

**MVP VERMONT**  
**PREFERRED PROVIDER ORGANIZATION**  
**MVP CATAMOUNT CHOICE**  
**SUBSCRIBER CONTRACT**

MVP Health Insurance Company  
625 State Street  
Schenectady, New York 12305  
(800) 777-4793

MVP VERMONT  
PREFERRED PROVIDER ORGANIZATION  
MVP CATAMOUNT CHOICE

**Subscriber Contract**

Issued by  
MVP Health Insurance Company  
625 State Street, Schenectady, New York 12305  
(800) 777-4793

This Subscriber Contract ("Contract") is a contract between you and MVP to provide for coverage of primary care, preventive care, chronic care, acute episodic care, and hospital services as described herein. Amendments, riders or endorsements may be added to this Contract. Read the entire Contract carefully. You must make sure you understand and comply with all of the terms and conditions therein.

The terms We, Us, and Our mean MVP, or any designated agents of MVP.

The terms You and Your mean the Subscriber and his or her Dependents Covered under this Contract unless otherwise specified.

**READ THIS ENTIRE SUBSCRIBER CONTRACT AND ANY AMENDMENTS, RIDERS AND ENDORSEMENTS CAREFULLY. IT DESCRIBES: (1) THE HEALTH CARE SERVICES FOR WHICH MVP PROVIDES BENEFITS; (2) THE LIMITATIONS AND EXCLUSIONS REGARDING SUCH BENEFITS; (3) OTHER TERMS AND CONDITIONS OF COVERAGE; (4) THE RIGHTS AND RESPONSIBILITIES OF MVP; AND (5) YOUR RIGHTS AND RESPONSIBILITIES. IT IS YOUR RESPONSIBILITY TO UNDERSTAND AND COMPLY WITH ALL TERMS AND CONDITIONS IN THIS CONTRACT. YOU SHOULD KEEP THIS CONTRACT WITH YOUR OTHER IMPORTANT PAPERS SO THAT IT IS AVAILABLE FOR YOUR FUTURE REFERENCE.**

MVP Health Insurance Company

By:

David W. Olikier  
President & Chief Executive Officer

## SUMMARY OF BENEFITS

		Individual	Family
In-Network Contract Year Deductible <sup>1</sup>		\$250	\$500 <sup>2</sup>
Out-of-Network Contract Year Deductible <sup>1</sup>		\$500	\$1000 <sup>2</sup>
<b>In Network Annual Out-of-Pocket Maximum<sup>3</sup></b>		\$800	\$1600 <sup>2</sup>
Out-of-Network Annual Out-of-Pocket Maximum <sup>3</sup>		\$1500	\$3000 <sup>2</sup>
<b>General Lifetime Maximum Benefit</b>	\$1,000,000		
<b>Durable Medical Equipment/External Prosthetic Devices/ Ostomy Supplies Lifetime Maximum Benefit</b>	\$25,000		
<b>Medical Foods Maximum Benefit per Member per year</b>	\$2,500		

BENEFIT	In-Network Coinsurance	Out-of-Network Coinsurance
<b>Inpatient Hospital Services</b>		
Maternity Care	20%	20%
Newborn Care	20%	20%
Breast Cancer Care	20%	20%
Physical Rehabilitation Care	20%	Not Available
Mental Health and Substance Abuse Services	20%	Not Available
<b>Outpatient Hospital/Facility and Ambulatory Services<sup>4</sup></b>		
Mental Health and Substance Abuse Services (Facility)	20%	Not Available
Therapeutic Services	20%	20%
Pre-admission Testing	20%	20%
Diagnostic Tests and Screenings	20%	20%
Diagnostic Laboratory	20%	20%
Diagnostic Radiology	20%	20%
Therapy Services (PT/ST/OT)	20%	Not Available
Breast Cancer Care	20%	20%
Cardiac Rehabilitation	20%	Not Available
<b>Covered Preventive Care Services:</b>		
Well Baby and Child Care (including immunizations)	Covered in Full	Not Available
Adult periodic physicals	Covered in Full	Not Available
Adult Immunizations (Must be provided during annual physical. Except for Influenza, Tetanus, Diphtheria, Hepatitis B and Hepatitis A.)	Covered in Full	Not Available
Mammography Screenings	Covered in Full	Not Available
Prostate Cancer Screening	Covered in Full	Not Available

<sup>1</sup> This Deductible does not apply to the following Covered Services: Maternity Care (and maternity-related care, including Diagnostic Services and Laboratory Services), Newborn Care, In-Network Diabetes Equipment and Supplies, Durable Medical Equipment, External Prosthetic Devices, including Breast Prostheses, and Ostomy Supplies. Also, there is no Deductible for covered Services that are subject to Copayment.

<sup>2</sup> The family deductible and out-of-pocket maximum shall be satisfied when either one insured or a combination of insureds satisfies the annual family deductible during contract year.

<sup>3</sup> The following Member payments do not count toward the In-Network or Out-of-Network Annual Out of Pocket Maximum: Prescription Drug Copayments, and Charges in excess of Allowable Charges.

<sup>4</sup> Includes Pre-admission testing, Surgery, Therapeutic Services, Diagnostic Services and Laboratory Services.

