SKIDMORE COLLEGE PPO MEDICAL PLAN

Summary Plan Description

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SECTION 1 - INTRODUCTION

This document is the Summary Plan Description (SPD) for the employer Skidmore College ("Skidmore") PPO Medical Plan, known as the PPO Medical Plan ("Plan"). The Plan is a self-insured health plan subject to federal law under the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. MVP Health Care, Inc. ("MVP") provides certain administrative services for the Plan, as described in this document.

The Skidmore College PPO Medical Plan is considered a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act and will maintain compliance with all Health Care Reform requirements.

Skidmore College can amend, modify, suspend or terminate the Plan at any time and for any reason. The Plan may be amended by publication of a replacement SPD or summary of material modification. If this Plan is amended or you receive other information about your benefits, keep those materials in one place with this SPD for easy reference.

Effective January 1, 2016, MVP administers the benefit plan described in the following pages for Skidmore College PPO Medical Plan. This SPD will help you to understand:

- What services can be covered under your benefit plan option;
- When you must contact MVP for approval before receiving services;
- How and when you can submit a claim for consideration;
- What services are not covered under the Plan, and what other limitations on coverage may apply; and,
- How and when you can submit an appeal if your claim is denied or reduced.

If you have any questions about your coverage or about how to use the Plan, you can contact MVP's Customer Care Center at 1-800-229-5851, Monday through Friday from 8 a.m. to 6 p.m. eastern time, excluding major holidays. **If needed, translation services are available.** You can also go to our website at www.mvphealthcare.com for more information.

SECTION 2 - ELIGIBILITY

Eligibility Requirements for Employees

To be eligible for coverage under this Plan, an Employee must fall into one of the following categories:

1. A full-time Employee or contracted of Skidmore College. An Employee is considered to be full-time if he or she normally works or is credited at least thirty (30) hours per week and is on the regular payroll of Skidmore for that work, and
2. A regularly scheduled part-time employee of Skidmore College who works a minimum of 1, 365 hours per year in a 12 month position; or
3. A part time employee of the company who has one (1) year or more of service and works less than 1, 365 hours per year; or
4. A Pre-Medicare retiree of Skidmore hired on or before September 3, 2008;
5. Covered Academic Employees while they are on approved paid leave or sabbatical;
6. A shared employee who performs a substantial portion of his or her duties in a position that is classified as a full-time position by Skidmore College (i.e. a position in which an employee would normally work or is credited with at least thirty (30) hours per week);
7. Completes the employment waiting period as an Employee.

An eligible Employee covered under this Plan who continues to meet the eligibility requirements will be referred to as a Plan Participant.

Eligibility Requirements for Spouses

Spouse – means the person to whom a Plan Participant is legally married, as determined by both State law and the Tax Code. Thus, your spouse is the person with whom you are eligible to file a joint Federal income tax return. The Plan does not recognize a spouse by common-law marriage.. A legally separated (pursuant to a decree of separation) or divorced former Spouse of the Plan Participant is eligible for coverage under this Plan in accordance with COBRA continuation coverage requirements.

Domestic Partner – To cover an eligible Domestic Partner of the same or opposite gender, the Plan Participant must submit, and MVP must accept, a complete Domestic Partnership Declaration. Briefly, to be a qualified Domestic Partner, you and your Domestic Partner must:

- Have shared the same household for at least six (6) consecutive months and intend to continue to do so indefinitely; Registration as a domestic partnership or a Domestic Partnership Declaration (you can obtain an affidavit from the Plan or from MVP);
- Be engaged in a committed relationship of mutual caring and support and intend to remain so indefinitely,
- Share responsibility for each other's common welfare and living expenses;
- Share financial interdependence;
- Confide yourselves to be life partners;
- Not be married (as defined by law); to, or in a committed relationship with, or legally separated without a dissolution of marriage from, anyone else;
- Not have had another Domestic Partner enrolled in the Plan within the prior twelve (12) months;
- Both be over 18 years old and mentally competent to consent to a contract;
- Not be related by blood to a degree or closeness that would prohibit marriage;
- Not be in the relationship solely for the purpose of obtaining health care coverage; amend
- Not have been previously legally married to each other while covered under the Plan.

The Plan Administrator shall have the right to request any form of documentation or evidence of the required relationship in order to administer the requirement set forth above. A list of acceptable documentation may be obtained from the Plan Administrator upon request. If coverage of a Domestic Partner is terminated under this SPD, then you must wait twelve (12) months before enrolling another Domestic Partner under this SPD.

Eligibility Requirements for Children and Dependents

Children and dependents of Employees and their Spouses, or Children of Domestic Partners are eligible for coverage through the last day of the month in which the eligible child reaches the age of 26,or older if they are disabled and meet the requirements set forth below:

- **Biological children, adopted children and children legally placed for adoption.** If you are divorced, you may enroll these children even if you are not the custodial parent. With respect to adoption, a child who has been placed with the Plan Participant for adoption and for whom the Plan Participant has assumed and retained a legal obligation to support. A child who has been placed with the Plan Participant for adoption and for whom the Plan Participant has assumed and retained a legal obligation to support.

- A child for whom the Plan Participant has been ordered to provide dependent health insurance coverage pursuant to a Qualified Medical Child Support Order, as defined by federal law, even if the child does not live with the Plan Participant.

- **Your Stepchildren,** including your Spouse's biological children, adopted children an children legally placed with him or her for adoption If your Spouse dies while your Stepchildren are enrolled in the Plan, you may continue their coverage as long as:

- You have been granted custody of them by Court Order;
- They are your dependents under the Internal Revenue Code (Tax Code); and
- They continue to live with you and rely on you for principal support.

- **Children of your Domestic Partner**: the child of the Plan Participant's Domestic Partner if the child lives with the Plan Participant.[and the Domestic Partner is enrolled in coverage]

- **Children in Legal Guardianship,** including grandchildren, siblings, nieces, or nephews for whom the court has granted you, your Spouse, or Domestic partner full and plenary Legal Guardianship for them and their estate. As long as you remain legal Guardian until your child reaches the age of 26, eligibility for coverage may continue the age of 26.

- **Mentally or Physically disabled children past the normal age limit**, provided they:
    - Become disabled before age 26
    - Were enrolled for health coverage under the Plan before age 26 and have remained continuously enrolled since then,
    - Are incapable of self-sustaining employment due to their disability,
    - Are chiefly dependent on you for support and maintenance,
    - Permanently reside with you,
    - Are eligible to be claimed as your dependents for federal income tax purposes, and
    - Are unmarried

To continue a disabled child's coverage past the normal age limit, you will be required to apply for coverage within 30 days after his or her 26 birthday and each Calendar Year thereafter, in order for the child's coverage to continue under the Plan. As part of the enrollment process, you must provide medical documentation substantiating the child's disability. In addition, the Plan Administrator may request any additional documentation deemed necessary to fully implement these requirements.

If the disabled child is approve for coverage, your employer may require you to provide proof that the child continues to be disabled at reasonable intervals, that meets the requirements set forth herein. Skidmore has the right to have the child examined by a doctor of Skidmore's choice at the expense of Skidmore to determine the existence and duration of her or his disability.

The Plan Participant must provide the Plan Administrator with a physician's certification, within thirty-one (31) days of the Dependent child reaching the limiting age, and each Calendar Year thereafter, in order for the child's coverage to continue under the Plan. The Plan Administrator can require you to provide documentation verifying that the child continues to qualify under this section.

Who is not Eligible under this SPD.

a. Any other persons not defined under the terms of the Plan, and as set forth in the SPD, as eligible.

b. A current Plan Participant may not be covered as a Dependent under the plan.

c. If both a husband and wife are Plan Participants, their children may be covered as eligible Dependents of the husband or of the wife, but not of both.

Eligibility Requirements for Rehired Employees

The Plan Administrator will treat a terminated employee who is rehired as a new hire on consistent terms with the Affordable Care Act (ACA). A returning employee who is classified as a new employee (pursuant to ACA) will be required to meet all eligibility and enrollment requirements. The same break-in-service rules under ACA will apply to Plan Participants returning to the Plan from COBRA coverage offered by the employer.

SECTION 3 - ENROLLMENT AND EFFECTIVE DATES

Initial Enrollment

You must follow the Plan Administrator's instructions for enrollment. The Plan will provide paper enrollment forms for you to sign and return.

For an initial enrollment, you and/or your Dependents will be covered as of the date *all* of the following are met:

- The Plan Participant meets all eligibility requirements,
- Eligible Dependents meet the requirements under the plan; and
- You have completed all enrollment requirements, and paid any required premium contribution. The Plan Administrator will provide information regarding the required pre-tax contribution amount during open enrollment.

Open Enrollment

You may enroll or add eligible Dependents without restriction during your employer's Open Enrollment period. Check with the Plan Administrator for information about open enrollment.

Changes to your elections

The requested change must be on account of a Change in Status, i.e., Qualifying Event, that affects eligibility for coverage for you, your Spouse, or eligible Dependent under an employer's plan consistent with the qualifying event.

Enrollment of Plan Participant's New Family Members

You may add eligible Dependents during a period other than Open Enrollment as follows:

To add a Spouse – You and your Spouse must fill out and return an enrollment form or any other requested documentation, and make any required contribution to the Plan Administrator. If you do so within thirty (30) days of the marriage, your Spouse will be added to your coverage effective as of the date of the marriage. If you do not complete the process before the end of the thirty-day period, coverage for your Spouse will be deferred until the first of the month following the next contribution due date after the next Open Enrollment period Provided the enrollment process has been completed.

To add a child –
If you have Plan Participant plus child or children coverage or family coverage, an eligible child, as defined under eligibility requirements for children, will automatically be covered from the moment of birth for forty-eight (48) hours following a vaginal delivery or for ninety-six (96) hours for a cesarean delivery. If you want to continue the child's coverage beyond this period, you must comply with the requirements as noted below. If you do not follow this procedure, the Plan will not provide coverage beyond the forty-eight (48) or ninety-six (96) hours, whichever is applicable. The Plan Administrator must be notified of the Qualifying event for this coverage to become effective.

If you have individual coverage, or Plan Participant plus child (one dependent) coverage that already covers an eligible child, your newborn child (natural or adoption) will not automatically be covered from the moment of birth. Under this coverage, you must comply with the next paragraph in order for the child to be covered from the moment of birth. If you do not follow this procedure, the Plan will not provide coverage for your additional eligible child.

- You must complete and return an enrollment form, any requested documentation, and the required contribution within thirty (30) days of the qualifying event and within the terms of the eligibility requirements for children set forth herein for, your child to be added to your coverage. If you satisfy these requirements, your child will be covered from the date of the qualifying event continuously for the duration of the applicable coverage period. Failure to meet requirement within the thirty-day period, coverage for your child will be delayed until the first (1st) of the month following the next contribution due date after the next open enrollment period provided the Plan Administrator gets the completed form, requested documents, and applicable contribution. . The following modification of coverage terms will apply as follows:
  - The Plan will not provide Benefits for a newborn child placed with you for adoption if a natural parent of the child has insurance coverage available for these services.
  - If a notice of revocation of adoption is filed or one of the natural parents revokes their consent to the adoption, the Plan will be entitled to recover the amount of Benefits provided by us.

To add a child for whom a court has ordered you to provide dependent health insurance coverage pursuant to a Medical Child Support Order ("MCSO"), you must mail the Plan Administrator a copy of the MCSO, by first class mail, postage prepaid. The Plan Administrator will make a determination as to whether the order is a Qualified Medical Child Support Order under the terms of the Plan and notify you and the affected children of the determination, in writing, within fifteen (15) days of receipt of the order. If the child is eligible for coverage, the Plan will enroll the child as of the later of: (1) date of the Plan Administrator's determination, or (2) the date the Plan Administrator receives any required contribution for the child. You may request a list of the requirements that apply to the MCSO to be classified as a Qualified Order under the Plan

Special Enrollment

You, your spouse and Dependents are eligible to enroll during a special enrollment period. In this case, you, your Spouse, or eligible Dependent is not required to wait until the next open enrollment period provided you, your Spouse or your eligible Dependents apply for coverage within thirty (30) days after an applicable qualifying event.

If you, your Spouse or your eligible Dependent do not enroll either initially or during an open enrollment period, then you, your Spouse or your eligible Dependent ordinarily will be required to wait until the next open enrollment period to enroll in coverage. However, if you, your Spouse or your Dependent qualify for a special enrollment period then you, your Spouse, and/or eligible Dependent are eligible to enroll during the Special Enrollment period. To qualify for a special enrollment period you must meet one of the following conditions:

Loss of eligibility for other coverage

- You and/or the eligible Dependent you seek to enroll, including your Spouse, must have been covered under a group health plan or had other health insurance coverage at the time coverage was previously offered under this Plan; and
- You stated in writing that the other coverage was the reason for declining enrollment at the time coverage under this Plan was offered. This condition, however, must be met only if Skidmore required that this statement be executed in writing, and provided you with notice of this requirement (including the consequences of not executing the written statement) at the time coverage was offered; *and*
- Coverage under this Plan was applied for within thirty (30) days after such loss of coverage or termination; *and*

- the coverage was terminated or lost due to one of the following reasons:
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    - The coverage provided in accordance with COBRA continuation coverage, as required by state or federal law, and was exhausted;
    - Legal separation, divorce or annulment;
    - Cessation of dependent status as defined under Eligibility requirements;
    - Death of the employee;
    - Termination of employment;
    - Reduction in the number of hours of employment that affects eligibility status;
    - Employer contributions towards such coverage were terminated;
    - A plan no longer offers any benefits to the class of similarly situated individuals;

Loss of eligibility under Medicaid or Children's Health Insurance Program ("CHIP") program
If you your Spouse, and/or your eligible Dependent were covered under a state Medicaid or CHIP program and the coverage under such program is terminated as a result of loss of eligibility for such coverage AND you, your Spouse and/or your eligible Dependent apply for coverage under the Plan within sixty (60) days after the date of termination of such coverage;

OR

If you become eligible for Medicaid or Children's Health Insurance Program ("CHIP") program and
you, your Spouse and/or your eligible Dependent become eligible for group health plan premium assistance under a state Medicaid or CHIP plan AND apply for coverage under the Plan within sixty (60) days after the date you, your Spouse and/or your eligible Dependent is determined to be eligible for such assistance.

When enrolling pursuant to this Section, coverage under the Plan will commence as of the first date of the applicable coverage period following the qualifying event, provided the Plan Administrator receives timely premium payment on your behalf.

Eligibility During Periods of Disability, Layoff, or Leave of Absence

Ask the Plan Administrator for the applicable rules regarding continued eligibility as a Participant in the Plan during the periods stated above.

Obligation to Provide Information

You must provide the Plan Administrator with the necessary information to determine your initial and continuing eligibility status. This information must be provided within thirty (30) days of the date of request. The Plan Administrator has the right to verify the adequacy and usefulness of the information in meeting the specified need.

When you, your Spouse, or your child is no longer eligible

You must immediately notify the Plan Administrator of any event that affects your eligibility. These events include, but are not limited to, divorce or annulment, death of your Spouse, Medicare eligibility or coverage under another health contract, policy or certificate, or reaching the age at which eligibility terminates, and a change or termination of any Medical Child Support Order.

Enrollment Changes

To change your coverage (such as a change from family to individual coverage), you must return a completed change form and any requested documentation to the Plan Administrator within thirty (30) days of such event. If you do not provide the information to the Plan within this timeframe, your change in contribution will not be effective until the first of the month following the next contribution due date after the change becomes effective and after the receipt of the completed form and documentation.

SECTION 4 - HOW THE PLAN WORKS

As a Member in the Skidmore College PPO Medical Plan you have access to a comprehensive medical benefit program including doctor's visits, hospitalizations, surgery, emergency care, home health care, routine physical exams, well child care, well woman exams and mammography, mental health and substance use disorder, and prescription drugs *(pharmacy benefits administered through OptumRx).* The following information is intended to help you make the best use of this Plan.

1. The Preferred Provider Organization Plan Design ("PPO"). The PPO plan design provides two levels of Benefits for Covered Services depending on whether you obtain Covered Services from a Participating Provider ("In Network Services") or a Non-Participating Provider ("Out of Network Services"). Depending on your choice, costs will vary as shown on the Summary of Covered Services exhibit that accompanies this SPD. You can reduce your out-of-pocket costs by following the requirements for In-Network Benefits.

2. In Network Services. To receive In Network Benefits you must receive services from a MVP Participating Provider. Benefits for some Covered Services are available only when provided by a Participating Provider. These services are marked as **In Network Only** in bold. If you receive Covered Services other than as described below and other sections of this SPD, the Plan will provide the standards applicable to Out of Network Benefits, unless such services are otherwise excluded under the terms and conditions of this SPD.

   A. The Provider Network:
      You have access to a comprehensive national network (CIGNA) of participating physicians, hospitals, labs and other facilities, as well as other Providers through the MVP Participating Provider Network. You can search for Participating Providers through MVP's website at www.mvphealthcare.com, or contact MVP's Customer Care Center for assistance.

