are solely responsible for all services rendered or not rendered to Members. MVP does not control the treatment or other professional actions of providers. MVP's decisions relate only to whether we will provide benefits under this Certificate and are not a substitute for the professional judgment of your provider.

9. Identification Cards. Possession of a card confers no automatic right to benefits. To be eligible for benefits, you must be listed on a completed enrollment form submitted to and accepted by us and your premiums must be paid in full.

10. Construction and Interpretation of this Certificate. Except as otherwise provided by law or regulation, MVP has the authority to determine to whether and to what extent Members are entitled to coverage and benefits and to construe disputed or unclear terms under this Certificate. MVP shall be deemed to have properly exercised such authority unless it acts arbitrarily and capriciously. In the event of any dispute or question concerning enrollment, eligibility, coverage, or other terms and conditions, this Certificate shall control.

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

12. Recovery of Overpayments. If we overpay you for a claim for Covered Services or if we determine that payment was made in error, we may, at our sole option, recover any overpayment or reduce other Benefits by the amount of such overpayment or payment in error. You agree to remit such amounts to us promptly upon request. In addition, if we overpay a Provider who or which renders covered services to you, or if we determine that payment to such a Provider was made in error, you agree to cooperate with us in recovering such overpayment. 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 sixty (60) days. We have the right to subtract any amount you owe us from any payment we make to you or your assignee (including benefits payments made to a Participating Provider).

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

14. Choice of Law. Unless federal law applies, this Certificate shall be governed by the laws of New York.

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

16. Statement of ERISA Rights.

    If your health plan is covered by the Federal Employee Retirement Income Security Act of 1974 ("ERISA"), you are entitled to certain rights and protections, described below.

    ERISA provides, among other things, 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 work sites

and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

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

qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

F. 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 as applicable). 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 as applicable).

G. Qualified Medical Child Support Orders. MVP shall enroll any otherwise eligible child, as defined in your Group or Subscriber Contract, for whom the Subscriber or Certificate-Holder has been ordered to provide dependent health insurance coverage pursuant to a Qualified Medical Child Support Order, as that term is defined in 29 USCA Section 1169. Coverage shall be subject to all the same rules and conditions set forth in the Group or Subscriber Contract with respect to obtaining benefits.