<b>BENEFIT</b>	<b>In-Network Coinsurance</b>	<b>Out-of-Network Coinsurance</b>
Cervical Cytology Screening	Covered in Full	Not Available
<b>Covered Professional Services &amp; Supplies</b>		
Provider Office Visits <sup>5</sup>	\$10 Copayment	\$10 Copayment
Therapeutic Services Office Setting	\$10 Copayment	\$10 Copayment
Maternity Care <sup>6</sup>	\$10 Copayment	\$10 Copayment
Child Birth Classes	You will be reimbursed up to \$40	You will be reimbursed up to \$40
Parenting Classes	You will be reimbursed up to \$25	You will be reimbursed up to \$25
Consultations (Inpatient setting)	20%	20%
Mental Health & Substance Abuse Services (office)	\$10 Copayment	Not Available
Chiropractic Care (office setting)	\$10 Copayment	Not Available
Inpatient Medical Care	20%	20%
Surgery		
Facility Setting	20%	20%
Office Setting	\$10 Copayment	\$10 Copayment
Second Surgical Opinions (office setting)	\$10 Copayment	\$10 Copayment
Assistant Surgeon (Inpatient setting)	20%	20%
Anesthesia Services (Inpatient setting)	20%	20%
Office Therapy Services (PT/ST/OT)	\$10 Copayment	Not Available
Office Laboratory Services <sup>7</sup>	0%	20%
Diagnostic Radiology Services <sup>7</sup>	\$10 Copayment	20%
Transplant Services/Donor Costs	20%	Not Available
Diabetes Equipment & Supplies <sup>8</sup>	20%	20%
Medical Foods	20%	Not Available
Durable Medical Equipment, External Prosthetic Devices, Ostomy Supplies and Breast Prostheses	20%	20%
<b>OTHER BENEFITS</b>		
Skilled Nursing Facility Services	20%	Not Available
Home Health Agency Services	20%	Not Available
Hospice Services	20%	Not Available
Emergency Services	20%	20%
Ambulance Services	20%	20%
Urgently-Needed Care	20%	20%
Basic Infertility Services		
Facility Setting	20%	20%
Office Setting	\$10 Copayment	\$10 Copayment
Abortion/Sterilization	20%	20%
Preventive Dental for Kids	\$25 Copayment	\$25 Copayment
Prescription Drug Coverage	\$10 Generic Formulary \$30 Brand Formulary \$50 Non-Formulary	\$10 Generic Formulary \$30 Brand Formulary \$50 Non-Formulary

<sup>5</sup> Includes office visits for: diagnosis and treatment, Second Surgical Opinions, Diabetes Treatment, Breast Cancer Care, and Diagnostic Services.

<sup>6</sup> Copayment applies to first diagnostic visit only (no Copayments apply thereafter).

<sup>7</sup> Processing/professional fees that are performed outside of the office setting are subject to Deductible and Coinsurance.

<sup>8</sup> For supplies, applicable per item per 30 day supply.

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## SECTION ONE – INTRODUCTION

### 1. Understanding Your Benefits

- A. Definitions. The capitalized words in this Contract are defined in Section Two or within the Section that they are used.
- B. Pre-Existing Conditions. This Contract has a Pre-Existing Condition Exclusion. Read Section Four to understand whether and to what extent this exclusion applies to you.
- C. Covered Services and Exclusions. Covered Services means the services specified in this Contract as eligible for Benefits. Covered Services are described in Sections Six through Fifteen. Covered Services must be Medically Necessary. Exclusions are described in Section Fifteen. MVP has protocols to help determine if a service is a Covered Service.

Some Covered Services are listed in more than one Section. These services are listed this way to make clear that they may be received in different settings. It does not mean that you get Benefits for additional services, such as additional days or visits. Also, where Covered Services have day or visit limits, these limits are total limits on the number of days, visits or dollars. These limits do not mean that the total number listed is available on both an In-network and Out-of-Network basis.

If you receive services that are not Covered Services, MVP will not pay for those services. You will have to pay all Charges for those services. However, this Contract applies to benefits only, and does not stop you from receiving services that are not, or might not be, eligible for Benefits.

- D. Preferred and Non-Preferred Providers. MVP provides two levels of Benefits for Covered Services depending on whether you use a Preferred Provider ("In Network") or a Non-Preferred Provider ("Out of Network"). You may get a copy of MVP's directory of Preferred Providers or ask if a provider is a Preferred Provider by calling MVP's Member Services Department. Call 1-888-MVP-MBRS or visit MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com). For more information about Mental Health and Substance Abuse Preferred Providers, call [PrimariLink] at [1-800-320-5895]. It is up to you to find out if a Provider is a Preferred Provider at the time you get services.

Benefits for some Covered Services are available only when provided by a Preferred Provider. These services are marked as "**In Network Only**" in bold.

2. Accessing In Network Services.

- A. In Network Inpatient Services. To get the In Network Benefit for Inpatient Services described in Section Six, you must be admitted by a Preferred Provider to a Preferred Hospital or facility.
- B. In Network Outpatient Services. Except for Emergency Services, to get the In Network Benefit for Outpatient Services described in Section Seven, you must get such services from a Preferred Hospital or facility.
- C. In Network Skilled Nursing Facility Services. To get the In Network Benefit for Skilled Nursing Facility Services described in Section Eight, you must be admitted by a Preferred Provider to a Preferred Skilled Nursing Facility. **In Network Only.**
- D. In Network Home Health Agency Services. To get the In Network Benefit for Home Health Agency Services described in Section Nine, the Home Health Agency Services must be provided in accordance with a written treatment plan that is supervised by a Preferred physician. You must also get such services from a Preferred Home Health Agency. **In Network Only.**
- E. In Network Hospice Services. To get the In Network Benefit for Hospice Services described in Section Nine, a Preferred Provider must certify your prognosis. The Hospice Services must be provided in accordance with a written Hospice care plan that is supervised by a Preferred physician. You must get such services from a Preferred Hospital or a Preferred Hospice. **In Network Only.**
- F. In-Network Preventive Care. To get the In Network Benefit for Preventive Care described in Section Eleven, you must get such services from a Preferred Provider. **In Network Only.**
- G. In Network Professional Services. Except as described in paragraphs H and I below, to get the In Network Benefit for Professional Services described in Section Twelve, you must get such services from a Preferred Provider.
- H. In Network Transplant Services/Donor Costs. To get the In Network Benefit for Transplant Services/Donor Costs, described in Section Twelve, the services must be provided by a Preferred Provider or by a Non-Preferred Provider who has been prior approved by MVP. The services must be performed at a facility within MVP's Specialty Network. **In Network Only.**
- I. In Network Supplies. To get the In Network Benefit for the supplies described in Section Twelve, you must have a prescription for such items and you must have the prescription filled by a Preferred pharmacy or by a Preferred Supplier. If you have the prescription filled by a Non-Preferred pharmacy or Non-Preferred Supplier, you must pay the provider's Charge and submit a claim for Retrospective Review. See Section Five.