3. Out of Network Services. If you choose to receive Medically Necessary Covered Services outside of MVP's network of Participating Providers, you can still receive Benefits, but at a reduced level of coverage and at higher out-of-pocket costs to you. Most covered Out of Network Services are reimbursed at a percentage of the Allowable Charge after you have met your annual Deductible. If the Non-Participating Provider's charge is more than the Allowable Charge under the Plan, you will be responsible for paying one hundred (100%) percent of the difference between MVP's Allowable Charges and the Non-Participating Provider's Charges in addition to any Deductible or Coinsurance. Charges that are in excess MVP's Allowable Charges such additional/excess charge are not applied to your annual out-of-pocket maximum.

   Day and visit limitations indicated with regard to Covered Services, these contractual limitations apply whether the Covered Service are in the SPD and Summary of Covered Services accessed In Network or Out of Network.

4. Understanding the Plan's Benefits for Covered Services. Below are key terms and provisions that will help you understand how the Plan provides Benefits and your responsibility for Charges submitted to the Plan for Covered Services.

Your Payments:

Annual Deductibles. The plan has an Out of Network Deductible provision. Deductibles are listed on the Summary of Covered Services, and the deductible amounts must be satisfied before the Plan will provide any payments towards Benefits or services obtained and as provided in this SPD. Amounts in excess of the Allowable Charge do not count toward the Annual Deductible applicable to Out of Network services.

The Individual Deductible amount applies to each covered Member for each Calendar Year. Once the Individual Deductible has been satisfied, the Plan provides the prescribed coverage/payments for Benefits that are Covered Services for the Member under the terms of the individual coverage contract and according to the Summary of Covered Services.

The Family Deductible amount applies to you and all your eligible Dependents covered under the plan for each Calendar Year. If you and your eligible Dependents have met the Family Deductible amount, you and your eligible Dependents do not have to pay any further Deductible for the rest of the Calendar Year. Although no one family member needs to pay more than the individual deductible, you and your eligible Dependents cannot apply more than such amount of an Individual Deductible toward satisfying the Family Deductible amount.

Coinsurance/Copayments. Coinsurance and Copayments are listed on your Summary of Covered Services. When you access Covered Services from a Provider you must pay any applicable Copayment and Coinsurance directly to the Provider.

Annual Out-of-Pocket Maximums: This plan contains a separate medical and pharmacy out of pocket maximum provision as well as a separate in and out of network out of pocket maximum. An Out of Pocket Maximum limits your payments for Covered Services during the Calendar Year. Please see the Summary of Covered Services exhibit for the Plan's Out of Pocket Maximums.

When you have met Your Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for individual coverage in a Plan Year, as stated in the Summary of Covered Services exhibit, the Plan will provide coverage at 100% of the Allowed amount for Covered Services for the remainder of that Plan Year. If you have other than individual coverage, the individual Out-of-Pocket Limit amount will apply to each person covered under this plan. Once a person within a family meets the individual Out-of-Pocket Limit amount, the Plan will provide coverage at 100% of the Allowed Amount for the rest of that Calendar Year for covered services utilized by that person. If other than individual coverage applies, when persons in the same family covered under this Plan have collectively met the family Out-of-Pocket Limit amount through payment of Copayments, Deductibles and Coinsurance for a Calendar Year, as provided in the Summary of Covered Services exhibit, the Plan will provide coverage at 100% of the Allowed Amount for the rest of that Calendar Year for all covered family members.

The Plan's Payments.

Lifetime Maximum. Some Covered Services are subject to a maximum amount of Benefits available during each Member's lifetime. The Lifetime Benefit Maximum, if applicable, is listed on your Summary of Covered Services exhibit that accompanies this SPD. After you have reached the Lifetime Benefit Maximum for those Services, you must pay 100% of all Charges incurred after reaching the Lifetime Benefit Maximum. All other Covered Services will continue to be available under the terms and conditions of the Plan.

Annual Maximums. Some Covered Services are subject to annual limits on the number of visits for those Services during the Calendar Year. Once the Annual Maximum is reached, no further Benefits will be paid for those Services by the Plan for the remainder of that Calendar Year. All other Covered Services not subject to the annual maximum will continue to be available under the terms and conditions of this Plan. Applicable Annual Maximums are listed on the Summary of Covered Services.

5. Medical Necessity.

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

- Recommended by your treating physician; and
- Determined by MVP's Medical Director or physician designee to meet the following criteria:
  1. The service is appropriate and consistent with the diagnosis and treatment of your medical condition;
  2. The service is not primarily for your convenience, the convenience of your family, or your provider;
  3. The service is required for the direct care and treatment or management of that condition;
  4. The service is 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
  5. The service is rendered in the most efficient and economical way and at the most economical level of care that can safely be provided to you, the member.

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SECTION 5 - UTILIZATION MANAGEMENT AND CLAIMS FILING

This Plan requires Prior Notice, Prior Authorization, Concurrent Notice, and/or Concurrent Review by or to MVP before you receive certain Covered Services. All services are subject to Retrospective Review. Approval of services through Prior Authorization or Concurrent Review is not a guarantee of Benefits. MVP may deny Benefits if there is material misrepresentation or fraud by a Member, and as otherwise permitted by law. **Failure to comply with these requirements may result in the denial of Benefits. Such reduction in Benefits does not count toward your Deductible, Copayments or Coinsurance and will not be counted toward your Annual Out-of-Pocket Maximum**.

1. Prior Notice. You must give Prior Notice to MVP before you receive certain Covered Services from an Out of Network Provider. When you use an In Network Provider, your Provider gives Prior Notice. MVP does not review, approve or deny Benefits at that time. The call is necessary for MVP to establish a Concurrent Review schedule.

   A. Prior Notice is required for the following In Network and Out of Network Covered Services:

      1. All Elective Inpatient Admissions;
      2. All Surgical Procedures except office surgery;

   B. How to Give Prior Notice.

      1. Generally. You or your Provider must contact MVP's Utilization Management Department at 1-800-568-0458 at least forty-eight (48) hours before you get the services listed above. You or your Provider must provide MVP with your name, MVP ID number, Provider's name and address, the services you will be receiving, dates of service and your diagnosis. **It is your responsibility to make sure that Prior Notice is given when using an Out of Network Provider.**

   C. MVP's Response to Prior Notice. MVP will provide a written notice confirming the call.

2. Prior Authorization. Prior Authorization means the required approval that must be obtained from MVP before you receive certain Covered Services. MVP reviews information about your medical condition and the proposed services in order to determine whether such services are Medically Necessary Covered Services as described in this Summary Plan Description.

A. When Prior Authorization is Required. Prior Authorization is required for the following In-Network and Out-of-Network Covered Services:

1. Non-Emergency Land and Air Ambulance Services;
2. Bariatric Surgery;
3. Skilled Nursing Facility Services;
4. Transplant Services;
5. Home Health Care (Out of Network)
6. Durable Medical Equipment, External Prosthetic Devices, Orthotic Devices;
7. Genetic Testing;
8. Oral Surgery for TMJ (covered only for medically necessary conditions);
9. Facility Based Sleep Studies
10. In-Office Procedures being done in Ambulatory Surgery Setting
11. Transgender Related Care & Services

B. How to Obtain Prior Authorization.

1. Generally. To request Prior Authorization, you or your Provider must contact MVP's Utilization Management Department at 1-800-229-5851. You or your Provider must provide MVP with your name, MVP ID number, your Provider's name and address, the date that services are requested, and your diagnosis. If the request is Urgent, you or your Provider must tell MVP and describe the circumstances that make it Urgent. You or your Provider must contact MVP at least five (5) days before your proposed admission or service date. You or your Provider must notify us if your admission or service date changes. **It is your responsibility to make sure that Prior Authorization is given when using an Out of Network Provider.**

C. Response to Requests for Prior Authorization.

1. Urgent Matters. If the request for Prior Authorization is Urgent and you or your Provider properly identify to MVP that the request is Urgent, as defined in subparagraph (a) below, and describe the circumstances that make it Urgent, MVP will respond as described below. Requests and claims for Retrospective Review are excluded from this paragraph.

   (a) Cases where:

      1. Application of the time periods described in subparagraph 2 below:

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

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

         C. A physician with knowledge of your medical condition determines that a Prior Authorization request is Urgent.

   (b) If all necessary information is received at the time of the request, MVP will notify you by telephone, and you and your Provider in writing, of the determination within seventy-two (72) hours of MVP's receipt of the request, and you and your Provider, in writing, within three (3) days.

(c) If all necessary information is not received at the time of the request, MVP will notify you and your Provider within twenty-four (24) hours after MVP's receipt of the request of any missing information that is needed to make a determination on the request. You and your Provider will have forty-eight (48) hours from the receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you and your Provider, by telephone and in writing, of the determination within forty-eight (48) hours after the sooner of: (a) MVP's receipt of the missing information; or (b) the expiration of your time to provide the missing information.

2. Non-Urgent Matters.

(a) If all necessary information is received at the time of the Prior Authorization request, MVP will notify you and your Provider, in writing, of the determination, within fifteen (15) days of MVP's receipt of the request.

(b) If all necessary information is not received at the time of the Prior Authorization request, MVP will notify you and your Provider, in writing, of any missing information that is needed to make a decision on the request. You and your Provider will have forty-five (45) days from the receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you and your Provider, in writing, of the determination within fifteen (15) days after the earlier of: (a) MVP's receipt of the missing information; or (b) the expiration of your time to provide the missing information.

3. Concurrent Notice. Concurrent Notice means the notice you or your Provider must give to MVP while you are receiving certain Covered Services. MVP does not review, approve or deny benefits at this time. Your call is necessary for MVP to assign a length of stay or other concurrent review schedule.

A. When Concurrent Notice is Required. Concurrent Notice is required for the following In Network and Out of Network services:

1. Emergency Inpatient Admissions;
2. Inpatient Maternity Care (call after delivery)
3. Detoxification Admissions.

B. How to Give Concurrent Notice. You or your Provider must contact MVP's Utilization Management Department at 1-800-229-5851 within forty-eight (48) hours (or as soon as reasonably possible) after you begin receiving these services. You or your Provider must provide MVP with your name, MVP ID number, Provider's name and address, services you are receiving, date(s) of service, and your diagnosis. **It is your responsibility to make sure that Concurrent Notice is given.**

C. MVP's Response to Concurrent Notice. MVP will provide a written notice confirming the call.

4. Concurrent Review. Concurrent Review means MVP's review of a request to extend a course of treatment to determine whether such services continue to be Medically Necessary Covered Services. MVP will contact your provider. You must ensure that your Provider gives MVP the clinical information needed to conduct this review before the end of each period for which your Benefits were approved.

A. Response to Concurrent Review.

1. Urgent Matters.

(a) If all necessary information is received at the time of the Concurrent Review, MVP will notify you and your Provider, in writing, of the determination within twenty-four (24) hours after the review.

(b) If all necessary information is not received at the time of the Concurrent Review, MVP will deny benefits.

2. Non-Urgent Matters.

(a) Pre-Service.

1. If all necessary information is received at the time of the Concurrent Review and services have not yet been provided to you, MVP will notify you and your provider of the determination, in writing, within fifteen (15) days after the review.

2. If all necessary information is not received at the time of the Concurrent Review and services have not yet been provided to you, MVP will notify you and your Provider, in writing, of any necessary information that is needed to complete the review. You and your Provider will have forty-five (45) days from the receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you and your Provider, in writing, of the determination within fifteen (15) days after the earlier of: (a) MVP's receipt of the missing information; or (b) the expiration of your time to provide the missing information. Except in cases of missing information, MVP's time to complete this review shall not exceed a total of fifteen (15) days.

(b) Post-Service.

1. If all necessary information is received at the time of the Concurrent Review and services have already been provided to you, MVP will notify you and your Provider, in writing, of the determination within thirty (30) days after the review.

2. If all necessary information is not received at the time of the Concurrent Review and services have already been provided to you, MVP will notify you and your Provider, in writing, of any necessary information that is needed to complete the review. You and your Provider will have forty-five (45) days from the receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you and your Provider, in writing, of the determination within thirty (30) days after the sooner of: (a) MVP's receipt of the missing information; or (b) the expiration of your time to provide the missing information.

5. Retrospective Review. Retrospective Review means MVP's review, after services have been provided to you, to determine whether such services were Medically Necessary Covered Services and whether and to what extent benefits are payable.

A. When Retrospective Review is Required. MVP will conduct Retrospective Review on all claims.

B. How to obtain Retrospective Review

1. In Network Services. When you obtain services In Network, the Provider will submit your claim and bill MVP directly.

2. Out of Network Services. When you obtain services Out of Network, in most cases, the Provider will bill you directly. In such cases, you must pay the Provider and request reimbursement from MVP or submit the Provider's bill and request that MVP pay the Provider. In either case, you must submit your claim to MVP by following the Claims Submission instructions below. In some cases, the Provider will bill MVP directly. In such

cases, the Provider must submit a claim to MVP by following the Claims Submission instructions below.

C. MVP's Response to Retrospective Review.

1. If all necessary information is received at the time of the claims submission, MVP will notify you of any adverse determination, in writing, within thirty (30) days after MVP's receipt of the claim.

2. If all necessary information is not received at the time of the claim, MVP will provide you and your Provider, within thirty (30) days after MVP's receipt of the claim, a fifteen (15) day notice of extension and a description of any missing information that is needed to decide the claim. You and your Provider will have forty-five (45) days from receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you of any adverse determination, in writing, within fifteen (15) days after the earlier of: (a) MVP's receipt of the missing information; or (b) the expiration of your time to provide MVP with the missing information.

6. Claims Filing.

A. Submit a properly completed claim form to MVP. You may request claims forms by contacting your Plan Administrator or MVP at 1-800-229-5851. You may also request or download claim forms by visiting MVP's web site at www.mvphealthcare.com.

B. Mail your properly completed claim forms, with any bills and receipts, by first class mail, postage prepaid, to MVP at:

Medical & Alternative Health Benefit
MVP Select Care, Inc.
P.O. Box 2207
Schenectady, New York 12301

Or, for Behavioral Health Claims:
Value Options
P.O. Box 1408
Latham, NY 12110

All bills must include the name of the Plan, the Member's name, the patient/Member's name, MVP ID number, the Provider's name, address and telephone number, the diagnosis, the types of services rendered, with diagnosis and procedure codes, the date(s) of service, and the Provider's Charges.

C. The Plan will provide Benefits for claims submitted only within the following guidelines: (1) if the claim is submitted by a Participating Provider, then one hundred and eighty (180) days from the date services were provided or as otherwise stipulated in the fee agreement between the Participating Provider and MVP, except when coordination of benefits applies and this Plan is the secondary payer; or (2) if the claim is submitted directly by you, your non-physician designee or a Non-Participating Provider, then two (2) years from the date services were provided, except when coordination of benefits applies and this Plan is the secondary plan. If your claim is subject to Coordination of Benefits, as described in your SPD, and this Plan is your secondary plan, you must submit your claim to MVP within two (2) years of the date of the final statement from your primary plan.

7. Right to Appeal. If you disagree with the determination on claims made under this section, you may file an appeal as described in the Appeals section of this SPD.

SECTION 6 - BENEFITS

The following are benefits that may be available to you, subject to all conditions and exclusions set forth in this SPD. The Plan will provide Benefits only if a Covered Service is Medically Necessary, unless otherwise provided for in this SPD. Please consult the Summary of Covered Services exhibit to determine whether the following benefits are provided by your employer and your responsibility for any cost-sharing in connection with the benefits.

For In-Network services, you must pay the applicable Deductible, Copayment and Coinsurance listed on your Summary of Covered Services. For Out of Network Services, you must pay the applicable Deductible and Coinsurance listed on your Summary of Covered Services. Additionally, if you receive services Out of Network, you must also pay one hundred (100%) percent of the difference, if any, between MVP's Allowable Charges and the Non-Participating Provider's Charges.

Benefits with a ☎ symbol require that you obtain Prior Authorization or give Notification or Concurrent Notice. Refer to Section 5, Utilization Management, to determine if Prior Notice, Prior Authorization, and/or Concurrent Notice is required in order for any of the following to be considered Covered Services. To request Prior Authorization, you or your Provider must contact the MVP Utilization Management Department at 1-800-568-0458.

HOSPITAL AND OTHER FACILITY SERVICES

Autologous Blood. Available if you require a major surgical procedure to be performed where blood replacement is frequently necessary. Limited to cost of the actual donation procedure.

Inpatient Physical Rehabilitation Care. Available when such services are Acute Services provided by a facility licensed to provide inpatient physical rehabilitation services or by a unit of a Hospital designated as providing such services. Please refer to the Summary of Covered Services for any benefit limits.

Inpatient Hospital Services. The following are available if you are receiving Services as a registered inpatient in a Hospital and are under the care of a licensed physician. Please refer to the Summary of Covered Services for any benefit limits.

A. Semi-private room;
B. Board and general nursing services;
C. Use of operating, recovery, delivery, endoscopic and treatment rooms and equipment;
D. Use of intensive care or special care units and equipment;
E. Dressings and casts;
F. Diagnostic Services, Supplies and Equipment;
G. Therapeutic Services;
H. Equipment, and supplies in connection with oxygen, anesthesia, and pathology services;
I. Laboratory Services;
J. Medical and surgical supplies; and
K. Therapy Services.