3. Out of Network Services. If you get Covered Services other than as described above, MVP will provide Out of Network Benefits, unless otherwise excluded under the terms and conditions of this Contract. MVP will not pay Benefits for any Covered Services marked **In Network Only** if you get them Out of Network.
4. Specialty Networks. There are some services, including transplant services, pharmacy services and bariatric surgery services, that you can only get from MVP Specialty Network Providers for MVP to approve Benefits. These services are marked “**Specialty Network Only**” in bold. You may ask if a Provider is a Specialty Network Provider by calling MVP’s Member Services Department. Call 1-888-MVP-MBRS (1-888-687-6277). It is up to you to make sure that a Provider is a Specialty Network Provider at the time you get services.
5. Payments under this Contract.
  - A. Your Payments.
    - i. Deductibles. This Contract has the following Deductibles: In Network Individual, In Network Family, Out of Network Individual, and Out of Network Family. These are listed on your Schedule.
      - a. Individual Deductibles.
        - (i) In Network. You must pay the In Network Individual Deductible before MVP will pay any In Network Benefits. If you have met your In Network Individual Deductible, you do not have to pay any In Network Individual Deductible for the rest of that Contract Year. The In Network Individual Deductible applies to each Member each Contract Year. You must still pay any applicable In Network Coinsurance. If you have met your In Network Individual Deductible, you must still pay the Out of Network Deductible if you get services Out of Network.
        - (ii) Out of Network. You must pay the Out of Network Individual Deductible before MVP will pay any Out of Network Benefits. If you have met your Out of Network Individual Deductible, you do not have to pay any Out of Network Individual Deductible for the rest of that Contract Year. You must still pay any applicable Out of Network Coinsurance and the difference, if any, between the Non-Preferred Provider's Charge and the Allowable Charge. The Out of Network Individual Deductible applies to each Member each Contract Year. If you have met your Out of

Network Individual Deductible, you must still pay the In Network Deductible if you get services In Network.

b. Family Deductibles.

(i) In Network. If you have family coverage, you and your Dependents may apply the amount of each person's In Network Deductible toward the In Network Family Deductible. Any one Individual or a combination of family members can satisfy the In-Network Family Deductible during the Contract Year. If the In Network Family Deductible has been met, you and your Dependents do not have to pay any further In Network Deductible for the rest of that Contract Year. You must still pay any applicable In Network Coinsurance. The In Network Family Deductible applies each Contract Year. If you're the In Network Family Deductible has been met, you must still pay the Out of Network Family Deductible if you get services Out of Network.

(ii) Out of Network. If you have family coverage, you and your Dependents may apply the amount of each person's Out of Network Deductible toward the Out of Network Family Deductible. Any one Individual or a combination of family members can satisfy the Out-of-Network Family Deductible during the Contract Year. If the Out of Network Family Deductible has been satisfied, you and your Dependents do not have to pay any further Out of Network Deductible for the rest of that Contract Year. You must still pay any applicable Out of Network Coinsurance and the difference, if any, between the Non-Preferred Provider Charge and the Allowable Charge. The Out of Network Family Deductible applies each Contract Year. If the Out of Network Family Deductible has been met, you must still pay the In Network Family Deductible if you get services In Network.

c. No Deductible Services. You do not have to pay any Deductible for certain Covered Services, including but not limited to services subject to Copayments, Prescription Drugs, and Chronic Care if the insured is participating in a chronic care management program or for Preventive Care. These are listed **in bold**.

d. Carry Over Credit. You may incur In Network and Out of Network Expenses in the fourth quarter of any Contract Year. These will be applied to your next Contract Year's In Network and

Out of Network Individual and Family Deductibles, respectively, if there is no break in your MVP coverage.

- ii. Coinsurance. This Contract has In Network Coinsurance and Out of Network Coinsurance. These are listed on your Schedule.
- iii. Preferred Providers. When you get Medically Necessary Covered Services from a Preferred Provider, you must, in most cases, pay any applicable In Network Deductible and Coinsurance to the Preferred Provider before MVP provides benefits. The In Network Deductible and Coinsurance for each Covered Service is listed on your Schedule. **In most cases, Deductible and Coinsurance amounts may be less when In-Network Providers are used. Use of Out-of-Network Providers involves higher cost-sharing amounts.**
- iv. Preventive Care by Preferred Providers. Preventive Care Covered Services from Preferred Providers are covered in full. **In Network Only.**
- v. Non-Preferred Providers. When you get Medically Necessary Covered Services from a Non-Preferred Provider, you must pay any applicable Out of Network Deductible and Coinsurance to the Non-Preferred Provider. The Out of Network Deductible and Coinsurance for each Covered Service is listed on your Schedule. **In most cases, you will pay a higher Deductible and Coinsurance when you use Non-Preferred Providers. You must also pay the difference, if any, between the Non-Preferred Provider's Charge and the Allowable Charge.**
- vi. Annual Out of Pocket Maximums. This Contract has the following Out of Pocket Annual Maximums: In Network Individual, In Network Family, Out of Network Individual, and Out of Network Family. These are the maximum amounts of Expenses each Member must pay during any Contract Year. These are listed on your Schedule.
  - a. Individual Annual Out of Pocket Maximums.
    - (i) In Network. After you pay In Network Expenses up to the In Network Individual Annual Out of Pocket Maximum in any one Contract Year, you do not have to pay any further In Network Expenses for the rest of that Contract Year. You must still make any payments that are not counted toward the annual Out of Pocket Maximum. The In Network Individual Annual Out of Pocket Maximum applies to each Member each Contract Year. If you have met your In Network Individual Annual Out of Pocket Maximum, you must still pay Out of Network Expenses up

to the Out of Network Individual Annual Out of Pocket Maximum if you get services Out of Network.

- (ii) Out of Network. After you pay Out of Network Expenses up to the Out of Network Individual Annual Out of Pocket Maximum in any one Contract Year, you do not have to pay any more Out of Network Expenses for the rest of that Contract Year. You must still make any payments that are not counted toward the Annual Out of Pocket Maximum, and the difference, if any between the Non-Preferred Provider's Charge and the Allowable Charge. The Out of Network Individual Annual Out of Pocket Maximum applies to each Member each Contract Year. If you have met your Out of Network Individual Annual Out of Pocket Maximum, you must still pay In Network Expenses up to the In Network Individual Annual Out of Pocket Maximum if you get services In Network.

b. Family Annual Out of Pocket Maximums.

- (i) In Network. If you have family coverage, you and your Dependents may apply the amount of each person's In Network Expenses toward the In Network Family Annual Out of Pocket Maximum. Any one Individual or a combination of family members can satisfy the Out-of-Pocket Family Maximum during the Contract Year. If the In Network Family Annual Out of Pocket Maximum has been satisfied in any one Contract Year, you and your Dependents do not have to pay any further In Network Expenses for the rest of that Contract Year. You must still make any payments that are not counted toward the annual Out of Pocket Maximum. The In Network Family Annual Out of Pocket Maximum applies each Contract Year. If the In Network Family Annual Out of Pocket Maximum has been satisfied, you must still pay Out of Network Expenses if you get services Out of Network.
- (ii) Out of Network. If you have family coverage, you and your Dependents may apply the amount of each person's Out of Network Expenses toward the Out of Network Family Annual Out of Pocket Maximum. If the Out of Network Family Annual Out of Pocket Maximum has been satisfied in any one Contract Year, you and your Dependents do not have to pay any further Out of Network Expenses for the rest of that Contract Year. You must still make any payments that are not counted toward the Annual Out of

Pocket Maximum, and the difference, if any between the Non-Preferred Provider's Charge and the Allowable Charge. The Out of Network Family Annual Out of Pocket Maximum applies each Contract Year. If the Out of Network Family Annual Out of Pocket Maximum has been satisfied, you must still pay In Network Expenses if you get services In Network.

- vii. The following **Do NOT** Count Toward Annual Out of Pocket Maximums. Even if you have met the Annual Out of Pocket Maximum for a Contract Year, you must still make these payments. These are listed in **bold** in this Contract.
  - a. Copayments for Prescription Drugs.
  - b. The difference, if any, between the Non-Preferred Provider's Charge and the Allowable Charge.
  - c. Any penalties you must pay (see paragraph viii below)
- viii. **Penalties. Your Benefits will be reduced to 50% of the Allowable Charge if you do not give a required Notification or if you do not get a required Prior Authorization from MVP. If MVP does not get the information required to conduct Concurrent Review, your benefits will be reduced to 50% of the Allowable Charge unless the information was not reasonably available to you. Read Section Five. If your Benefits are reduced, you must pay the Provider the amount of the reduction PLUS any applicable Copayment, Deductible and Coinsurance, AND the difference, if any, between the Allowable Charge and a Non-Preferred Provider's Charge.**

B. MVP's Payments.

- i. Preferred Providers. MVP will pay Preferred Providers a percentage of the Allowable Charge. Preferred Providers will accept MVP's payment, plus any applicable Copayment or In Network Deductible and Coinsurance paid by you, as payment in full.
- ii. Non-Preferred Providers. MVP will pay Non-Preferred Providers at a lower percentage of the Allowable Charge. MVP, in our discretion, may reimburse you or pay the Non-Preferred Provider directly.
- iii. Annual Benefit Maximums. These are the maximum amounts of days, visits or Benefits available during any one Contract Year. After we have paid any Annual Benefit Maximum for a Covered Service in any Contract Year, you must pay all Charges for that Covered Service. After you

exceed the amount of days or visits available for a Covered Service during any one Contract Year, you must pay all Charges for that Covered Service. Covered Services that are subject to an Annual Benefit Maximum are marked in **bold**.

- iv. Lifetime Benefit Maximums. These are the maximum amounts of Benefits available during each Member's lifetime. There are two different Lifetime Benefit Maximums, described below. The amount of each Lifetime Benefit Maximum is listed on your Schedule. After you have reached the Lifetime Benefit Maximum, you must pay all Charges.
  - a. General Lifetime Benefit Maximum. This includes all In Network and Out of Network Benefits paid by MVP.
  - b. Lifetime Benefit Maximum for Durable Medical Equipment, External Prosthetic Devices and Ostomy Supplies. This includes any In Network and Out of Network Benefits paid by MVP and all In Network and Out of Network Coinsurance paid by you for Durable Medical Equipment, External Prosthetic Devices, and Ostomy Supplies.

## SECTION TWO – DEFINITIONS

- 1. The following terms have special meanings in this Contract.
  - A. Acute Services means services that are expected to provide significant, measurable clinical improvement within a period of time not to exceed two (2) months.
  - B. Allowable Charge means the maximum Benefit available under this Contract. The Allowable Charge is established in accordance with a Fee Agreement; Usual, Customary and Reasonable Charges or by law.
  - C. Benefits means payments made by MVP to you or a Provider for Covered Services.
  - D. Charge means the maximum fee charged by a Preferred Provider or Non-Preferred Provider which MVP will accept as a basis for calculating benefit amounts paid under this Contract. The maximum amount may be established by Fee Agreement, state law or Usual, Customary and Reasonable (UCR) criteria as defined in this Contract.
  - E. Chronic Care means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include , but are not

limited to, diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.

- F. Chronic Care Management means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.
- G. Coinsurance means a dollar amount, expressed as a stated percentage of the Allowable Charge, that you must pay for Covered Services. You must pay any Coinsurance directly to the Provider.
- H. Copayment means a fixed dollar amount you must pay for Covered Services. You must pay any Copayment directly to the Provider.
- I. Contract Year means the twelve month period beginning at 12:01 a.m. on your effective date and ending at 12:00 midnight, Eastern Time, on the last day of the twelve (12) month period
- J. Creditable Coverage includes coverage defined under applicable federal law as creditable coverage including:
- |   |  |
|---|--|
| (1) A group health plan such as one obtained through an employer or spouse's employer | (6) Government-sponsored health benefit programs such as CHAMPUS/TRICARE           |
| (2) A health insurance policy or contract   | (7) A health benefit plan under section 5(e) of the Peace Corps                    |
| (3) Self-insured group health benefit plans   | (8) A medical program of the Indian Health Service Act or of a tribal organization |
| (4) Medicaid  | (9) Federal Employees Health Benefits Program                                      |
| (5) Medicare  | (10) A State health benefits risk pool   |
|   | (11) A public health plan  |

Subject to federal law, the definition of Creditable Coverage includes any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer, which includes, but is not limited to comprehensive non-group, small group and large group policies.

Creditable coverage does not include:

- (1) Accident-only coverage.
- (2) Worker's compensation or similar insurance.
- (3) Automobile medical payment insurance.
- (4) Limited scope dental or vision benefits.
- (5) Long-term care benefits provided in a separate policy.