Hospital Outpatient Cardiac Rehabilitation Care. Available when such services are Acute Services and are provided by a Hospital or free standing facility. Please refer to the Summary of Covered Services for any benefit limits.

Outpatient Hospital Services:

Pre-admission testing. Tests given to you before your admission to a Hospital will be covered if:

A. Your physician has ordered the tests;

B. An operating room and inpatient bed at the Hospital have been reserved prior to performance of the tests;
C. Surgery occurs within seven (7) days of the tests; and
D. You are physically present at the Hospital for the tests.

Outpatient Therapeutic Services.
A. Radiation Therapy - the use of x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes for treatment of disease;
B. Chemotherapy and Cancer Hormone Therapy - the 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;
C. Dialysis - the removal of waste materials when a Member has acute kidney failure or chronic, irreversible kidney deficiency, and the use of equipment and disposable medical supplies. Benefits for Dialysis will continue until you become eligible for Medicare;
D. Infusion Therapy - the treatment of disease by injection of curative agents;
E. Inhalation Therapy - the inhalation of medicine, water vapor and/or gases to treat impaired breathing;
F. Items used in and provided by the Hospital or facility when performing Therapeutic Services, such as prescribed drugs, medications, serum, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items.

Outpatient Diagnostic Services. Services ordered by a physician and used in, or provided by, a Hospital or facility to determine a definite condition or disease. These include, but are not limited to, radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, PET scan, MRIs, CAT scan, electroencephalograms (EEG), electrocardiograms (ECG), and body scans.

Outpatient Laboratory Services. Services ordered by a physician for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital, Alternate Facility or in a Physician's office. *Out of Network Laboratory Services order by a participating provider will be covered with no cost share or balance billing.*

Outpatient Therapy Services. Physical, occupational and speech therapy services. See description under the Other Professional Services heading.

Gynecological Health Care Services. Gynecological health care services means preventive and routine reproductive health and gynecological care. Such services include annual screening, cervical cytology screening, contraceptive services, evaluation of breast masses, gynecological dermatological conditions, gynecological oncology, genetic counseling, infertility/gynecologic endocrinology, urological conditions, urological evaluation for infertility in patient's spouse, high risk pregnancy referral to perinatologist, counseling and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists and the termination of pregnancy. Includes coverage for follow-up services required as a result of problems identified during such visits.

Bone Mineral Density Measurements or Tests. Bone mineral density measurements or tests for Members who meet the criteria under the Federal Medicare Program or the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, Members qualifying for Coverage shall include:

A. Members previously diagnosed as having osteoporosis or having a family history of osteoporosis;
B. Members with symptoms or conditions indicative of the presence of osteoporosis, or the significant risk of osteoporosis;
C. Members on a prescribed drug regimen posing a significant risk of osteoporosis;
D. Members with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
E. Members of such age, gender and/or other physiological characteristics, which pose a significant risk for osteoporosis.

Renal Dialysis. Hemodialysis or peritoneal dialysis, when provided in a Hospital or freestanding facility, which has an operating certificate issued by the New York State Department of Health, pursuant to Article Twenty-Eight (28) of the New York State Public Health Law or, if provided outside the State of New York, a comparable certificate or license for the state where services are rendered, as follows:

A. Dialysis treatment on a walk-in basis if the program is approved by the appropriate governmental authorities.
B. For home treatment, the Plan covers the reasonable rental cost of equipment, plus all appropriate and necessary supplies required for home dialysis treatment when ordered by your physician. Coverage will not include any furniture, electrical, or other fixtures or plumbing needed to perform the dialysis treatment at home.
C. For these home and facility based Services to be covered, the treatments must be provided, supervised, or arranged by the physician and you must be a registered patient of an MVP approved kidney disease treatment center.

The Benefits for ambulatory and home dialysis have no time limit, and continue until you become eligible for Medicare.

Outpatient Surgery. Available for Hospital and facility charges for surgery. Surgery means generally accepted invasive, operative, and cutting procedures. This includes, but is not limited to specialized instrumentation, endoscopic examinations, colonoscopies and correction of fractures and dislocations, and the pre- and post-operative care usually rendered in connection with such procedures.

Outpatient High End Radiology. The plan will provide for high end radiology and diagnostic services including but not limited to Outpatient High End Radiology (CAT Scans, PET Scans, MRI's and Nuclear Medicine Scans).

EMERGENCY CARE/SERVICES

Emergency Ambulance Services. Airborne and non-airborne Ambulance Services to a Hospital, when used for an Emergency Medical Condition. Coverage is only for transportation to the nearest appropriate facility. Covered service for air ambulance is limited to emergencies where local ambulance service is not available or appropriate *(☎ See also Non-Emergency Ambulance Transport Services under the "Special Services" section.)*

Emergency Services. Facility and Physician benefits are available In Network or Out of Network.

A. Emergency services provided by a Participating or Non-Participating Provider mean Medically Necessary Covered Services to evaluate and treat an Emergency Medical Condition.

B. You, your Provider, or a member of your family must call MVP at 1-800-229-5851, within forty-eight (48) hours, **if you are admitted** to the Hospital after you have received Emergency services.

Urgent Care. Urgent care services provided in and out of your network.

PHYSICIAN SERVICES

Allergy Injections. The repeated administration of specific allergens to patients for the purpose of providing protection against the allergic symptoms and inflammatory reactions associated with natural exposure to the allergens.

Allergy Testing. Testing needed to confirm the presence of specific antibodies. Standard methods of testing with proven efficacy are covered when medically indicated and performed by a licensed professional.

Anesthesia Services. Available when provided by a Provider in connection with Covered Services. *Out of Network Anesthesia Services order by a participating provider will be covered with no cost share or balance billing.*

Breast Cancer Care. The Plan will provide Benefits for mastectomy and treatment of physical complications of mastectomy, including but not limited to, such as lymphedema, lymph node dissection, or lumpectomy for the treatment of breast cancer. Following a mastectomy covered under the plan the Plan will provide Benefits for all stages of reconstruction of the breast on which the mastectomy was performed. The Plan also will provide Benefits for surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined appropriate by your Provider after consultation with you. The Plan also will provide Benefits for breast prostheses required as a result of covered Breast Cancer Care that is covered by the plan.

Chemotherapy, Radiation. See description in Outpatient Hospital Services section under the Hospital and Other Facility Services heading.

Delivery of Covered Services Using Telehealth

If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review, quality assurance requirements, and other terms and conditions of the Contract that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You when your location is different than your Provider's location.

Laboratory Services, X-Rays, Medical Diagnostic Services. Available when provided in a Provider's office or an approved facility covered by the plan.

Nurse Visits. In a Provider's office.

Physician Consultations in Office. Inpatient or office consultations by Providers when requested by your attending physician for the evaluation of your condition.

Physician Inpatient Hospital Visits. Visits in conjunction with a medically necessary admission.

Physician Office Visits. Available for the examination, diagnosis, and treatment of an injury, illness or condition and laboratory services provided at the time of such visit. Coverage includes injections given during a covered office visit, such as desensitization treatments to alleviate allergies.

Physician Outpatient Consultations. Inpatient or office consultations by Providers when requested by your attending physician for the evaluation of your condition.

Physician Visits to Skilled Nursing Facility or Patient's Home. Available for the evaluation and treatment of your condition.

Second Opinions. Coverage for second surgical opinions when your Provider has made a recommendation on the need for covered elective Surgery. You are not required to have a second surgical opinion. The second opinion must be given by a board-certified specialist who examines you and who, by reason of his or her specialty, is competent to consider the proposed Surgery.

Coverage is also available for a second medical opinion from 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 for a recommended course of treatment for cancer.

Surgery. All settings.

Breast Reconstruction. Inpatient and outpatient services for the reconstruction of the breast on which a mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. These services will be performed in the manner that your attending physician, in consultation with you, determines is appropriate.

Office Surgery. Surgery and surgical care rendered in a Provider's office.

Oral Surgery Services. Oral surgery that is medical in nature. Includes coverage for related inpatient hospital charges when MVP deems the hospital setting to be medically necessary. MVP will pay as the secondary insurer in the event that you also have dental insurance. *(Removal of impacted wisdom teeth are covered.)*

Multiple Surgical Procedures. Charges for multiple surgical procedures will be a covered expense subject to the following provision. If more than one (1) eligible surgical procedure is performed at the same time, the Plan's reimbursement will be based on the full Allowable Charge for the primary procedure. The Plan's reimbursement for additional procedures may be reduced to one-half (1/2) of the Allowable Charge for the additional procedures.

Assistant Surgeon's Charges. If the services of an assistant surgeon are determined to be medically necessary, the Plan's reimbursement for the assistant surgeon's covered charge will be limited to twenty (20%) percent of the Allowable Charge for the surgical procedure.

MATERNITY CARE

Inpatient Hospital Maternity Care. Inpatient Services for a covered mother and newborn for at least forty-eight (48) hours after a non-cesarean delivery or for at least ninety-six (96) hours after a cesarean delivery in a Hospital or birthing center. The Plan will provide Benefits for the services either of a physician or a certified nurse-midwife to perform the delivery and any necessary follow-up treatment. The attending physician, with the mother or mother's designated representative, may decide to discharge the mother sooner. The Plan will also provide Benefits for Medically Necessary Inpatient Services in connection with maternity care to the same extent that this Plan provides and covers such services in connection with illness or disease. The Plan will provide Benefits for home deliveries and certified nurse-midwife services.

If the Member opts to be discharged from the Hospital earlier than the time periods set forth above, she is entitled one (1) home care visit. She must request the home care visit from her 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, the Plan will provide the home care visit within twenty-four (24) hours after discharge from the Hospital or from the time of her request, whichever is later. A home care visit will be provided to the Member without charge and shall be in addition to any home care coverage to which the Member may otherwise be entitled under the Plan.

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

If additional medical or surgical services are determined to be Medically Necessary in connection with maternity care, they will be provided to the Member and covered under the Plan to the same extent that the Plan provides and covers such services in connection with illness or disease.

PREVENTIVE CARE

The Plan will provide Benefits for the following Preventive Care Services, subject to all conditions and exclusions set forth in this SPD. They do not need to be Medically Necessary. The Affordable Care Act (ACA) requires non-grandfathered plans to provide coverage for "preventive care" without cost sharing. (e.g., coinsurance, deductible or copayment) when the services are provided In Network.

Adult Routine Physical and Immunizations. Routine Physicals and work related travel immunizations (including Flu Shots) for covered persons.

Diagnostic Screening for Prostate Cancer. Screening performed in the outpatient department of a participating Hospital, facility, or Provider's office 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.

Well Child Care. For Dependent children from the date of birth to attainment of age twenty one (21). Well Child Care means an initial newborn check-up in the Hospital and well child visits. Well child visits include a medical history, a complete physical examination, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit. Such laboratory tests must be performed in the office or in a clinical laboratory. All well child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics. Well Child Care also includes immunizations against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type B, and hepatitis B, and other necessary immunizations (including immunizations for school and travel). Services not described above and services which exceed the frequency levels described above are not covered under Well Child Care benefit.

Well-baby and Well-Child Visits: Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21.

Well Woman Care.

Mammography Screenings. Mammography screening for breast cancer performed in a facility or Provider's office, 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 whose mother, sister or daughter has a prior history of breast cancer;
B. A single baseline mammogram for Members age thirty-five (35) to thirty-nine (39) years of age;
C. An annual mammogram for Members age forty (40) or older.

Primary and Preventive Obstetric and Gynecologic Services. Primary and preventive obstetric and gynecologic services from a qualified provider of such services for no fewer than two (2) examinations annually for such services or to any care related to pregnancy. Coverage includes follow-up services required as a result of such annual examinations.

Cervical Cancer Screening. Annual cervical cytology screening performed in the outpatient department of a Hospital, facility or in a Provider's office. This includes an annual pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

Additional Preventive Services. The Patient Protection and Affordable Care Act, or ACA defines preventive care services as follows:

a) Items or services recommended with an A or B rating by the U.S. Preventive Services Task Force
b) Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
c) Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
d) Preventive care and screenings for women supported by the Health Resources and Services Administration per the August 1, 2011 guidance includes, but not limited to, the following:

- Well-Woman visits
- Screening for gestational diabetes
- Human Papillomavirus Testing
- Breastfeeding support and counseling *(including breast pump and pump supplies)*
- Screening and counseling for interpersonal and domestic violence
- Counseling for sexually transmitted infections
- Counseling and screening for human immune-deficiency virus
- Contraceptive methods and counseling *(FDA approved contraceptive methods including implantable contraceptive devices, sterilization procedures and patient education and counseling for women with reproductive capacity. Please contact your Plan Administrator for pharmacy benefit information.)*

These Additional Preventive Services referenced above shall be covered without cost-sharing when received from In-Network Providers. Cost sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to non-preventative services that are provided during the same visit as the preventive services.. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will apply.

A list of the preventive services covered under this paragraph is available on MVP's website at www.mvphealthcare.com, or will be mailed to you upon request. You may request the list by calling the Customer Care Center number on your identification card.

OTHER PROFESSIONAL SERVICES

Acupuncture. An alternative treatment that is not covered unless specifically listed in your Summary of Covered Services. *(Available under the Alternative Health Care benefit. Please contact your Plan Administrator for more information.)*

Cardiac Rehabilitation in Office. Covered as listed in your Summary of Covered Services.

Chiropractic Treatment. Available if medically necessary and provided by a licensed chiropractor. Chiropractic services means services to detect or correct 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.

Coverage for Participation in Approved Clinical Trials The Plan will cover charges (including physician charges, labs, x-rays, professional fees and other routine medical costs) incurred due to participation in an Approved Clinical Trial conducted in relation to the prevention, detection or treatment of , to the treatment of cancer or other life-threatening diseases or conditions provided the charges are:

- Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under the Plan if the individual were not participating in the Approved Clinical Trail; and

- Not attributable to any device, item, service or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided or dispensed by the provider of the Approved Clinical Trial.

A Participant or Dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

- Satisfies the protocol prescribed by Approved Clinical Trial provider; and
- Either:

    i. The individual's network participating provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or

    ii. The individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

An Approved Clinical Trail means a Phase I, II, III or IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD) or the Department of Veterans Affairs (VA); (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services (HHS) determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Routine patient costs include all items and services consistent with the coverage provided by the Plan that are typically covered for a qualified individual who is not enrolled in a clinical trial

Excluded Expenses include:

- Expenses incurred due to participation in an Approved Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

- Expenses incurred at a non-network provider if a network participating provider will accept the patient in an Approved Clinical Trial.

- expenses incurred for travel, food and lodging;

Diabetes Education and Treatment. Diabetes education for proper self-management and treatment, limited to: visits Medically Necessary upon diagnosis of diabetes; where a physician diagnoses a significant change in a patient's condition which necessitates changes in self-management; or where reeducation or refresher education is necessary. Coverage for education will include home visits when Medically Necessary. Education may be provided by a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the New York Education Law or comparable legislation if services are provided outside the State of New York, or their staff; as part of an office visit for diabetes diagnosis or

treatment; or by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician; upon the referral of a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the New York Education Law or comparable legislation if services are provided outside the State of New York; provided that education provided by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician shall be limited to group settings wherever practicable.

Transgender Related Care & Services. ☎ Services related to or leading up to transsexual surgery, including but not limited to, hospital services, procedures, treatments or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender. (Hormone therapies covered under pharmacy benefit).

Health Education and Nutrition Counseling. Available when provided by Providers as part of a medical treatment program. Medical criteria may apply. *(Also covered under your Alternative Health Care benefit).*

Physical, Occupational, Speech Therapy Services. Available up to the visit limit when such services are Acute Services provided by a Provider or in the outpatient department of a Hospital or a facility.

Podiatry Care. Available for diabetics only. Routine foot care not covered.

INFERTILITY SERVICES

Infertility Services. The Plan will provide Benefits for Basic and Advanced Infertility Services.

The Plan will provide Benefits for Basic **and Advanced** Infertility Services for Members who are over age twenty-one (21) and under age forty-four (44) who have been unable to conceive after one year of unprotected intercourse or insemination. Coverage for infertility services is subject to the following conditions:

A. Diagnoses and treatment must be prescribed as part of a treating physician's overall plan of care and must be consistent with the guidelines established by MVP.

Basic Infertility Services. Includes the initial evaluation and testing for infertility including history and physical exam of female and male partner; education of both partners regarding fertility; semen analysis; endometrial biopsy; post-coital examination and laboratory screenings.

Advanced Infertility Services. Includes but is not limited to Laporoscopy and subsequent surgical treatments based on findings; Artificial insemination or intrauterine insemination (IUI), GIFT, and Zift services are covered. (Annual Limit $10,000)

No benefits are payable for the following advanced infertility treatments:

1. Reversals of vasectomies or tubal ligations;
2. External pump for the administration of infertility drugs;
3. Sperm banking; and
4. Gender selection

FAMILY PLANNING

Female Sterilization. The Plan will provide coverage for Female Sterilization as a covered in full benefit.

Intrauterine Device Insertion and Removal. The Plan will provide coverage for Intrauterine Device Insertion and Removal as a covered in full benefit as prescribed under Preventive Care Services. Device also is covered.

Vasectomy. Covered as surgery.

SPECIAL SERVICES

Dental. A dentist or dental surgeon's services for the treatment of an accidental injury to sound and natural **teeth are covered when services are provided within twelve (12) months of the accident or treatment** necessary due to congenital disease or anomaly. (Removal of impacted wisdom teeth is covered).

Home Health Care.

Home Health Agency. Means an organization licensed or certified by Medicare to operate as a Home Health Agency or certified under Article 36 of the New York Public Health Law, or if outside the state of New York, certified under a similar certification process required by the state where the services are provided.

Home Health Agency Services. Available up to the visit limit for following services.

A. Part time or intermittent nursing care by or under the supervision of a registered nurse.
B. Part time intermittent home health aide services, provided that such services consist primarily of caring for the patient and do not include Custodial Care.
C. Therapy Services if provided by Home Health Agency personnel. This means Acute Services, limited to physical therapy, occupational therapy, and speech therapy.
D. Supplies and drugs prescribed by a Provider and laboratory services, to the same extent that laboratory services would have been covered if you were an inpatient at a Hospital or Skilled Nursing Facility.

Conditions for Home Health Agency Services. When medically necessary, the Plan will provide Benefits for Home Health Agency services upon approval by MVP Health Care and if:

A. The services are supervised by a licensed physician under a written treatment plan;
B. The services are provided by a Home Health Agency;
C. Without these services you would need to be admitted to a Hospital or Skilled Nursing Facility; and
D. You or your designated representative consent in writing to the treatment plan.
E. Prior authorization is required for these services provided Out-of-Network. ☎

Hospice Services.

Hospice. Means an organization engaged in providing services to terminally ill persons that is federally certified to provide Hospice services or accredited as a hospice by the Joint Committee of Accreditation of Health Care Organizations. Also included are Hospice organizations certified pursuant to Article 40 of the New York Public Health law; or if the Hospice is located outside of New York, under a similar certification process required by the state in which the Hospice organization is located.

Hospice Services. The following services are available only once per each Member's lifetime:

1. Up to the day limit listed on your Summary of Covered Services exhibit provided by a Hospice in a Hospital or home setting.
2. Up to the visit limit listed on your Summary of Covered Services Exhibit for bereavement counseling for your family either before or after your death.

Conditions for Hospice Services. When medically necessary, the Plan will provide Benefits for Hospice services that include home care and outpatient services provided by the Hospice, including drugs and medical supplies, under the following conditions.

1. A licensed physician certifies and MVP agrees that your life expectancy is six (6) months or less; and
2. The Hospice services are supervised by a licensed Provider under a written Hospice care plan.

Non-Emergency Ambulance Transport Services. ☎ Available when services are Medically Necessary. Includes transportation to and from a Hospital, between Hospitals and between a Hospital and a Skilled Nursing Facility.

Skilled Nursing Facility Services. ☎

Skilled Nursing Facility. Means a licensed facility that provides twenty-four (24) hour inpatient skilled nursing care and related services. It is certified as a Skilled Nursing Facility by Medicare or accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations. A Skilled Nursing Home is also a nursing home defined in Section 2801 of the New York Public Health Law, or if located outside the state of New York, a comparable certificate or license for the state where the services are rendered. A Skilled Nursing Facility is not, other than occasionally, a place that provides minimal, custodial, ambulatory or part-time care services.

Skilled Nursing Facility Services. The Plan will provide Benefits for the inpatient services listed below for up to the day limit when medically necessary and approved. However, the days shall be consecutive. You may not select the day or days for which the Plan will provide Benefits. The Plan will provide Benefits for the day you are admitted, but not for the day you are discharged. If you are admitted and discharged on the same day, the Plan will provide Benefits for that day.

A. Room and board in a semiprivate room;
B. Skilled nursing care;
C. Drugs, medications, supplies and equipment used in and furnished by the Skilled Nursing Facility;
D. Other services provided by the Skilled Nursing Facility that would be covered if you were an inpatient in a Hospital.

Conditions For Skilled Nursing Facility Services. When medically necessary, the Plan will provide Skilled Nursing Facility Benefits if you are under the care of a licensed physician, you would otherwise need further Inpatient Services, and skilled nursing services are medically required to treat your condition.

Care that is most appropriately provided in a Skilled Nursing Facility but is provided on an inpatient basis in a Hospital may be covered under your Skilled Nursing Facility Benefits.

Palliative Care Services. The Plan will provide Benefits for Hospice services which shall include Palliative Care services for Members with a serious illness who may have a prognosis of more than six (6) months and may be pursuing curative interventions. For Palliative Care, the hospice Benefit will apply toward the Palliative Care Program. Each hospice day counts as two (2) palliative care days.

TMJ. ☎ If medically necessary and approved, coverage provided based on service rendered.

Transplant Services. ☎ Coverage is available for organ and bone marrow transplant services. You may obtain a description of our Network by calling the MVP Customer Care Center at 1-800-229-5851.

The Plan will also provide Benefits for live donor medical expenses up to your coverage limitations after payment of any applicable Copayments.

MVP does not provide Benefits for donor costs associated with transplant surgeries, unless, both the recipient and the donor are covered by us and legally related.

Bariatric Surgery. ☎ Coverage is available for medically necessary surgical treatment of morbid obesity. All bariatric surgical services require prior authorization and prior completion of a multidisciplinary weight management program. For more information or to obtain a description of the MVP Network, please contact the MVP Customer Care Center at 1-800-229-5851.

Infusion Therapy. Treatment of disease by injection of curative agents. May be performed in a physician's office, outpatient facility, or a home setting.

Vision Services: The Plan will provide Benefits for the following Vision Services, subject to all conditions and exclusions set forth in this SPD. The Plan will only provide Benefits if a Covered Services is Medically Necessary.

1. The Plan will provide Benefits for a Vision Exam once every two calendar years. A Vision Exam means an eye care exam for prescribing, fitting or determining your need for eye glasses or contact lenses.

2. Lenses, Frames and Hardware are covered up to the limit as noted on your benefit summary.

DME, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES ☎

Disposable Medical Supplies. Supplies that are primarily and customarily used only for a medical purpose, including but not limited to sterile bandages, cleansing solution and catheter supplies. These supplies will be appropriate for use in the home and are meant to be discarded after usage.

Durable Medical Equipment. ☎ Benefits for the purchase, rental, repair or replacement of Durable Medical Equipment authorized by a Provider and obtained from a Provider. The option of whether to rent or purchase authorized Durable Medical Equipment is at the sole discretion of the Plan. *(Includes insulin pump and pump supplies).*

External Prosthetic Devices. ☎ The Plan will provide Benefits for the purchase, repair and replacement of covered External Prosthetic Devices, as well as medical appliances, including external breast prostheses for Members who received covered Breast Cancer Care, and ostomy supplies, when authorized by a licensed physician. Replacement of external breast prostheses are covered once every two (2) Calendar Years, if replacement is Medically Necessary. Custom prosthetics will not be covered if a standard device exists, unless a custom device is Medically Necessary.

Orthotics. ☎ The Plan will provide Benefits for Orthotics that are medically necessary.

Foot Orthotics. The Plan will provide Benefits for custom made foot orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot, when Medically Necessary up to the limit listed on the Summary of Benefits.

Wigs. Covered following Chemotherapy up to the limit listed on the Summary of Covered Services.

Speech Generating Devices. Speech devices that provide an individual with severe speech impairment the ability to meet his or her functional speaking needs. Speech generating devices produce either digitized or synthesized speech, and should be considered medically necessary.

MENTAL HEALTH SERVICES

A Clinical Intake Specialist can help in selecting a Provider, carefully matching you with a Provider that meets your specific clinical requirements and is geographically accessible.

Mental Health Condition. Means a condition or disorder involving mental illness that falls under a diagnostic category listed in the mental disorders section of the International Classification of Disease

(ICD-CM-9), or the Diagnostic and Statistical Manual of Mental Disorders, as periodically revised. Mental Health Condition does not include:

a. Mental Retardation, provided however that we would provide Benefits for Acute Mental Health Services when other diagnoses are present;
b. Learning Disorders;
c. Motor Disorders;
d. Communication Disorders;
e. Dementia, provided however that we would provide Benefits for Acute Mental Health Services when other diagnoses are present;
f. Partner Relational Problems;
g. Academic Problems;
h. Religious or Spiritual Problems;
i. Acculturation Problems.

Mental Health Services. Benefits are available for the treatment of Mental Health Conditions for the services set forth below. All inpatient services require prior notice.

A. Inpatient Services.

For Covered Services accessed within New York State, for purposes of this subsection, "Hospital" is defined as the inpatient services 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. For Covered Services accessed outside New York State, comparable legislation will be reviewed.

Your Plan will also cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

B. Outpatient and Professional Services.

The Plan will cover outpatient mental health care services, including but not limited to partial Hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker with at least three years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof.

The following Benefits are available for outpatient mental health services:

1. Outpatient Provider visits;

2. Outpatient psychiatric emergency visits. A psychiatric emergency is defined as a situation in which a person appears to have a mental illness for which immediate observation care and treatment is appropriate and the absence of treatment is likely to result in serious harm to him or others.

3. Partial Hospitalization. (PHP) The Plan will provide Benefits listed in a structured therapeutic program that may be either attached to a hospital or free standing. The program may provide medical/psychiatric treatment services for a minimum of 6 hours a day 3 to 5 days per week, for members who require intensive treatment and structure.

4. Intensive Outpatient. (IOP) The Plan will provide a level of care in the continuum between day treatment and traditional outpatient treatment. IOP services provide comprehensive and coordinated treatment plans which include multiple services and modalities delivered in an outpatient setting with a minimum of 3 hours per day, 2 to 4 times per week. (No less than nine (9) hours per week).

Benefits shall be paid for the above-mentioned Services ONLY when such Services are performed and billed by a facility 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 when services are provided outside the State of New York.

SUBSTANCE USE DISORDER SERVICES

A Clinical Intake Specialist can help in selecting a Provider, carefully matching you with a Provider that meets your specific clinical requirements and is geographically accessible.

Substance Use Disorder. Means a disorder involving alcohol or substance use that falls as listed in the mental disorders section of the International Classification of Disease (ICD-CM-9), or the Diagnostic and Statistical Manual of Mental Disorders, as periodically revised. Substance use disorder does not include:

a. Caffeine Related Disorders
b. Nicotine Related Disorders

Substance Use DisorderServices. Your Plan provides Benefits for Acute Substance Abuse Conditions for the services set forth below.

A. Inpatient Services.

Detoxification Treatment for Alcohol and/or Substance Dependence. Active treatment for detoxification needed because of alcohol dependence or substance dependence. Within New York State, care must be received from an Office of Alcoholism and Substance Use Disorder Services (OASAS) certified facility. Outside New York State, care must be received in a facility whose alcoholism and/or substance use disorder treatment program has been approved by the Joint Commission of Accreditation of Hospitals.

Your Plan also will cover inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASES certified Facilities defined in 14 NYCRR 819.2(a)(1); and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; and in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

B. Outpatient and Professional Services. This Plan will cover outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance abuse, including methadone treatment provided at a facility or practitioner's office. Provided the person in need of treatment is a Member under this Plan, benefits are also available for family counseling visits. 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.

1. Partial Hospitalization. (PHP) The Plan will provide Benefits listed in a structured therapeutic program that may be either attached to a hospital or free standing. The program may provide medical/psychiatric treatment services for a minimum of 6 hours a day 3 to 5 days per week, for members who require intensive treatment and structure.

2. Intensive Outpatient. (IOP) The Plan will provide a level of care in the continuum between day treatment and traditional outpatient treatment. IOP services provide comprehensive and coordinated treatment plans which include multiple services and modalities delivered in an outpatient setting with a minimum of 3 hours per day, 2 to 4 times per week. (No less than nine (9) hours per week).

Within New York State, coverage is limited to facilities certified by the Office of Alcoholism and Substance Use Disorder Services or licensed by such Office as outpatient clinics or medically supervised ambulatory substance abuse programs or multidisciplinary group practices approved by MVP. In other states, coverage is limited to those facilities accredited by the Joint Commission on Accreditation of Hospitals as alcoholism or chemical dependence substance abuse treatment programs.

Coverage for Autism Spectrum Disorder. We will provide Benefits for the screening, diagnosis, and treatment of Autism Spectrum Disorder. Furthermore, we will not exclude any screening, diagnosis, or treatment on the basis that the individual is diagnosed with Autism Spectrum Disorder. Benefits will be subject to the same Copayments, Deductibles and/or Coinsurance as other similar coverage under this Plan.

A. Treatment of Autism Spectrum Disorder shall include the following care and Assistive Communication Devices prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist:

i. Behavioral Health Treatment;
ii. Psychiatric Care;
iii. Psychological Care;
iv. medical care provided by a licensed health care provider;
v. Therapeutic Care, including therapeutic care which is deemed habilitative or nonrestorative;
vi. Pharmacy Care if your group has purchased a prescription drug rider and your policy provides coverage for prescription drugs; and

B. The following definitions apply to this Benefit:

i. Autism Spectrum Disorder means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders. This includes autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder or pervasive developmental disorder not otherwise specified.

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

iii. Behavioral Health Treatment means counseling and treatment programs, when provided by a licensed provider, and Applied Behavior Analysis, when provided or supervised by a behavior

analyst certified pursuant to the behavior analyst certification board, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. Individuals that provide Behavioral Health Treatment under the supervision of a certified behavior analyst pursuant to this paragraph shall be subject to standards of professionalism, supervision and relevant experience pursuant to regulations promulgated by the Superintendent in consultation with the Commissioners of Health and Education.

iv. Diagnosis of Autism Spectrum Disorder means assessments, evaluations, or tests to diagnose whether an individual has Autism Spectrum Disorder.

v. Pharmacy Care means medications prescribed by a licensed health care provider legally authorized to prescribe under title eight of the education law.

vi. Psychiatric Care means a direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

vii. Psychological Care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

viii. Therapeutic Care means services provided by a licensed or certified speech therapist, occupational therapist social worker or physical therapist.

ix. Assistive Communication Device means a device that may include an item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a member diagnosed with Autism Spectrum Disorder. Coverage includes the services of a speech-language pathologist to conduct a formal evaluation to determine the need for an Assistive Communication Device(s). Based on the formal evaluation, we will provide coverage for the rental or purchase of an Assistive Communication Device when prescribed or ordered by a licensed physician or a licensed psychologist for a member diagnosed with Autism Spectrum Disorder who is unable to communicate through normal means, such as speech or in writing, when the evaluation indicates that an Assistive Communication Device is likely to provide the member with improved communication. We will determine whether the device should be purchased or rented.

Coverage is limited to dedicated communication devices which are devices that generally are not useful to a person in the absence of a communication impairment. Items such as laptops, desktops, or tablet computers are not covered items but software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech generating device is a covered item. Installation of the program and/or technical support is not separately reimbursable.

We will cover replacement or repair of the Assistive Communication Device and we will determine whether to repair or replace the particular device. Coverage includes replacement or repair of the device made necessary because of normal wear and tear, damage, loss or theft. Coverage for replacement or repair will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. We will not provide coverage for delivery or service charges or for routine maintenance. Prior approval of Assistive Communication Device is required. Refer to the prior approval procedures in your Contract.

C. Coverage may be denied on the basis that such treatment is being provided to the covered person pursuant to an individualized education plan under article eighty-nine of the education law. The provision of services pursuant to an individualized family service plan under section twenty-five hundred forty-five of the public health law, an individualized education plan under article eighty-nine of the education law, or an individualized service plan pursuant to regulations of the office for persons with developmental disabilities shall not affect coverage

under the policy for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed physician or licensed psychologist.

PRESCRIPTION DRUGS

Skidmore College has arranged for OptumRx Pharmacy Services to administer the Plan's prescription drug coverage, a summary of which is described below. For more detailed information on the Plan's prescription drug coverage, prior approval requirements or to file a claim for reimbursement, contact OptumRx directly at OptumRx Pharmacy Services, Inc. at 1- 800-788-4863.

This Pharmacy Plan contains a separate Out of Pocket Maximum provision. An Out of Pocket Maximum limits your payments for Covered Services during the Calendar Year. Please refer to the Benefit Summary below.

A. Formulary Generic and Brand Drugs. Each prescription for a generic drug (except generic drugs excluded under the OptumRx Drug Formulary) is subject to copayment/coinsurance per prescription item up to a thirty (30) day supply.

B. Non-Formulary Drugs. Each prescription for a drug that is excluded under the OptumRx Drug Formulary is subject to copayment/coinsurance per prescription item up to a thirty (30) day supply and may require prior authorization.

D. Mail Order Drugs. Each prescription for a mail order drug will be reviewed for medical necessity and must be for up to a 90 day supply and is subject to copayment/coinsurance per prescription.