K. Custodial Services means services mainly for maintenance or meant to help you in your daily living activities. Custodial Services include, but are not limited to:

- (1) help in walking, bathing and other personal hygiene, toileting, getting in and out of bed
- (2) dressing
- (3) feeding
- (4) preparation of special diets
- (5) administration of oral medications
- (6) routine changing of dressings
- (7) child care
- (8) adult day care
- (9) residential care
- (10) care not requiring skilled professionals

This term also means services that are not expected to provide significant, measurable clinical improvement within a period of time not to exceed two (2) months.

L. Dependent means a person other than the Subscriber, listed on the Subscriber's enrollment application, including family members of a civil union as defined by Vermont law, for whom MVP has received the required premium.

M. Deductible means a dollar amount, other than the difference between a Non-Preferred Provider's Charge and the Allowable Charge, and any premium payments or contributions, you must pay each Contract Year before we provide any Benefits. You must pay any Deductible directly to the Provider.

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

O. Eligible Individual, as used in Section Three and as defined by Vermont State law, means a person who, on the effective date of this Contract:

- i. is an Uninsured Vermont resident
- ii. is a dependent of an Uninsured Vermont resident;
- iii. does not have access to coverage under an employer-sponsored health plan;
- iv. has lost private or employer-sponsored insurance in the prior 12 months (in this case, the individual need not be uninsured for 12 months prior to enrolling in Catamount) for the following reasons:
  - a. loss of employment;
  - b. death of the principal insurance policy holder;
  - c. divorce or dissolution of a civil union'

- d. no longer qualifying as a dependent under the plan of a parent or caretaker relative; or
    - e. no longer qualifying for COBRA, VIPER or other state continuation coverage;
  - v. has lost college or university sponsored health insurance due to graduation, leave of absence or otherwise having terminated studies.
  - vi. is an individual with income under 300 percent of the federal poverty level who is eligible for an employer-sponsored insurance plan however:
    - a. the individual's employer-sponsored insurance plan is not an approved employer-sponsored plan under section 1974 of Title 33;
    - b. enrolling the individual in an approved employer-sponsored plan combined with premium assistance under section 1974 of Title 33 offered by the agency of human services is not cost-effective to the state as compared to enrolling the individual in Catamount Health combined with the assistance under subchapter 3a of chapter 19 of Title 33; or
    - c. the individual is eligible for employer-sponsored insurance premium assistance under section 1974 of Title 33, but is unable to enroll in the employer's insurance plan until the next open enrollment period.
- P. Emergency Medical Condition means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:
- i. placing the member's physical or mental health in serious jeopardy; or
  - ii. serious impairment to bodily functions; or
  - iii. serious dysfunction of any bodily organ or part.
- Q. Emergency Services are Covered Services provided to diagnose and treat an Emergency Medical Condition.
- R. Expenses means Coinsurance and Deductible payments for Covered Services made to Preferred Providers or Non-Preferred Providers. Expenses do not include Copayments for Prescription Drugs. Expenses also do not include payments you make to a Non-Preferred Provider for the difference between the Non-Preferred Provider's Charge and the Allowable Charge.
- S. Experimental or Investigational Services means 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. Such Services shall include

coverage of routine costs for patients who participate in approved cancer clinical trials as required by Vermont law.

- T. Fee Agreement means an arrangement between MVP and Preferred Providers to provide Covered Services to Members.
- U. Health Care Professional means an individual, partnership, corporation, facility, or (including a hospital) institution licensed or certified or authorized by law to provide professional health care services.
- V. Health Service means any medically necessary treatment or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including services ordered by a health care professional and medically necessary services to assist in activities of daily living.
- W. Hospital means a duly licensed, short-term, acute care facility that primarily provides diagnostic and therapeutic services for diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians. It must have organized departments of medicine and major surgery. It must 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 schools, colleges or camps;
  - Facilities for the aged;
  - Any military or veterans hospital or soldiers home, or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered for Emergency Medical Conditions, where a legal liability exists for charges made to the individual for such services; and
  - Residential Care Facilities.
- X. In Network Benefits means Benefits paid by MVP when Covered Services are provided by Preferred Providers in accordance with the terms and conditions of this Contract.
- Y. Member means the Subscriber or his or her Dependents.
- Z. Mental Health Condition means any condition or disorder involving mental illness that falls under any diagnostic category listed in the Mental Disorders Section of the International Classification of Disease (ICD-CM-9), as periodically revised, and the following conditions listed in the "V Codes" Section of the International Classification of Disease:

- i. Personal history of mental disorder (ICD-9-CM codes V11.00 through V11.99);
- ii. Psychological trauma (ICD-9-CM code V15.40);
- iii. Psychiatric condition (ICD-9-CM code V17.00);
- iv. Other family circumstances and other psychosocial circumstances (ICD-9-CM codes V61.00 through V62.99, except V61.10 (marital counseling)); and
- v. Observation for suspected mental condition (ICD-9-CM code V71.00).

Mental Health Condition does not include:

- i. Hyperkinetic Syndrome of Childhood (ICD-9-CM codes 314.00 through 314.99); provided however that we will provide Benefits for Acute Mental Health Services when other diagnoses are present;
- ii. Specific Delays in Development (ICD-9-CM codes 315.00 through 315.99);
- iii. Psychic Factors associated with diseases classified elsewhere in the ICD-9-CM (ICD-9-CM code 316.00); and
- iv. Mental retardation (ICD-9-CM codes 317.00 through 319.99), Autistic Disease of Childhood (ICD-9-CM Code 299.00) provided however that we will provide Benefits for Acute Mental Health Services when other diagnoses are present.

AA. Mental Health Services means services to diagnose or treat a Mental Health Condition.

BB. Medical or Scientific Evidence means the following sources:

- i. 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;
- ii. 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);
- iii. medical journals recognized by the federal Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act;

- iv. 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;
- v. 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.

CC. Medically Necessary or Medical Necessity means that a Covered Service is:

- i. Appropriate, in terms of type, amount, frequency, level, setting and duration, for the diagnosis or treatment of your condition;
- ii. Consistent with generally accepted practice parameters as recognized by health care providers in the same or similar specialty as typically treat or manage the diagnosis or condition;
- iii. One which:
  - a. helps restore or maintain your health;
  - b. prevents deterioration of or palliate your condition; or
  - c. prevents the reasonably likely onset of a health problem or detect an incipient problem.

Even though a Provider prescribes, performs, orders, recommends, or approves a service, that does not mean that the service is Medically Necessary or that we must provide benefits for the service.

MVP maintains protocols to assist in determining whether a service is Medically Necessary.