SECTION 7 - EXCLUSIONS

In addition to any exclusions and limitations described in other sections of the SPD:

1. The Plan will not provide Benefits for the following Hospital and Skilled Nursing Facility services:

   A. A private room, unless it is Medically Necessary. If you stay in a private room when it is not Medically Necessary, you must pay the difference between the charge for the private room and the charge for a semi-private room.
   B. Any inpatient days that are for Custodial Care or social programs.
   C. Any inpatient days that are for diagnostic purposes, such as x-rays, laboratory tests, or physical checkups, unless approved as Medically Necessary.
   D. An inpatient stay while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available to you.

2. Services Not Covered. **The Plan will also not provide Benefits for the following**:

   A. Services Starting Before Coverage Begins. If you are receiving services on the day your coverage under this Plan begins, the Plan will not provide Benefits for any services you receive:

      i. Prior to your Effective Date; or
      ii. On or after your Effective Date if the service is covered or required to be covered under any other health benefits contract, certificate, summary plan description, program or plan.

      If the service is not covered and is not required to be covered under any other health benefits certificate, program or plan, the Plan will provide Benefits provided that you comply with the terms of the SPD.

   B. Non-Covered Services. Services not listed in the SPD as a Covered Service or any service that is related to services not covered under this SPD, even if such service is prescribed by your Provider. This includes services in excess of any limitations or maximums described in the SPD.

   C. Non-Medically Necessary Services. Services that are not Medically Necessary as defined in the SPD.

   D. Non-Provider Services. Services provided by a person or entity that MVP does not approve for the given service or who is not defined as a Provider. The Plan will not provide Benefits for services provided by a person who provides services as part of his or her education or training program.

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

   F. Athletic Equipment. Devices or equipment used primarily for the purpose of athletic activities.

   G. Alternative Services. Alternative or complementary health services, products, remedies, treatments and therapies including, but not limited to acupuncture, biofeedback (except for treatment of urinary or fecal incontinence), massage therapy, hypnosis and hypnotherapy, naturopathy, homeopathy, primal therapy, chelation therapy, carbon dioxide therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, aroma therapy, hair analysis, thermograms and thermography, yoga, meditation, and recreational therapy and any related diagnostic testing. (Your Plan provides for a separate Alternative Health Services benefit. Please refer to the Summary of Covered Services for benefit description).

H. Blood Products. Charges for whole blood, blood plasma, packed blood cells, or other blood products or derivatives if a volunteer blood replacement program is available. If a program is not available, the Plan will provide Benefits if billed by a Participating Provider. The Plan will also provide Benefits for administration and processing charges. The Plan will not provide Benefits for the storage and destruction of blood. The Plan will provide Benefits for autologous blood donations when they are Medically Necessary.

I. Certification Examinations. Except as specifically provided in this SPD, the Plan will not provide Benefits for any services related to routine physical examination, immunization and/or testing to certify health status, including, but not limited to, examinations required for school, employment, insurance, marriage, licensing, camp, sports, adoption, medical research, custody or divorce.

J. Chiropractic Services. Chiropractic services when such services are performed by a provider other than a licensed chiropractor, including but not limited to doctors of osteopathy.

K. Cosmetic Services and Surgery. Services or surgeries that are primarily intended to improve your appearance. Such services include, but are not limited to plastic surgery and scar repair surgery where no functional defect is present. The Plan will provide Benefits for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, including breast reconstruction and symmetry surgery. The Plan will also provide Benefits for reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

L. Court-Ordered Services. Court-ordered services, or for administratively-ordered services, such as by the Department of Motor Vehicles. Such services include, but are not limited to special medical reports not directly related to treatment and reports prepared in connection with legal actions unless they are Medically Necessary Covered Services and are obtained in accordance with MVP protocols regarding such treatment.

M. Criminal Behavior. Services related to intentionally self-inflicted injury or illness, or your participation in a felony, riot or insurrection. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition. The felony, riot or insurrection will be determined by the law of the state where the criminal behavior occurred.

N. Custodial Care. Custodial Care or for bed rest or convenience reasons.

O. Dental Services. Except for care or treatment due to accidental injury to sound natural teeth within twelve (12) months of the accident, and except for dental care or treatment necessary due to congenital disease or anomaly, the Plan will not provide Benefits for dental services. (Removal of impacted wisdom teeth are covered).

P. Dietician Services. Except as specifically provided in this SPD, the Plan will not provide Benefits for dietician services, homemaker services, home delivered meals, or other food or food-related services. (Your Plan provides for a separate Alternative Health Services benefit. Please refer to the Summary of Covered Services for benefit description).

Q. Educational and Vocational Services. Except as specifically provided in this SPD, the Plan will not provide Benefits for services required to determine appropriate educational or vocational placements or services or for other educational or vocational testing. The Plan 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 or vocational evaluations, including, but not limited to therapy services, cognitive retraining and

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

R. Employer Services. Services furnished by a medical department or clinic provided by your employer as part of your employment.

S. Experimental or Investigational Services. Except as specifically provided in this paragraph, the Plan will not provide Benefits for services which MVP determines are Experimental or Investigational Services. However, the Plan will provide Benefits for Experimental or Investigational Services if MVP determines: (a) that the proposed service has demonstrated promise in treating the underlying condition through a clinical trial sanctioned by the United States Food and Drug Administration see earlier section on Approved Clinical Trial); and (b) that an expert panel with quality assurance and technology assessment expertise has reviewed the proposed service and deemed it appropriate.

T. Exploratory Counseling. Exploratory counseling for personal growth and development or other similar reasons.

U. Family Services. Services provided by your immediate family.

V. Intentionally left blank.

W. Foot Care. Routine or palliative foot care, including but not limited to any services in connection with corns, calluses, flat feet, fallen arches, weak feet, toenails, chronic foot strain, or symptomatic complaints of the feet. However, the Plan will provide Benefits for Medically Necessary foot care.

X. Government Benefits. Services for which Benefits are available to you under any federal, state, or local government program, except Medicaid, but including Medicare to the extent it is your primary payer. This exclusion applies even if you fail to enroll, do not make a proper or timely claim, fail to pay the charges for the program, fail to appear at any hearing, or otherwise do not claim the Benefits available to you.

Y. Government Hospital. Services you receive in a hospital, facility or institution that 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, the Plan will provide Benefits for otherwise covered emergency services in such hospital, facility or institution if your condition is an emergency medical condition. The Plan will also provide Benefits for otherwise Covered Services provided to a veteran for non-service connected disability.

Z. Home Modifications and Fixtures and Home Appliances. Purchase, rental, repair, replacement or maintenance of home modifications and fixtures including but not limited to installation of electrical power, water supply or sanitary waste disposal, elevators, escalators, ramps, seat lift chairs, stair glides, handrails, swimming pools, whirlpool baths, home tracking systems, exercise or physical fitness equipment, air or water purifiers, central or unit air conditioners, humidifiers, dehumidifiers, and emergency alert systems and equipment, and business or vehicle modifications, or for services for evaluation, fitting or modification of such modifications and fixtures.

AA. Late Submitted Charges. The Plan will only provide Benefits for claims submitted within the following: (1) if the claim is submitted by a Participating Provider, then one hundred and eighty (180) days from the date services were provided or as otherwise stipulated in the fee agreement between the Participating Provider and MVP, except when coordination of benefits applies and this Plan is the secondary payer; or (2) if the claim is submitted directly by you, your non-physician designee or a Non-Participating Provider, then two (2) year from the date services were provided, except when coordination of benefits applies and this Plan is the secondary plan.

If your claim is subject to Coordination of Benefits, as described in your SPD, and this Plan is your secondary plan, you must submit your claim to MVP within two (2) years of the date of the final statement from your primary plan.

BB. Intentionally left blank.

CC. Military Service-Connected Illnesses, Injuries and Conditions. Services in connection with any military service-connected illness, injury, or condition if the Veteran's Administration is responsible for providing such services.

DD. No-Fault Automobile Insurance or similar Benefits. Services that are covered by mandatory automobile no-fault or similar Benefits or applied to the no-fault or similar deductible. This exclusion applies even if you do not make a proper or timely claim for Benefits available to you under any available no-fault or similar policy or if you fail to appear at any hearing. The Plan will also not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you receive money from that lawsuit and have repaid the medical expenses you received payment for under the no-fault or similar policy.

EE. Personal Hygiene and Comfort and Convenience Items and Services. Purchase, rental, repair, replacement or maintenance of personal hygiene or comfort and convenience items or provider services including, but not limited to, massage services, spa services, and other provider services, central or unit air conditioners, air or water purifiers, waterbeds, massage equipment, radio, telephone, television, beauty and barber services, commodes, furniture, hypoallergenic bedding, mattresses, dehumidifiers, humidifiers, hygiene equipment, saunas, whirlpool baths, exercise or physical fitness equipment, exercise programs or videos, emergency alert systems and equipment, handrails, heat appliances, and business or vehicle modifications, or for services for evaluation, fitting or modification of such items.

FF. Private Duty Nursing. Services provided by a private duty nurse unless specifically identified in your Summary of Covered Services.

GG. Intentionally left blank.

HH. Reversal of Elective Sterilization. The Plan will not provide benefits for reversals of elective sterilization unless specifically provided in the SPD.

II. Self-Help Education and Training. Except as specifically provided in the SPD, the Plan will not provide Benefits for self-diagnosis, self-treatment or self-help training.

JJ. Caffeine Cessation Services. Programs to help you alleviate caffeine dependence.

KK. Special Charges. Stand-by services, missed appointments, new patient processing, interest, copies of provider records, completion of claim forms, Provider's time to write reports, or postage, shipping, handling or tax.

LL. Support Therapies. Except as specifically provided in the SPD, the Plan will not provide Benefits for support therapies including, but not limited to, marriage counseling, pastoral or religious counseling, sex counseling, or other social counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, and play therapy.

MM. Terminated Coverage. Services rendered on and after the termination date of your coverage under this Plan unless termination occurs while receiving inpatient services.

NN. Intentionally left blank.

OO. Travel and Transportation Costs. Except as specifically provided in the SPD, the Plan will not provide Benefits for travel and transportation expenses and related expenses such as meals and lodging.

PP. Unlicensed Provider. Services provided by an unlicensed provider or those that are outside of a provider's scope of practice.

QQ. Utilization Management Compliance. Services that exceed the number of visits authorized in a referral, by Prior Authorization or Concurrent Review, or for services that exceed a day or visit limit described in the SPD.

RR. Vision and Examinations, Therapies and Supplies. Except as specifically provided in the SPD, the Plan will not provide Benefits for any services related to vision therapy or training, vision perception training or orthoptics, or for the correction of refractive errors by means of any surgical or other procedures, including radial keratotomy, or for services for disorder of vision correction or accommodations. However, the Plan will provide Benefits for Medically Necessary eye care.

SS. Weight Loss Services. Except as specifically provided in the SPD, services or programs in connection with weight reduction, dietary control, dietary supplements, and exercise classes, or for surgical weight loss procedures, unless it is in connection with Benefits for Medically Necessary Covered Services for the treatment of morbid obesity. MVP uses protocols to determine morbid obesity. (Your Plan provides for a separate Alternative Health Services benefit. Please refer to the Summary of Covered Services for benefit description).

TT. Wigs, Cranial Prostheses and Hair Replacements. Except as specifically provided in the SPD, the Plan will not provide Benefits for treatment for or replacement of hair loss, including wigs, toupees, hair pieces, hair transplants or any drug, supply, material, device, program or service that provides hair or promises hair growth, whether or not such item has been prescribed for you by your Provider. *(Wigs are covered following Chemotherapy).*

UU. Workers' Compensation. Services for which you have received or are eligible to receive Benefits under a workers' compensation act or similar law. This exclusion applies even if you do not receive such Benefits because you did not submit a proper or timely claim for Benefits or because you fail to appear at a hearing. The Plan also will not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the workers' compensation act or similar law.

VV. Coverage Outside the United States Canada or Mexico. Except for Emergency Services, the Plan will not provide Benefits for services accessed outside the United States, its possessions or the countries of Canada and Mexico.

WW. War and Terrorism. Services for injuries or sickness resulting from an act of terrorism or act of war (declared or undeclared).

XX. Coverage for injury or illness resulting from employment. Treatment for an injury, or illness that arises out of, or as the result employment for wage or profit, regardless of whether such treatment is covered by any Workers' Compensation or other similar coverage or if so covered, whether such treatment is found compensable there under.

YY. Self-Inflicted. Any loss due to an intentionally self-inflicted injury. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

ZZ. Intentionally left blank.

AAA. Communication Aids. The Plan will not provide benefits for the purchase, rental, repair, or replacement of communication aides. Communication aides that do not generate synthesized or digital speech are not covered. Examples of non-covered communication aides include the following: telecommunication devices for the deaf (TDDs), teletype machines (TTYs), Braille typewriters, flash cards, devices that allow the patient to communicate written/typed (rather than synthesized) messages to others.

BBB. Hearing Aids. The Plan will not provide benefits for the purchase, repair or replacement of hearing aids.

CCC. Prescription Drugs. Except as specifically provided by the SPD, the MVP Medical Plan will not provide Benefits for prescription and non-prescription drugs except for: (i) those that are administered to you in the course of covered outpatient or inpatient treatment in a Hospital or Skilled Nursing Facility, through Covered Home Care or Hospice Services, or for immunizations; (ii) medical foods prescribed for the Medically Necessary treatment for an inherited metabolic disease if otherwise covered under the SPD; and (iii) drugs prescribed for the Medically Necessary treatment of diabetes if otherwise covered under the SPD.

DDD. Diabetic Supplies. Except as specifically provided in the SPD, the MVP Medical Plan will not provide Benefits for test strips and control solutions, urine testing strips, insulin, lancets and automatic lancing devices, insulin cartridges for the visually impaired, insulin syringes and injection aids under the MVP medical Plan. Services may be covered under separate pharmacy benefit plan. Please contact your Plan Administrator for more information.

SECTION 8 – APPEALS

Depending on the circumstances explained below, you may have internal and/or external appeal rights if you receive an adverse benefit determination in connection with a claim for benefits. An appeal means a written or verbal expression of disagreement with the adverse determination submitted by or on behalf of a Plan Participant or Member regarding benefit matters governed by this document. It includes requests to change a determination that services are not Medically Necessary, experimental / investigational or are not Covered Services. You, your appointed representative (such as a family member, friend, or lawyer), or a Provider acting on your behalf, may submit an appeal. You must call MVP at 1-800-229-5851 in order to appoint a representative. Your decision as to whether or not to submit an appeal has no effect on your rights to any other Benefits under this Plan. At your request and free of charge, MVP will provide you with reasonable access to and copies of documents, records, and other information relevant to your appeal. First and Second Level Internal Appeals are mandatory. This means that you must commence and complete the First Level and Second Level Appeals process before you may seek any other internal or external remedy, including court action.

I. INTERNAL APPEALS

1. Internal Appeal Reviewers.

   A. First Level Internal Appeals. Internal medical appeals are reviewed by one of MVP's medical directors. Non-medical appeals are reviewed by MVP's Vice President of Health Services Medical Affairs; the Vice President of Member Advocacy and Quality Administration; or another member of MVP's staff with the necessary education and experience to decide the matter. First level appeals are reviewed by persons who were not involved in making the initial decision, and who are not subordinate to such persons.

   B. Second Level Internal Appeals. Second level internal appeals are reviewed by a panel comprised of MVP medical and administrative staff. The members of this panel have the necessary education, training, and experience to resolve the matter. In some instances, MVP may also use independent organizations to provide medical specialists practicing in the same or similar specialty as consultants for the particular appeal. Second level appeals are reviewed by persons not involved in making the initial decision or the first level appeal decision, and who are not subordinate to such persons. More information about the panel reviewing your appeal will be included in MVP's written response to the appeal.

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

3. Time Limit for Submitting a First Level Internal Appeal. You must submit a first level appeal within one hundred eighty (180) days of receiving MVP's decision regarding the matter that is the subject of the appeal. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral appeal by calling MVP at 1-800-229-5851. You may submit a written appeal to MVP Health Care, Attn: Member Appeals Department, 625 State St. Schenectady, New York 12305. If the appeal is Urgent, you must identify to MVP that it is Urgent and describe the circumstances that make the appeal Urgent.

4. MVP's Response to First Level Internal Appeals. MVP will respond to first level internal appeals as follows:

   A. Urgent Appeals:

1. In cases where application of the time periods described in subparagraph B below:
    a. Could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or
    b. Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or
2. A physician with knowledge of your medical condition determines that the appeal is urgent.

MVP will notify you of the decision within twenty-four (24) hours after MVP's receipt of the appeal. You will be notified of the decision both by telephone and in writing.

B. Non-Urgent Pre-Service Appeals. In cases where you have not yet received the services that are the subject of the appeal and you identify this to MVP, MVP will notify you of the decision within fifteen (15) calendar days after our receipt of the appeal. You will be notified of the decision in writing.

C. Non-Urgent Post-Service Appeals. In cases where you have already received the services that are the subject of the appeal, MVP will notify you of the decision within fifteen (15) calendar days after MVP's receipt of the appeal. You will be notified of the decision in writing.