DD. Non-Preferred Provider means a Provider that is not a Preferred Provider. Some Providers must be Preferred Providers in order for their services to be Covered Services.

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

- FF. Pre-existing Condition means the existence of symptoms that would cause an ordinary, prudent person to seek diagnosis, care or treatment. It also means any physical or mental condition, illness, injury, disease, or ailment for which medical advice, diagnosis, care or treatment was recommended or received by a provider within the twelve (12) month period preceding your effective date under this Contract. It does not include genetic information in the absence of a diagnosis of the condition related to such information and does not include pregnancy.
- GG. Preferred Provider means a Provider who has an agreement with MVP to provide Covered Services to Members.
- HH. Preventive Care means health services provided by health care professionals to identify and treat asymptomatic individuals who have developed risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.
- II. Primary Care means health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and shall include prenatal care and the treatment of mental illness.
- JJ. Provider means properly licensed or certified physicians and health care professionals performing services within their licensure or certification. It also means Hospitals, ambulatory surgery centers, birth centers, Skilled Nursing Facilities, federally qualified mental health or substance abuse treatment facilities, Home Health Agencies, Hospices, Durable Medical Equipment and External Prosthetic Device suppliers, and Ambulance services. Some Providers must be Preferred Providers for their services to be Covered.
- KK. Schedule means the document attached to this Contract which describes the applicable Copayments, Deductible, Coinsurance, Annual Out of Pocket Maximums, Annual Benefit Maximums, Lifetime Benefit Maximums and similar information.
- LL. Single Confinement means consecutive days of Inpatient Services. It also means successive confinements, when discharge and readmission for the same condition occur within a period of not more than 90 days. To measure a Hospital stay, we count the day of admission and each day after until the day of discharge. The day of discharge does not count.
- MM. Spouse means the Subscriber's spouse under a legally valid marriage or civil union as defined by Vermont law.

- NN. Subscriber means the person to whom this Contract is issued, who continues to meet residency requirements, and for whom the required premium has been received by MVP.
- OO. Substance Abuse Condition means the following disorders involving alcohol or substance abuse that falls as listed in the Mental Disorders Section in the International Classification of Diseases Manual (ICD-9-CM):
- i. Alcohol and drug psychoses (ICD-9-CM codes 291.00 through 292.99);
  - ii. Alcohol dependence syndromes (ICD-9-CM codes 303.00 through 303.99);
  - iii. Drug dependence (ICD-9-CM codes 304.00 through 304.99); and
  - iv. Non-dependent abuse of drugs (ICD-9-CM codes 305.00 through 305.99), except tobacco use disorder (ICD-9-CM code 305.10) and other, mixed or unspecified drug abuse (ICD-9-CM code 305.90).
- PP. Substance Abuse Services means services to diagnose or treat a Substance Abuse Condition.
- QQ. Therapy Services means acute services limited to Physical Therapy (PT), Speech Therapy (ST) and Occupational Therapy (OT).
- RR. Totally Disabled or Total Disability means incapable of engaging in any employment or occupation for which the person is or becomes qualified by reason of education, training or experience. Such person must not, in fact, engage in any employment or occupation for wage or profit.
- SS. Uninsured means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur and had no creditable private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application, or lost creditable private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:
- i. the individual's private insurance or employer-sponsored coverage ended because of:
    - a. loss of employment;
    - b. death of the principal insurance policyholder;
    - c. divorce or dissolution of a civil union;
    - d. no longer qualifying as a dependent under the plan of a parent or caretaker relative; or
    - e. no longer qualifying for COBRA, VIPER, or other state continuation coverage; or

- ii. college- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.

TT. Urgently-Needed Care provided by a Preferred Provider means Medically Necessary Covered Services to treat an illness or condition that if not treated within 24 hours presents a serious risk of harm.

Urgently-Needed Care provided by a Non-Preferred Provider means Medically Necessary Covered Services to screen and stabilize a condition that if not treated within 24 hours presents a serious risk of harm, so that you can be safely transported to a Preferred Provider; provided that such services were received because you were unable to get services from a Preferred Provider.

UU. Usual, Customary and Reasonable (UCR) Charges are established based on a percentile of national prevailing charge data compiled for a specific procedure and adjusted for geographic differences. When you get Covered Services from a Non-Preferred Provider, the Allowable Amount is determined by UCR Charges.

### **SECTION THREE – ELIGIBILITY AND ENROLLMENT**

**Any references to Coverage of Children under this Contract apply ONLY to non-subsidized contracts.**

1. Who Is Eligible To Be Covered Under This Contract.

An Eligible Individual as defined in Section Two of this Contract may enroll in MVP Catamount Choice Plan and be covered as the Subscriber under this Contract.

- A. If the Subscriber chooses individual coverage, then only he or she is covered.
- B. If Subscriber plus Spouse only coverage is offered and the Subscriber chooses such coverage, then only the Subscriber and his or her Spouse may be covered.
- C. If Subscriber plus child or children only coverage is offered and the Subscriber chooses such coverage, then only the Subscriber and his or her child(ren), as described below, may be covered.
- D. If family coverage is offered and the Subscriber chooses such coverage, then the Subscriber, his or her Spouse and his or her child(ren), as described below, may also be covered.

2. Children Covered Under This Contract. To be covered, the Subscriber's children must meet the requirements of paragraph A or B below. The Subscriber's children must also be related to the Subscriber in one of the ways set forth in paragraph C.

- A. The Subscriber's unmarried children who are under age nineteen (19), live with the Subscriber, and are chiefly dependent upon the Subscriber for support and maintenance; or
  - B. The Subscriber's unmarried children who are over age nineteen (19) and incapable of self-sustaining employment because of developmental disability, mental retardation, or physical disability, if the incapacity occurred before the child reached age nineteen (19). The child must live with the Subscriber and be chiefly dependent upon the Subscriber for support and maintenance. You must provide a physician's certification, within thirty-one (31) days after the child's nineteenth birthday, and each Contract Year thereafter, in order for the child's coverage to continue under this section. We can require you to provide documentation verifying that the child is qualified and continues to qualify under this section.
  - C. The Subscriber's children must also be related to the Subscriber in one of the following ways:
    - i. The Subscriber's natural child;
    - ii. The Subscriber's legally adopted child;
    - iii. A child for whom the Subscriber is the legal guardian or for whom the Subscriber has legal custody;
    - iv. The Subscriber's stepchild;
    - v. A child under age eighteen (18) who has been placed with the Subscriber for adoption and for whom the Subscriber has assumed and retains a legal obligation to support;
    - vi. A child of the Subscriber's Dependent, from the moment of birth for thirty-one (31) days. Benefits are limited to benefits for covered services for injury, sickness, necessary care and treatment of medically diagnosed congenital defects or birth abnormalities, or any combination of these, and well child care; or
    - vii. A child for whom the Subscriber has been ordered to provide dependent health insurance coverage pursuant to a qualified medical support order, even if the child does not live with the Subscriber.
    - viii. A child of the Subscriber's partner in a Civil Union as defined by Vermont Law
3. Initial Enrollment - To apply for coverage, the Subscriber must fill out and sign a form that tells us whether he or she wants individual, two-person, or family coverage. The names of all persons seeking coverage must be listed on this form. If the Subscriber is seeking coverage for his or her spouse, the spouse must also sign the form. The Subscriber must send this form to MVP and give MVP any supporting documentation we may ask for to determine and verify your eligibility.

4. Enrollment of Subscriber's New Family Members.

- A. To add a Spouse. You and your Spouse must fill out and return an enrollment form, any requested documentation, and any required premium. If you return the completed form, requested documentation, and required premium within thirty (30) days of the marriage or civil union, your Spouse will be added to your coverage effective as of the date of the marriage or civil union. If you do not, your Spouse will be added to your coverage as of the first of the month following the next premium due date after the next open enrollment period when we get the completed form, requested documents and applicable premium.
- B. To add a child.
- i. Your newborn natural child or a newborn child placed with you for adoption, will automatically be covered from the moment of birth for 31 days. Coverage is limited to benefits for otherwise covered services for injury, sickness, necessary care and treatment of medically diagnosed congenital defects or birth abnormalities, or any combination of these, and well child care. If you want to continue the child's coverage beyond 31 days, you must comply with paragraph (ii) below. If you do not follow this procedure, we will not provide coverage beyond the 31 days.
  - ii. For coverage beyond the 31 days described in paragraph (i) above, you must complete and return an enrollment form, any requested documentation, and the required premium. If you do so within 31 days of the date of birth, adoption, placement for adoption, legal guardianship, legal custody, or within 31 days of the date the child became your step child, your child will be added to your coverage effective as of the date of birth, adoption, placement for adoption, or legal guardianship, legal custody, or as of the date the child became your step child. If you do not do so within 31 days of the events described, your child will be added to your coverage as of the first of the month following the next premium due date after we get the completed form, requested documents, and applicable premium. If you do not notify us, we will not provide coverage, beyond the initial 31 days, for the child.
    - a. We 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.
    - b. If a notice of revocation of adoption is filed or one of the natural parents revokes their consent to the adoption, we will be entitled to recover the amount of benefits provided by us.
  - iii. To add a child for whom a court has ordered you to provide dependent health insurance coverage pursuant to a qualified medical support order, you must mail us a copy of the order, by first class mail, postage prepaid. If the child

is otherwise eligible for coverage, we will process the child's enrollment within ten (10) days of receiving the order. The child will be added to your coverage three (3) days from the date you mailed the order to us. You must pay us any required premium for coverage to be effective.

5. Obligation to Provide Information. You must give us information needed to determine your initial and continuing eligibility status. This information must be provided within 30 days of our request subject to applicable state and federal law. We have the right to verify this information.
6. When you, your Spouse or your child is no longer eligible. You must immediately notify us of any event that affects your eligibility. Such events include, divorce or annulment, death of your Spouse, or coverage under another contract, policy or certificate, a child marrying or reaching the age at which eligibility terminates, and a change or termination of any medical support order.
7. Enrollment Changes. If you want to change your coverage to one with a lower premium, (such as a change from family to individual coverage), you must return a completed change form and any requested documentation to your Group within 30 days of such event so that the change in premium will be effective as of the date of the event. If you do not, or if your Group does not provide the information to MVP in a timely manner, your change in premium will not be effective until the first of the month following the next premium due date after the form and documentation are received. This paragraph only involves the effective date of changes in premiums.
8. Persons Not Eligible For Coverage Under This Contract.
  - A. A person eligible for Medicare, Medicaid, the Vermont Health Access Plan, Dr. Dynasaur or any other state or federal program.
  - B. A person who had private or employer-sponsored coverage that included both hospital and physician services within 12 months prior to the month of application.
  - C. A person of the age of majority who is claimed on a tax return as a dependent of a resident of another state.
  - D. A person who is not a Vermont resident.

#### **SECTION FOUR PRE-EXISTING CONDITIONS**

1. We will not provide benefits during the first twelve months of this contract for any services for or related to a Pre-Existing Condition.
2. A Pre-Existing Condition is the existence of symptoms that would cause an ordinary, prudent person to seek diagnosis, care or treatment. It is also any physical or mental condition, illness, injury, disease, or ailment for which medical advice, diagnosis, care or treatment was recommended or received by a provider within the twelve (12) month period preceding your Effective Date under this Contract. An example of such a condition includes, but is not limited to, a pregnancy existing on your Effective Date under this

Contract. It does not include genetic information in the absence of a diagnosis of the condition related to such information.

3. This Pre-Existing Condition exclusion does not apply to:
  - A. chronic care if the individual is participating in a chronic care management program (See Section Fourteen); or
  - B. individuals and their dependents who produce evidence of continuous creditable coverage during the previous nine (9) months. A period of continuous creditable coverage is coverage that occurred without a break of 63 days or more.

If an individual has a preexisting condition excluded under a subsequent policy, such exclusion shall not continue longer than the period required under the original contract or 12 months, whichever is less.

4. Effect of Creditable Coverage. If a Pre-Existing Condition exclusion applies to you, the exclusion period may be reduced. The time you were covered under Creditable Coverage (as defined in Section Two) before you became covered under this Contract will be counted to reduce the exclusion period. This is only if there was not a break in coverage greater than 63 days between termination of the previous Creditable Coverage and your Effective Date under this Contract.