5. Second Level Internal Appeals.

A. Time Limit for Submitting Second Level Internal Appeal. If you are not satisfied with the decision in response to the first level appeal, you may submit a second level appeal. You must submit this appeal within one hundred eighty (180) days of receiving MVP's decision in response to the first level appeal. You should describe the reasons you disagree with the decision, and provide any further information you think is relevant. You may submit an oral appeal by calling MVP at 1-800-229-5851. You may submit a written appeal to MVP Health Care Attn: Member Appeals Department, 625 State St. Schenectady, New York 12305. If the appeal is Urgent, you must identify to MVP that it is Urgent and describe the circumstances that make the appeal Urgent.

B. Right to Appear Before Appeals Panel. As described in paragraph two (2), second level appeals are reviewed by a panel. You also have the right to appear before the panel to discuss your appeal. If you cannot appear before the panel in person, you may communicate with the panel by conference call or other appropriate technology. You must notify MVP at the time of submitting your appeal if you wish to appear before or communicate with the panel. If the panel's next meeting date is not convenient for you, you may request that your appeal be heard at a later date.

6. MVP's Response to Second Level Internal Appeals. MVP will respond to second level internal appeals as follows.

A. Urgent Appeals:

1. In cases where application of the time periods described in subparagraph B below:

a. Could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or
b. Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or

2. A physician with knowledge of your medical condition determines that a Pre-Certification or concurrent review request is urgent.

MVP will notify you of the decision within forty-eight (48) hours after MVP's receipt of the appeal. You will be notified of the decision both by telephone and in writing.

B. Non-Urgent Pre-Service Appeals. In cases where you have not yet received the services that are the subject of the appeal and you identify this to MVP, MVP will notify you of the decision within fifteen (15) calendar days after our receipt of the appeal. You will be notified of the decision in writing.

C. Non-Urgent Post-Service Appeals. In cases where you have already received the services that are the subject of the appeal, MVP will notify you of the decision within fifteen (15) calendar days after MVP's receipt of the appeal. You will be notified of the decision in writing.

II. EXTERNAL APPEALS

Standard External Appeals. Under the following circumstances, you may request a standard External Appeal:

(a) If you have completed all levels of internal appeal of an adverse benefit determination (for reasons other than eligibility) and the adverse benefit determination was upheld, and/or

(b) If, at any point during the internal claim or appeal process, the Plan fails to adhere to the internal claims and appeals requirements outlined in this document.

Expedited External Appeals. Under the following circumstances, you may be eligible to file an expedited external appeal:

(a) If you receive an adverse benefit determination (claim denial) that:
- involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, and
- you have filed a request for an expedited internal appeal.

(b) If you receive a final adverse benefit determination (claim denial upheld on internal appeal) and:
- you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, or
- if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

How to File an External Appeal

Your External Appeal request must be received by MVP within four (4) months after the receipt of a notice of a final adverse benefit determination (the denial of your Internal Appeal).

You (or your authorized representative) may file your Appeal either verbally or in writing as follows:

- To file an Appeal, verbally, you can call MVP's Customer Care Center at 1-800-229-5851. You should have your claim denial notice, ID card and any other information you would like to have considered in connection with the Appeal with you when you make your call.
- To file a written Appeal, you can write a letter to MVP's Member Appeals Department stating your position. You must send the letter to MVP Health Care, Attn: Member Appeals Department, 625 State Street, Schenectady, NY 12305.

For more information on how to file an Appeal, including how to designate an authorized representative, contact MVP's Customer Care Center at 1-800-229-5851.

The Decision Makers

Within five (5) business days from the receipt of the External Appeal, MVP will complete a preliminary review of your request in order to determine your eligibility for an External Appeal. Within one (1) business day after completion of the preliminary review, MVP will issue to you or your authorized representative and an Independent Review Organization (IRO) written notification of your eligibility for an External Appeal. If your request is complete but it is not eligible for External Appeal, the notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to make the request complete and you will have an opportunity to provide such required information.

MVP will assign an eligible and complete External Appeal request to an IRO for purposes of conducting the appeal. Please note that the IROs are independent from MVP and MVP does not make External Appeal Determinations. MVP will maintain contracts with no fewer than three (3) IROs for assignments of External Appeal request, The assignments will be made in a random and unbiased manner.

The External Appeal Process

Standard External Appeals. Within five (5) business days after the External Appeal request has been assigned to an IRO, MVP must provide to the IRO the documents and any information considered in making the adverse determination that was made earlier. If MVP fails to timely provide the information, the IRO may terminate the External Appeal and reverse the adverse benefit determination. Thus, rendering a determination in your favor.

The IRO will review all of the information and documents timely received and it will not be bound by any decisions or conclusions reached during the Claims and Internal Appeal process. The IRO also will, to the extent the information and documents are available and the IRO considers them appropriate, consider other sources of information including, but not limited to, your medical records, your health care professional's recommendations, the terms of the Plan, appropriate industry practice guidelines, and clinical review criteria.

The IRO will provide, to you and the Plan, written notice of its decision within forty-five (45) days after it receives the request for the External Appeal. Upon receipt of a notice of a final External Appeal decision that reverses the final adverse benefit determination, the Plan will immediately provide coverage or payment for the claim.

Expedited External Appeals. Immediately upon receipt of the request for an expedited External Appeal, MVP will complete a preliminary review of your request in order to determine your eligibility for an External Appeal. Immediately after completing of the preliminary review, MVP will issue to you or your authorized representative written notification of your eligibility for an External Appeal. If your request is complete but it is not eligible for External Appeal, the notice will include the reasons

why the request is ineligible. If your request is incomplete, the notice will describe the information or materials needed to make the request complete. You will have an opportunity to submit the required information to complete your request.

Upon a determination that a request is eligible for an expedited External Review, MVP will assign an IRO for review and transmit all necessary documents and information to the IRO. The IRO will provide notice, to you and the Plan of the final External Appeal decision as expeditiously as possible, but in no event will such notice be later than seventy-two (72) hours after the IRO receives the request for the expedited External Appeal. Upon receipt of a notice of a final External Appeal decision that reverses the final adverse benefit determination, the Plan will immediately provide coverage or payment for the claim.

For both standard and expedited External Appeals, the determination of the assigned IRO is final and binding on the Plan, the member and MVP.

Right To Sue

When an initial claim denial is upheld after the Appeals process, and you have complied in full with the Plan's Claim and Appeal procedures, as well as any time limits for taking legal action, you may bring a civil action under Section 502(a) of the federal law commonly known as "ERISA" regarding the denied claim. Any questions relative to this right should be addressed to your own legal advisor or you may seek assistance as set forth below:

For Assistance

For further questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

SECTION 9 - COORDINATION OF BENEFITS

When You Have Other Health Benefits

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

Benefits payable under the Plan will be secondary to benefits provided or required by any group or individual automobile; homeowner's or premises insurance, including medical payments, personal injury protection, or no-fault coverage, regardless of any provision to the contrary in any other policy of insurance.

Health Plans

The following are considered to be health plans:

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

B. Any Blue Cross, Blue Shield, or other service type group plan;

C. Any self-insured or non-insured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;

D. Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid, CHAMPUS/TRICARE and any plan whose Benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall be Secondary Plans; and

E. If you have an accident and you are covered for accident-related expenses under any of the following types of coverage, the other payer is primary and we are secondary:
- No-Fault auto insurance;
- Group auto insurance;
- Traditional fault-type auto insurance;
- Uninsured or underinsured motorists insurance;
- Automobile-medical payment insurance;
- Homeowner's insurance;
- Personal injury protection insurance;
- Financial responsibility insurance;
- Medical reimbursement insurance coverage that you did not purchase; or
- Any other property and liability insurance providing medical payment Benefits.

Rules to Determine Payment

A. If your other plan does not have a Coordination of Benefits provision which coordinates Benefits, the Plan will always be the Primary Plan for purposes of paying claims.

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

C. If you are covered as a dependent under two plans, then the rules are as follows: (i) the coverage of the parent whose birthday is first in a year will be primary and the parent whose birthday is later in the year will be secondary; (ii) if both parents have the same birthday, the Benefits of the plan in effect longer will be primary; (iii) if the other plan does not have this rule, but instead has a rule based upon the parents gender; and if as a result, the plans do not agree on the order of Benefits, then the rule in the other plan will determine the order of payment for the claimed Benefits.

D. There are special rules for a child of separated or divorced parents.

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

2. If no such court decree exists, or if the Plan of the parent designated under such a court decree as responsible for the child's health care coverage and expenses does not have actual knowledge of the court decree, Benefits for the child are determined in the following order:
   - First, the Plan of the parent with custody of the child;
   - Then, the Plan of the spouse of the parent with custody of the child;
   - Finally, the Plan of the parent not having custody of the child.

E. A plan which covers you as an active employee or as that employee's dependent is primary. A plan which covers you as a laid-off or retired employee (or as that employee's dependent) is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on which plan is primary, this subsection (E) is ignored.

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

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

This Plan as Secondary Plan

If this Plan is considered the secondary payer, you are required to follow the rules and procedures of the primary plan before this Plan will make payment. If this Plan is to make payment on a secondary basis, the rules and procedures of this Plan, as otherwise stated in this SPD, must also be followed. When this Plan is the Secondary Plan, Benefits under the SPD will be reduced so that the total Benefits payable under the Primary Plan and this Plan do not exceed your expenses for an item of covered service or benefit. This Plan will not pay more than it would have paid if it was the Primary Plan. This Plan counts as actually paid by the Primary Plan any items of expense that would have been paid if you had made the proper claim.

Recovery of Overpayment

If the Plan provides Benefits greater than it should have, the Plan has the right to recover the overpayment from you or from any other person, insurance company, or organization which may have gained from the overpayment. This Plan may reduce or withhold future payments for covered Benefits or services to recover any incorrect payments. If the overpayment includes services which you received under this Plan, the amount of the overpayment will be based on prevailing rates for those services. You agree to do what is necessary to assist the Plan recover the excess payment. Such assistance to the Plan includes, but is not limited to: (1) agreeing to complete and file claim forms with other organizations or insurance companies and endorsing checks issued to you over to us, and (2) authorizing the Plan to complete and file claim forms with other organizations or insurance companies on your behalf. Whether this Plan is the primary or secondary plan, you will be responsible for all applicable Copayments, Coinsurance and/or Deductibles.

In the event that you receive Benefits or services under this Plan, including but not limited to coverage for drugs (prescription or otherwise), after coverage has lapsed or has been terminated, the Plan is entitled to recover payment for such services through any and all reasonable means, including but not limited to, the collections process.

Payments to Others

The Plan may repay to any other person, insurance company or organization the amount which it paid for your covered services and which it decides should have been paid. These payments are treated in the same manner as Benefits paid.

Support of Plan Activities

By accepting Benefits under the Plan, you agree to assist the Plan when necessary to carry out its obligations and to operate efficiently. Your failure to support Plan activities will lead to the suspension or denial of your Benefits, and those of any of your Dependents. **Your failure to return the Plan's annual Coordination of Benefits confirmation letter will be considered a failure to support Plan activities and will lead to the suspension or denial of Benefits as described herein.**

SECTION 10 - MEDICARE

When you become eligible for Medicare, you must enroll in Part A and Part B and notify the Plan Administrator in writing. Except as described below, Medicare then becomes your Primary Plan as of the first day that you would be entitled to Medicare benefits if you had applied for Medicare when first eligible. **This Plan will not provide Benefits for any service or care for which Benefits are payable under Medicare.** When you are eligible for Medicare, the Plan will reduce Plan Benefits by the amount Medicare would have paid for the services or care. This reduction is made even if: you fail to enroll in Medicare; you do not pay the contributions or other charges for Medicare; or you get services at a hospital or from a provider that cannot bill Medicare**.**

(For more information contact the MVP Coordination of Benefits Department at 1-800-556-2477)

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

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

1. The Plan Participant is in "current employment status" (working actively in a group with 20 or more employees and not retired) with the group; and

2. The Plan is required by law to have this SPD pay Benefits before Medicare pays.

In this case, Medicare is the Secondary Plan.

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

1. The Plan Participant is in “current employment status” (working actively in a group with 100 or more employees and not retired) with the group; and

2. The Plan is a large group health plan, as defined by law, that is required by law to have this SPD pay its Benefits before Medicare pays.

In this case, Medicare is the Secondary Plan.

C. Eligibility for Medicare By Reason of End-Stage Renal Disease. You are entitled to Benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. The Plan will not reduce the benefits under the terms of the Plan, as set forth in the SPD’s, and the Plan will provide claims for Benefits and services before Medicare pays, during the waiting period (this means that Medicare is the Secondary Plan during this waiting period). The Plan will also provide Benefits before Medicare pays during the coordination period with Medicare. After the waiting period, Medicare will pay its Benefits before the Plan provides Benefits under the terms of the Plan and as set forth in the SPD (this means that Medicare is the Primary Plan after this waiting period).

This Plan as Primary Plan

- If this exclusion does not apply and the Plan is the Primary Plan, as set forth under the terms of the Plan, the Plan will provide Benefits under its terms and as set forth in the SPD.
- The Benefits provided by Medicare will be reduced to provide Benefits only to the extent not provided by the SPD.

This Plan as Secondary Plan

If this exclusion applies and this Plan is the Secondary Plan, you must follow Medicare's rules, the terms of the SPD, and pay all Deductible, Copayments and Coinsurance before this Plan will provide Benefits. The Benefits provided by the Plan will be reduced to provide Benefits only to the extent not provided by Medicare.

Recovery of Overpayment

If the Plan provides more Benefits than it should have, the Plan has the right to recover the overpayment from you or from any other person, insurance company, agency or organization that benefitted from the overpayment. Your cooperation with the Plan to recover the overpayment is required under the terms of the Plan.

SECTION 11 - TERMINATION

This Section describes how your coverage may terminate. When your coverage terminates, it ends at 12:00 Midnight Eastern Time on the termination date. You may be eligible for continuation of Benefits after benefits terminate as described below. See the Continuation Coverage section of this SPD for information about COBRA coverage.

Automatic Termination

Your coverage will automatically terminate in the event of any of the following:

Termination of Your Status as Plan Participant. Your coverage will automatically terminate on the earlier of: (i) the date your employment is terminated; or (ii) the date of a change in your employment which makes you ineligible as a Plan Participant.

Your Death. If you have individual coverage, your coverage will automatically terminate on the date of your death. If you have two-person or family coverage, coverage will automatically terminate on the earlier of: (i) the date of your death, or (ii) the date to which your contribution is paid. Your Spouse or Dependents must immediately notify the Plan Administrator of your death and may be eligible for continuation of coverage under COBRA.

Dissolution of Marriage. If you become divorced, your marriage is annulled or otherwise legally dissolved or your domestic partnerships ends or you become legally separated pursuant to a written separation agreement or separation decree, your Spouse's coverage will automatically terminate on the earlier of; (i) the date of dissolution, or (ii) the date to which your contribution is paid. You must immediately notify the Plan Administrator of any such dissolution. Your Spouse may be eligible for continuation of coverage under COBRA.

Termination of Coverage of a Child. Your child's coverage under this Plan will automatically terminate on the earlier of: (i) date up to which your contribution is paid or (ii) the end of the month in which the child reaches the limiting age under this SPD (his or her twenty-sixth (26^{th}) birthday),.

If your child is covered under this Plan because he/she is incapable of self-sustaining employment and the child becomes capable of self-sustaining employment, the child's coverage will automatically terminate on the later of: (i) date the child becomes so capable or (ii) the end of the month in which the child reaches the limiting age under the terms of the Plan and as set forth in the SPD. You must immediately notify the Plan Administrator when your child is no longer eligible for coverage. Your child may be eligible for continuation of coverage under COBRA.

Special Rule for Children Covered Pursuant to Qualified Medical Child Support Orders

The Plan will provide Benefits for Covered Services for an eligible child or children in accordance with the applicable requirements of any Qualified Medical Child Support Order as defined by federal law and under the terms of the Plan. You must immediately provide the Plan Administrator with a copy of any Medical Child Support Order. The Plan Administrator will then notify you and any affected child or children of the receipt and status of such Medical Child Support Order and will provide a copy of the Plan's procedures for determining whether the Medical Child Support Order is a Qualified Medical Child Support Order. The Plan Administrator will, within fifteen (15) days of receipt of the Order, notify you and any affected child or children, in writing, of this determination and of any additional contribution required in Order for the child or children to be covered under the Plan. If the child or children are eligible under the terms of the Plan and as set forth in the SPD and the Plan Administrator determines that the Order is a Qualified Medical Child Support Order under the terms of the Plan, the child or children will be enrolled in the Plan the later of: (i) the date of the Plan Administrator's determination or (ii) the date of the Plan's receipt of any additional required contribution.

The Plan Administrator will not terminate the coverage of a child required to be covered pursuant to a Qualified Medical Child Support Order until you provide the Plan Administrator with satisfactory written proof that:

a. The Order is no longer in effect, or
b. The child is or will be enrolled in comparable coverage that will take effect not later than the date coverage under the Plan, and as set forth in the SPD would terminate.

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

Non-Payment of Contribution. Your coverage will terminate on the date for which your contribution should have been paid if you do not pay the premium contribution when such payment is due and as set forth in the SPD.

The Plan's Termination of Your Coverage

Rescission for Fraud or Misrepresentation. Your coverage may be rescinded if you commit fraud or make an intentional misrepresentation of material fact. The Plan is entitled to all remedies provided for in law and equity. This includes, but is not limited to, recovery from you for any charges for Benefits or services that were provided, attorneys' fees, costs of suit, and interest. The Plan Administrator will provide you with 30 days written notice of such rescission.

Failure to Make Premium Contribution. If you are responsible for paying a contribution to cover premiums required for your coverage to continue under the Plan, and you fail to make such contribution in a timely manner, your coverage may be terminated on a date as specified by your Plan Administrator under the terms of the Plan and as set forth in the SPD.

Your Option to Terminate Coverage

You cannot terminate your coverage under the Plan mid-year unless you have experienced a qualifying event as defined by Section 125 of the Internal Revenue Code. Notice of the qualifying event is required to be given to the Plan Administrator within thirty (30) days of such qualifying event (i.e. change in marital status, change in number of dependents, change in employment status). The Plan Administrator has the right to request additional supporting documentation to substantiate the qualifying event. The Plan Administrator reserves the right to determine whether you have experienced an event that would permit an election change under the Plan, and whether your requested election change is consistent with such event. Should a qualifying event be deemed acceptable by the Plan Administrator, termination off coverage will be effective on the last day of the month in which any termination was requested.

Obligations on Termination

Once your coverage ends, the Plan will not provide any more Benefits except for Covered Services received before the termination of coverage unless you are terminated while receiving inpatient services.

Right to Recover

If the Plan incorrectly provides Benefits after your coverage under the Plan has been terminated, the Plan may recover from you the charges for Benefits or services provided, and any attorneys' fees, costs, and interest.

SECTION 12 - CONTINUATION COVERAGE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this notice because you are covered under Skidmore College PPO Medical Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your eligible family members who are covered under the Plan when the event that would otherwise cause you to lose your group health coverage occurs.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you may request a copy of your COBRA rights from the Plan Administrator.

The Plan Administrator is Benefit Strategies, LLC. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must self-pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because of either one of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because of any of the following qualifying events :

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct

- Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because of any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross
- misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within thirty (30) days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within sixty (60) days after the qualifying event occurs. You must send this notice to this Plan Administrator. If you elect to continue coverage under COBRA, you have forty-five (45) days from the date of your election to make your first contribution payment.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage under the Plan. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to thirty-six (36) months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of eighteen (18) month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage. You must provide a copy of the determination notice from the office of the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent

children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within sixty (60) days of the second qualifying event**. **The notice of the qualifying event must be sent to the Plan Administrator**

Termination of COBRA Coverage

COBRA coverage will terminate before the end of the maximum periods described above on the earliest of:

- The date, after your election to obtain COBRA coverage, when you first become:
  - Covered under any other group health plan (as an employee or otherwise); or
  - Entitled to Benefits under Medicare.
- The date you fail to pay the required premium in a timely manner.

Supplementary Suspension, Continuation and Conversion Coverage.

To the extent required by law, if a Plan Participant enters active duty but the Plan does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect in writing to the Plan Administrator, within sixty (60) days of being ordered to active duty, to continue coverage under the Plan for yourself and eligible Dependents. Such continued coverage shall not be subject to proof of insurability. You must pay the required premium contribution in advance of the applicable month of coverage to the Plan Administrator, but not more frequently than once a month.

- This paragraph applies only to the extent required by law and only if you are a member of a reserve component of the Armed Forces of the United States, including the National Guard, you serve no more than five (5) years of active duty, and you either:
  - voluntarily or involuntarily enter upon active duty (other than for the purpose of determining your physical fitness and other than for training); or
  - have your active duty voluntarily or involuntarily extended during the period when the President in office authorized to order units of the ready reserve or members of the reserve component to active duty; provided that such additional duty is at the request and for the convenience to the Federal Government.

- Supplementary continuation shall not be available to any person who is, or could be covered by Medicare or any other group coverage. Coverage available through the Federal government for active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.
- In the event that you are reemployed or restored to participation in the Plan upon return to civilian status after the period of continuation coverage or suspension, you (and your covered dependents if other than individual coverage applies), shall be entitled to resume coverage under the Plan . If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty provided the applicable premium contribution has been paid from that date. No exclusion or waiting period shall be imposed in connection with resumed coverage except regarding:
  - A condition that arose during the period of active duty and that has been determined by the U.S. Secretary of Veteran's Affairs to be a condition incurred in the line of duty; or
  - A waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months. In the event that you are not reemployed or restored to participation in the Plan upon return to civilian status, you may, within thirty-one (31) days of the termination of active duty, or discharge from hospitalization incident to active duty which continues for a period of not more than one (1) year, submit a written request for Continuation Coverage to the Plan Administrator.

- The maximum period of Supplementary Continuation Coverage for the Plan Participant and his or her Dependents shall be the lesser of: (1) the eighteen (18) month period beginning on the date on which

the Plan Participant's absence begins; or (2) the day after the date on which the Plan Participant fails to apply for or return to a position of employment, as determined by federal law.

- If you are in the armed services please refer to Section 25, subparagraph J for additional information regarding the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA") or contact the Plan Administrator..
- Certain individuals may be eligible for a second 60 day COBRA election period under the Trade Adjustment Assistance Reform Act of 2002.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact your Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.**

Keep Your Plan Informed of Address Change

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SECTION 13 - GENERAL PROVISIONS AND REQUIRED NOTICES OF RIGHTS UNDER FEDERAL LAW

A. Statement of Federal Rights. You are entitled to certain rights and protections under federal law, as described below.

1. ERISA provides that all Plan participants shall be entitled to:

a. Receive Information About Your Plan and Benefits. You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA). You may receive, 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 SPD. The Plan Administrator may make a reasonable charge for the copies. You are entitled to 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. You may continue health care coverage for yourself, spouse or eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your eligible dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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 eligible Dependents. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate

against you in any way to prevent you from getting a 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 get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not get them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you get the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 getting documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

2. 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 forty eight (48) hours following a vaginal delivery, or less than ninety six (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 forty eight (48) hours (or ninety six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider get authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of forty eight (48) hours (or 96 hours).

3. Women's Health and Cancer Rights Act of 1998. Federal law requires us to notify you of our Benefits for reconstructive surgery following mastectomy. The Women's Health and Cancer Rights Act of 1998 requires that we provide Benefits for reconstruction of the breast on which a mastectomy has been performed and/or the other breast (to produce a symmetrical appearance). We also cover prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as required by the Act. Benefits for the above services are subject to all terms and conditions of the Plan. For example, they require the same Coinsurance, Copayments and Deductibles as the rest of your coverage. If you have any questions about your rights under this Act, please contact your Plan Administrator or contact MVP at 1-800-229-5851.

4. Qualified Medical Child Support Orders. Your Plan Administrator maintains procedures for determining whether a child support order directing a participant to provide medical Benefits for

one or more children is a Qualified Medical Child Support Order. You may obtain a copy of these procedures, without charge, from your Plan Administrator.

5. HIPAA Procedures.

   a. The Plan may disclose Protected Health Information ("PHI") to the Plan Sponsor to carry out the following administration functions for the Plan:

      i. To determine if an individual is participating in the Plan;
      ii. To modify, amend or terminate the Plan;
      iii. To obtain premium bids from Health Plans to provide insurance coverage under the Plan, including reinsurance;
      iv. To perform administrative functions such as Utilization Review and Audit functions.

   b. With respect to PHI that the Plan Sponsor receives from the Plan, the Plan Sponsor shall:

      i. Not further use or disclose the PHI other than as permitted or required by the Plan Documents or as required by law;
      ii. Ensure that any agents, including an insurance broker or a subcontractor, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
      iii. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
      iv. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for herein, of which it becomes aware;
      v. Make available PHI as required by 45 C.F.R.§164.524;
      vi. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;
      vii. Make available the PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;
      viii. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for purposes of determining compliance by the Plan;
      ix. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and not retain copies when the PHI is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible;
      x. Ensure that adequate separation between the Plan and the Plan Sponsor is established and supported by reasonable and appropriate security measures.

   c. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a written certification by the Plan Sponsor that the Plan Documents have been amended to incorporate the provisions of subparagraph a of this paragraph.

   d. The Plan will disclose, as permitted or required by the Plan, PHI to only the following classes of employees or other persons under the control of the Plan Sponsor: Human Resources and his or her designee, including but not limited to HR Director, AP/Payroll Director, Payroll Manager, HR Representatives, Payroll Specialists, Benefits Coordinator.

   e. The classes of employees or the persons identified above shall use and disclose only the minimum amount of PHI necessary to perform the Plan administration functions set forth in subparagraph b of this section.

f. Participants can report complaints concerning the Plan Sponsor's use or disclosure of PHI to: Skidmore College Privacy Officer, 815 North Broadway, Saratoga Springs, NY 12866.

g. For purposes of this paragraph, the terms Protected Health Information and PHI mean individually identifiable information that is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of the individual; the provision of health care to the individual; or past, present or future payment for the provision of health care to the individual.

6. Rights of Persons Serving in the Armed Forces. In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), to the extent required by law, if a Plan Member enters active duty in the armed forces of the United States of America but the Plan does not voluntarily maintain your coverage, your coverage shall be suspended unless you elect in writing to the Plan Administrator, within sixty (60) days of being ordered to active duty, to continue coverage under this Plan for yourself and eligible Dependents. Such continued coverage shall not be subject to proof of insurability. You must pay the required premium contribution in advance of the applicable month of coverage to the Plan Administrator, but not more frequently than once a month.

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

      i. voluntarily or involuntarily enter upon active duty (other than for the purpose of determining your physical fitness and other than for training); or
      ii. have your active duty voluntarily or involuntarily extended during the period when the President in office authorized to order units of the ready reserve or members of the reserve component to active duty; provided that such additional duty is at the request and for the convenience to the Federal Government.

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

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

      i. A condition that arose during the period of active duty and that has been determined by the U.S. Secretary of Veteran's Affairs to be a condition incurred in the line of duty; or
      ii. A Waiting Period imposed that had not been completed prior to the period of suspension. The sum of the Waiting Periods imposed prior and subsequent to the suspension shall not exceed eleven months.

      In the event that you are not reemployed or restored to participation in the Plan upon return to civilian status, you may, within thirty-one (31) days of the termination of active duty, or discharge from hospitalization incident to active duty which continues for a period of not more than one (1) year, submit a written request for Continuation Coverage to the Plan Administrator.

d. The maximum period of Supplementary Continuation Coverage for the Plan Participant and his or her eligible Dependents shall be the lesser of: (1) the twenty-four (24) month period beginning on the date on which the Plan Member's absence begins; or (2) the day after the date on which the Plan Member fails to apply for or return to a position of employment, as determined by federal law.

SECTION 14 - THIRD PARTY RECOVERY

1. Reimbursement

This paragraph applies when you or your legal representative, estate or heirs (sometimes collectively referred to herein as the "Representatives" and individually as a "Representative") recovers damages, by settlement, verdict or otherwise, for an injury, sickness or other condition. If you or any Representative has made, or in the future may make, such a recovery, including a recovery from any insurance company, the Plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness. These Benefits are specifically excluded.

However, if the Plan does advance payment or provides care for such an injury, sickness or other condition, you or your Representative(s) shall promptly transfer monies or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by you or your Representative(s) to the Plan for the reasonable value of the Benefits and services advanced or provided by the Plan to you, regardless of whether or not [1] you were fully compensated, or "made-whole" for your loss; [2] liability for payment is admitted by you or any other party; or [3] the recovery by you or your Representative(s) is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over you, your Representative(s) or any other party, to receive reimbursement of the Benefits advanced on your behalf. This reimbursement shall be from any recovery made by you or your Representative(s), and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this subsection regarding Reimbursement, and because of the Plan's advancement of Benefits, you hereby [1] acknowledge that the Plan shall have first priority against the proceeds of any such settlement, arbitration award, verdict, or any other amounts received by you or your Representative(s); and [2] assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. You or your Representatives shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of Benefits. By accepting any Benefits advanced by the Plan under this paragraph 1, you and your Representative(s) acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by another person, held by you or by another, are being held for the benefit of the Plan under these provisions. Should you or your Representative(s) fail to reimburse the Plan as required by this subsection, the Plan shall have a right to offset future Benefits and claims otherwise payable under this Plan to the extent of the value of the Benefits advanced under this Section to the extent not recovered by the Plan.

You and your Representative(s) shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the Benefits provided. You and your Representatives [1] agree not to take any action that prejudices the Plan's rights of reimbursement and [2] consent to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this subsection and/or to set off from any future Benefits otherwise payable under the Plan the value of Benefits advanced under this paragraph 1 to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. Neither you nor any Representative shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

In cases of occupational illness or injury, the Plan's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the Plan's interest and the Plan shall be reimbursed in first priority from any such award or settlement.

The Plan shall recover the full amount of Benefits and claims advanced and paid hereunder, without regard to any claim or fault on the part of any of your beneficiaries, whether under comparative negligence or otherwise.

2. <u>Subrogation</u>

This subsection with respect to Subrogation applies when another party is, or may be considered, liable for your injury, sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced Benefits.

In consideration for the advancement of Benefits, the Plan is subrogated to all of your rights against any party liable for your injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the Benefits advanced to you under the Plan. The Plan may assert this right independently of you. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as your rights under the Plan to bring an action to clarify your rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

You are obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan under this subsection. In the event you fail to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future Benefits otherwise payable under the Plan the value of benefits advanced under this subsection to the extent not recovered by the Plan.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any other claim of your or any of your Representatives, regardless of whether you are fully compensated for your damages. The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of your legal representation shall be borne solely by you.

3. <u>Cumulative Rights</u>

The Plan or MVP, on behalf of the Plan, may choose to exercise its right to reimbursement or subrogation or both.

4. <u>Your Obligations</u>

A. Promptly notify MVP when notice is given to any third party to pursue a claim for injuries, illnesses or conditions that may be the legal responsibility of a third party.

B. Cooperate with MVP to protect rights to reimbursement and subrogation, including:

1. Signing and delivering, within thirty (30) days of a reasonable request to do so, any documents needed to secure a subrogation claim, to protect rights to reimbursement, or to effect the assignment or lien described in this subsection regarding Cumulative Rights as set forth above;

2. Providing any relevant information;

3. Getting the consent of your Employer before releasing any party from liability for payment of medical expenses;

4. Taking such other actions as may be needed to assist in making a full recovery of the cost of all Benefits provided; and

5. Not taking any action that prejudices the Plans rights to reimbursement or subrogation, including but not limited to making any settlement or recovery which specifically attempts to reduce or exclude the full cost of Benefits provided by this Plan.

5. Consequence of Failure to Comply

If you fail to comply with the requirements of any of these subsections, you shall be responsible for all Benefits provided by this Plan in addition to costs, attorneys' fees, and interest incurred by MVP and/or the Plan in securing repayment. Your future Benefits may be reduced or withheld to recover monies owed to the Plan.

SECTION 15 - DEFINITIONS

The following terms have special meanings and will be capitalized when used in this Summary Plan Description.

Acute Services - services which, according to generally accepted professional standards, are expected to provide significant, measurable clinical improvement within a reasonable and medically predictable period of time.

Allowed Amount or Allowable Charge - means the maximum amount MVP will pay for the services or supplies covered under this Plan, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. MVP will determine the Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount MVP has negotiated with the Participating Provider. Except as provided below, the Allowed Amount for Non-Participating Providers will be the FAIR Health rate at the 90th percentile. MVP will utilize the FAIR Health Database, a national, independent, nonprofit corporation whose mission is to bring transparency to healthcare costs and health insurance information through comprehensive data products, consumer resources and the support of health services research. For further information visit www.fairhealthconsumer.org.

In the event a FH reimbursement rate has not been established for a service provided, the claim will be processed at charges, a discount from a third party network partner or a negotiated discount as the Allowed Amount.

The Non-Participating Provider's actual charge may exceed the Allowed Amount. You must pay the difference between the Allowed Amount and the Non-Participating Provider's charge. Contact MVP at the number on Your ID card or visit our website at www.mvphealthcare.com for information on your financial responsibility when you receive services from a Non-Participating Provider.

Exception Claims: MVP will process certain out-of-network provider claims as noted below at the in-network benefit level and apply charges or a negotiated discount if we can obtain one as the Allowed Amount.

- When care to an out-of-network facility or provider has been authorized as in-network due to access or special circumstances; at charges or negotiated discount
- When care is emergent or urgent (such as emergency room, emergency admission, emergency transport and the related care that is part of that emergent or urgent incident);
- When accessing in-network care through a participating facility and surgeon, but certain services without the member's knowledge or control are provided by non-participating providers, like anesthesiology, assistant surgeon, lab or radiology services.
- When a participating provider orders DME for a member through an out-of-network DME vendor.

Benefit(s) - payments made to you or on your behalf to the Provider by the Plan after you have received Covered Services.

Calendar Year - the twelve (12) month period beginning at 12:01 A.M., Eastern Time, on January 1 and ending at 12:00 Midnight Eastern Time, on December 31. However, if you were not covered under this SPD for this entire period, Calendar Year means the period from your Effective Date until 12:00 Midnight Eastern Time, on December 31.

Charge - the total amount billed by a Provider for a service.

Coinsurance - a dollar amount, expressed as a stated percentage of the Allowable Charge.

Concurrent Notice. Concurrent Notice means the notice you or your Provider must give to MVP while you are receiving certain Covered Services. MVP does not review, approve or deny Benefits at this time. Your call is necessary for MVP to assign a length of stay or other concurrent review schedule.

Copayment - a fixed dollar amount you must pay each time a Covered Service is provided.

Covered Services - services specified in this SPD as eligible for Benefits. MVP maintains protocols to assist in determining whether a service is a Covered Service.

Custodial Care - services primarily for maintenance or designed to help you in your daily living activities. Custodial Care includes, but is not limited to: assistance in walking, bathing and other personal hygiene, toileting; getting in and out of bed; dressing; feeding; preparation of special diets; administration of oral medications; Routine changing of dressings; child care; adult day care; or care not requiring skilled professionals.

This term also means services that, according to generally accepted professional standards, are not expected to provide significant, measurable clinical improvement within a reasonable and medically predictable period of time.

Deductible - a dollar amount you must pay before the Plan provides Benefits under this SPD.

Dependent - a person other than the Plan Participant, listed on the Plan Participant's enrollment application who meets all eligibility requirements.

Diagnostic Services, Supplies and Equipment - services ordered by a physician, and used in or provided by a Hospital or facility, to determine a definite condition or disease. Diagnostic Services include radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scan, electroencephalograms (EEG) electrocardiograms (ECG), organ scans, allergy testing (percutaneous, intracutaneous, patch and RAST testing) and other medical and surgical diagnostic services.

Disposable Supplies - supplies that are primarily and customarily used only for a medical purpose. Such supplies will be appropriate for use in the home and are meant to be discarded after usage. Disposable supplies can include, but are not limited to sterile bandages, cleansing solutions and catheter supplies.

Domestic Partner - your domestic partner of the same or opposite gender, subject to completion and submission of a Domestic Partnership Declaration and the required supporting documentation, and acceptance by your employer group.

Durable Medical Equipment - 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, orthotics, respirators and insulin pumps.

Effective Date - the date your coverage under this SPD begins. Coverage begins at 12:01 A.M., Eastern Time, on that date.

Emergency Medical Condition - a medical or behavioral condition that manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the afflicted person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of the person or others in serious jeopardy;
- Serious impairment of the person's bodily functions;
- Serious dysfunction of any bodily organ or part of the person; or
- Serious disfigurement of the person.

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

Experimental or Investigational Services - services that are either generally not accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

A. Approved Clinical Trial - The term "approved clinical trial" is defined as a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:
    1. A federally funded or approved trial.
    2. A clinical trial conducted under an FDA investigational new drug application.
    3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

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

Fee Agreement - an arrangement between MVP and Participating Providers to provide Covered Services to Members.

Foot Orthotic - a mechanical appliance for orthopedic use specifically related to the foot. They are defined as shoe inserts that can be flexible, semi-rigid and can extend beyond the toes.

Hospital - a duly licensed, short-term, acute care facility that primarily provides diagnostic and therapeutic services for diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians. It must have organized departments of medicine and major surgery, and provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. The following are not Hospitals:

Convalescent homes.
Convalescent, rest or nursing facilities.
Facilities primarily affording custodial or educational care.
Health resorts, spas or sanitariums.
Infirmaries at school, colleges or camps.
Facilities for the aged.

In-Network Benefits - Benefits paid by MVP when Covered Services are provided by Participating Providers in accordance with the terms and conditions of this SPD.

Internal Prosthetic Devices - devices that replace all or some of the functions of a permanently inoperative and/or malfunctioning internal body part. Examples include, but are not limited to cardiac pacemakers, cochlear implants, and ventricular assist devices (VAD).

Medical or Scientific Evidence - the following sources:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in

Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);

- Medical journals recognized by the Federal Secretary of Health and Human Services, under Section 1861 (t)(2) of the Federal Social Security Act;
- The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and the United States Pharmacopoeia-Drug Information;
- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and peer-reviewed abstracts accepted for presentation at major medical association meetings.

Member - both the Plan Participant and his or her Dependents.

Non-Participating Provider - a Provider that does not have a fee agreement with MVP.

Orthotics - a device added to the body to stabilize or immobilize an injured body part, prevent deformity or to protect against further injury, such as ankle braces, finger splints and arm slings. This does not include Foot Orthotics.

Out-of-Network Benefits - Benefits paid by MVP when Covered Services are provided by Non-Participating Providers in accordance with the terms and conditions of this SPD.

Out-of-Pocket Maximum – An Out of Pocket Maximum limits your payments for Covered Services during the Plan Year.

Participating Provider - a Provider that has a fee agreement with MVP.

Plan Participant - the person to whom this SPD is issued, who meets and continues to meet all eligibility requirements, and who applies and is accepted for Coverage.

Plan Year - the twelve (12) month period beginning at 12:01 A.M., Eastern Time, on January 1 and ending at 12:00 Midnight Eastern Time, on December 31. However, if you were not covered under this SPD for this entire period, Plan Year means the period from your Effective Date until 12:00 Midnight Eastern Time, on December 31.

Primary Care Physician (PCP) - a Participating Provider who has an agreement with MVP to provide covered primary health care services to Members. Examples of a PCP include: general practitioners, internists, obstetricians/gynecologists for routine care and pediatricians.

Prior Authorization. Prior Authorization means the required approval that must be obtained from MVP before you receive certain Covered Services.

Provider - properly licensed or certified physicians, health care professionals, Hospitals, ambulatory surgery centers, birth centers, skilled nursing facilities, psychiatric hospitals, home health agencies, hospices, inpatient and outpatient alcoholism and substance abuse treatment facilities, Durable Medical Equipment and External Prosthetic Device suppliers, Ambulance services providers and other facilities performing services within their licensure or certification and approved as an MVP provider. Some Providers must be Participating Providers for their services to be Covered Services.

Retrospective Review. Retrospective Review means MVP's review, after services have been provided to you, to determine whether such services were Medically Necessary Covered Services and whether and to what extent Benefits are payable.

Spouse – person married to the Plan Participant in a legally valid marriage (based on laws in the state of celebration and not based on the laws in the Participant's state of residence). A legally separated (pursuant to a decree of separation) or divorced former Spouse of the Plan Participant is not eligible under this Plan. The term "Spouse" will not include civil union partners or domestic partners.

Subscriber – Subscriber means any Eligible Employee for whom coverage provided by this Plan is in effect.

Therapeutic Services:

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

Chemotherapy and Cancer Hormone Therapy - 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;

Dialysis - removal of waste materials when a Member has acute kidney failure or chronic, irreversible kidney deficiency, and the use of equipment and disposable medical supplies. Benefits for Dialysis will continue until you become eligible for Medicare;

Infusion Therapy - treatment of disease by injection of curative agents;

Inhalation Therapy - inhalation of medicine, water vapor and/or gases to treat impaired breathing;

Items used in and provided by the Hospital or facility when performing Therapeutic Services, such as prescribed drugs, medications, serum, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items.

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

Waiting Period - the time period before which the Plan will provide Benefits to a Plan Participant or the Plan Participants' eligible Dependent(s).

PLAN INFORMATION

Plan Name:
Skidmore College PPO Medical Plan

Plan Sponsor:
Skidmore College
815 North Broadway
Saratoga Springs, NY 12866

Plan Administrator:
Same as above.

Named Fiduciary:
Same as above.

Claims and Appeals Administrator:
MVP Health Care, Inc.
625 State Street
PO Box 2207
Schenectady, NY 12301
1-800-229-5851

Plan Identification:
Employer Identification Number (EIN): 14-1514576
Plan Number (PN): 501

Plan Year:
Plan records are kept on a plan-year basis, which begins on January 1st and ends on December 31st.

Agent for Service of Legal Process:
The agent for service of legal process is the Plan Administrator. Legal process must be served in writing to the Plan Administrator at the address stated for the Plan Administrator above.

Type of Plan and Plan Funding:
The Plan is a self-funded health plan. Skidmore College has the discretion to pay Benefits out of its general assets. Contributions for funding Benefits are provided by the Employer and by payroll deduction contributions of the Employee. The level of Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contribution.

SKIDMORE COLLEGE PPO MEDICAL PLAN

Summary of Covered Services

A. Medicare Eligible Participant Covered Services. If Medicare is your Primary Plan, this is your Secondary Plan. You may refer to Section 10 for a description of how this Plan works if Medicare is your Primary Plan.
B. Covered Services for All Plan Participants. This chart is a summary of Covered Services and your Benefits. You must consult the Benefits sections of this SPD for more detailed information about Covered Services and your Benefits. In the event of any inconsistencies between this chart and the Benefits sections of this SPD, the Benefits sections will control.

All limits are combined In and Out of Network and are Calendar Year unless otherwise specified.
All Benefits are subject to Deductible unless otherwise specified. Benefits with a ☎ symbol require that you obtain Prior Certification or give Prior Notice or Concurrent Notice. See Section 5 for details.

SERVICE CATEGORY	IN NETWORK	OUT OF NETWORK
Annual Deductible	N/A	$200 Individual / $500 Family
Coinsurance	N/A	80% of Allowable Charge
Medical Out-of-Pocket Maximum	$1,500 Individual / $3,000 Family	$3,000 Individual / $6,000 Family
Pharmacy Out-of-Pocket Maximum	$5,350 Individual / $10,700 Family	Not Applicable
HOSPITAL /FACILITY SERVICES		
Hospital Inpatient Services (120 days of confinement max, one copay per individual per year)	$250 Copayment	80% of Allowable Charges
Hospital Inpatient Physical Rehab (60 day visit limit)	$250 Copayment	80% of Allowable Charges
Hospital Outpatient Surgery☎	$100 Copayment	80% of Allowable Charges
Hospital Outpatient Therapeutic Services	$40 Copayment	80% of Allowable Charges
Hospital Outpatient Lab Services	Covered in Full	80% of Allowable Charges
Hospital Outpatient Radiology and Diagnostic Services	Covered in Full	80% of Allowable Charges
Hospital Maternity Care – Birthing Center	$250 Copayment	80% of Allowable Charges
Newborn Nursery	Covered in Full	80% of Allowable Charges
Pre-Admission Testing	Covered in Full	80% of Allowable Charges
SPECIAL SERVICES		
Skilled Nursing Facility ☎ (120 day limit per year)	$250 Copayment	80% of Allowable Charges
Home Health Care (200 visits per year)	$40 Copayment	80% of Allowable Charges
Hospice (210 day lifetime maximum) (Bereavement Counseling – 5 days)	Covered in Full	80% of Allowable Charges
Transgender Related Care & Services ☎ *(includes counseling and gender reassignment surgery)*	Copayment based on services rendered	80% of Allowable Charges
EMERGENCY ROOM, URGENT CARE AND AMBULANCE		
Emergency Ambulance (Land and Air) ☎ Non-Emergency Ambulance Services (when Medically Necessary)	$100 Copayment	$100 Copayment
Urgent Care Center	$25 Copayment	80% of Allowable Charges

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SERVICE CATEGORY	IN NETWORK	OUT OF NETWORK
Ambulance (Land & Air when Medically Necessary – Emergency)	$100 Copayment	$100 Copayment
PREVENTIVE CARE		
Routine Adult Physicals – One per plan year	Covered in Full	80% of Allowable Charges
Well Child Care including Immunizations	Covered in Full	80% of Allowable Charges
Flu Shots	Covered in Full	80% of Allowable Charges
Routine Gynecological Visits	Covered in Full	80% of Allowable Charges
Well Woman Care	Covered in Full	80% of Allowable Charges
PROFESSIONAL SERVICES AND SUPPLIES		
Physician Office Visits – PCP	$20 Copayment	80% of Allowable Charges
Physician Office Visits – Specialty	$40 Copayment	80% of Allowable Charges
Hospital Inpatient Physician Care	Covered in Full	80% of Allowable Charges
Allergy Testing	Covered in Full	80% of Allowable Charges
Allergy Injections	Covered in Full	80% of Allowable Charges
Physician Surgical Procedures *(All settings)*	Covered in Full	80% of Allowable Charges
Chiropractic Care (20 day visit limit)	$40 Copayment	80% of Allowable Charges
Maternity Care (Pre Natal and Post Natal Care)	$20 Copay for initial visit only	80% of Allowable Charges
Acupuncture	Covered under Alternative Health Benefit	
Provider Office Lab Services	Covered in Full	80% of Allowable Charges
Provider Office Radiology and Diagnostic Services (X-ray, MRI, CAT)	Covered in Full	80% of Allowable Charges
PT/ST/OT (Combined 80 days per year)	$40 Copayment	80% of Allowable Charges
Cardiac Rehabilitation – up to 36 visits	$40 Copayment	80% of Allowable Charges
Bariatric Surgery Services ☎	Copayments based on services rendered	80% of Allowable Charges
Transplant Services ☎	Copayment based on services rendered	80% of Allowable Charges
Diabetic Treatment	$20 PCP / $40 Specialist	80% of Allowable Charges
Diabetic Drugs, Monitors, Equipment and Supplies	Covered under Rx benefit	Covered under Rx benefit
Disposable Medical Supplies	Covered in Full	80% of Allowable Charges
Durable Medical Equipment ☎ (includes Insulin pump and pump supplies)	Covered in Full	80% of Allowable Charges
Orthotics / Prosthetics ☎	20% Coinsurance	50% of Allowable Charges
Foot Orthotics	20% Coinsurance	50% of Allowable Charges

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SERVICE CATEGORY	IN NETWORK	OUT OF NETWORK
Hearing Testing and Evaluations	$20 PCP / $40 Specialist	80% of Allowable Charges
Hearing Aids	Not Covered	Not Covered
Wigs (following Chemotherapy) (up to $300 maximum)	Covered in Full	Covered in Full
MENTAL HEALTH SERVICES		
Inpatient Hospital	$250 Copayment	80% of Allowable Charges
Inpatient Provider Visits	Covered in Full	80% of Allowable Charges
Residential Treatment	$250 Copayment	80% of Allowable Charges
Outpatient Provider Visits	$20 Copayment	80% of Allowable Charges
Outpatient Facility Visits (includes Office Visits, IOP and PHP)	$20 Copayment	80% of Allowable Charges
SUBSTANCE ABUSE SERVICES		
Inpatient Hospital Detox/Rehab	$250 Copayment	80% of Allowable Charges
Inpatient Provider Visits	$20 Copayment	80% of Allowable Charges
Residential Treatment	$250 Copayment	80% of Allowable Charges
Outpatient Provider Visits (includes Office Visits, IOP and PHP)	$20 Copayment	80% of Allowable Charges
INFERTILITY SERVICES		
Basic & Advanced Infertility Treatment (includes IVF, GIFT, ZIFT) $10,000 Annual Max	Covered in Full	80% of Allowable Charges
Infertility Rx	Covered under pharmacy benefit	Covered under pharmacy benefit
VISION CARE		
Routine Eye Exam *(1 visit every two years)*	$20 Copayment	80% of Allowable Charges
Frames / Lenses	Reimbursement up to $150	
DENTAL SERVICES		
Accidental Dental	$40 Copayment	80% of Allowable Charges
TMJ (medical in nature only)	Copayment based on services rendered	80% of Allowable Charges
Oral Surgery (when medically necessary) (includes removal of boney impacted teeth)	Copayment based on services rendered	80% of Allowable Charges

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SERVICE CATEGORY	IN NETWORK	OUT OF NETWORK
PRESCRIPTION DRUGS (Pharmacy benefits administered through Optum Rx) Please contact your Plan Administrator for further information		
Prescription Drug Benefits More information about prescription drug coverage is available at Optum Rx at 1- 800-788-4863 or www.optumrx.com		
Pharmacy Out of Pocket Maximum	Participating Pharmacy: $5,350 Individual / $10,700 Family	
Retail Pharmacy (30 day supply)	Generic: $10 Copay Brand: $25 Copay Non-Formulary: $40 Copay	
Mail Order (90 day supply)	Generic: $25 Copay Brand: $62.50 Copay Non-Formulary: $100 Copay	
Alternative Health Care		
Alternative Health Care Services *(Includes acupuncture, fitness center memberships, fitness classes, fitness training coach, yoga, homeopathic, hypnotherapy, nutritional counseling, massage therapy, and weight control programs. Products purchased through these programs are excluded. Child birth classes, and registration fees for walking and running events.* ***Employee must complete the Skidmore College reimbursement form and attach receipts.***	100% Coverage up to $300 per year per covered employee/contract ($300 limit is the maximum benefit per contract, per calendar year regardless of family size); products purchased through these Programs are not covered.	

MVP HEALTH CARE

SKIDMORE COLLEGE PPO MEDICAL PLAN
Summary Plan Description

The effective date of the SKIDMORE COLLEGE PPO MEDICAL PLAN is January 1, 2016. It is agreed by SKIDMORE COLLEGE that the provisions of this document are correct and will be the basis for the administration of the SKIDMORE COLLEGE PPO MEDICAL PLAN.

Dated this 17 day of February 2017

By: Lynn Sanchi

Title: Assistant Director of Benefits