For an eligible individual, as such term is defined in Section 2741 of Title XXVII of the Public Health Service Act, a carrier offering Catamount Health shall not limit coverage of preexisting conditions

## **SECTION FIVE -- UTILIZATION MANAGEMENT AND CLAIMS FILING**

This Contract requires Notification and Prior Authorization before you get certain Covered Services. All services are subject to Retrospective Review. The purpose of Utilization Management is to determine whether and to what extent Benefits are payable by MVP. MVP's approval of services through Authorization or Concurrent Review is not a guarantee of benefits. MVP may deny benefits in cases where there is material misrepresentation or fraud by a Member, and as otherwise permitted by law.

1. Notification. Notification means the notice you must give to MVP before you get 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 Notification is Required.
    - i. Notification is required for the following:
      - a. In and Out of Network Surgery except when performed in a physician's office.

- b. Out of Network Non-Emergency Ambulance Services.
    - c. Out of Network participation in a clinical trial for cancer.
  - B. How to give Notification. You must contact MVP's Utilization Management Department at 1-800-380-3530 extension 3 at least 48 hours before you get the services listed above. You must provide us with your name, MVP ID number, your Provider's name and address, the services you will be receiving, dates of service and your diagnosis.
  - C. MVP's Response to Notification. MVP will provide you with a written notice confirming your call.
- 2. Prior Authorization. Prior Authorization means the required approval that you must get from MVP before you get 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. **It is up to you to make sure that Prior Authorization is obtained.** If you do not get Prior Authorization from us before you get certain Covered Services, your Benefits will be reduced to 50% of the Allowable Charge. (See Paragraph D below). Covered Services that require Prior Authorization are marked in **bold**.
  - A. When Prior Authorization is Required.
    - i. Prior Authorization is required for the following In Network services:
      - a. Inpatient Mental Health and Substance Abuse Services. (**In-Network Only**)
      - b. Inpatient Physical Rehabilitation Care.
      - c. Surgery.
      - d. Skilled Nursing Facility Services (**In Network Only**).
      - e. Home Health Agency Services (**In Network Only**).
      - f. Non-Emergency Ambulance Services.
      - g. Hospice Services (**In Network Only**).
      - h. Outpatient Mental Health Services whether in the outpatient department of a Preferred Hospital or Preferred Facility or in a Preferred Provider's office.
      - i. Outpatient Substance Abuse Services whether in the outpatient department of a Preferred Hospital or Preferred Facility or in a Preferred Provider's office.
      - j. Chiropractic Treatment if you use more than 8 visits in any one Contract Year. (**In Network Only**).
      - k. Transplant Services (**Specialty Network Only**).
      - l. Durable Medical Equipment and External Prosthetic Devices.
      - m. Bariatric Surgery (**Specialty Network Only**).

B. How to get Prior Authorization.

- i. Generally. To request Prior Authorization you must contact MVP's Utilization Management Department at 1-800-380-3530 extension 3. You must provide us 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 or involves Urgently-Needed Care, you must tell us and describe the circumstances that make it Urgent. You must contact us at least fifteen (15) days prior to your proposed admission or service date. You must notify us if your admit or service date changes. A family member or Provider may call for you. **However, it is up to you to make sure that precertification is obtained.**
- ii. In Network Mental Health Services and Substance Abuse Services. To request Prior Authorization, you or your representative must contact [Primarilink] at [1-800-320-5895] phone, [(802) 258-3749] fax, or [PO Box 803, Brattleboro, Vermont 05302] address. You or your representative must provide your name, MVP ID number, your Provider's name and address, the date(s) that services are requested, and your diagnosis.
- iii. In Network Chiropractic Treatment. To request Prior Authorization, you or your representative must contact [Landmark] at [1-800-638-4557] phone, [800-599-8350] fax, or [Landmark Healthcare, 1750 Howe Avenue, Sacramento, California 95825] address. You or your representative must provide your name, MVP ID number, your Provider's name and address, the date(s) that services are requested, and your diagnosis.

C. MVP's Response to Requests for Prior Authorization.

- i. Claims for Urgent Matters. If your request for Prior Authorization meets the requirements of paragraph 1(a) or 1(b) below and you properly identify to MVP that the request is Urgent, we will respond as described below. Requests and claims for Retrospective Review are excluded from this paragraph.
  - a. In cases involving Urgently Needed Care, we will notify you and your Provider, by telephone, of our decision within 24 hours of the time that Prior Authorization is requested. You and your Provider will be notified, in writing, within 24 hours of the telephone notice.
  - b. In cases where:
    - (i) application of the time periods described in paragraph 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
  - (ii) a physician with knowledge of your medical condition determines that a Prior Authorization request is urgent, if all necessary information is received at the time of the request, we will notify your Provider, by telephone and you and your Provider in writing, of our decision within 48 hours after our receipt of the request. If all necessary information is not received at the time of the request, we will notify you and your Provider within 24 hours after our receipt of the request of any missing information that is needed to decide the request. You and your Provider will have 48 hours from the receipt of our notice to provide us with the missing information. In such cases, we will notify you and your Provider, by telephone and in writing, of our decision within 24 hours after: (a) our receipt of the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner. If we deny Benefits, you must pay all Charges.
- ii. Non-Urgent Prior Authorization Requests. If all necessary information is received at the time of the Prior Authorization or prior approval request, we will notify you of our decision within three (3) working days. Except in cases involving Mental Health Services or Substance Abuse Services, in the event of an adverse determination, we will also notify your Provider, by telephone of our decision. If all necessary information is not received at the time of the prior approval or Prior Authorization request, we will notify you and your Provider within 5 days after our receipt of the request of any missing information that is needed to decide the request. You and your Provider will have 45 days from the receipt of our notice to provide us with the missing information. In such cases, we will notify you and your Provider, in writing, of our decision within three (3) working days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner. If we deny Benefits, you must pay all charges.

- D. **Failure to give Notification or get Prior Authorization.** If you fail to give Notification or get Prior Authorization when required, MVP will reduce payment of any otherwise payable Benefit to fifty percent (50%) of the Allowable Charge. Additionally, if we conduct Retrospective Review and determine that any admission and/or service(s), whether received In Network or Out of Network, was not Medically Necessary, we will not provide Benefits.
3. Concurrent Notice. Concurrent Notice means the notice you 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 concurrent review schedule.
- A. When Concurrent Notice is Required. Concurrent Notice is required for the following services, whether In Network or out of Network:
- i. Emergency Inpatient Admissions
  - ii. Inpatient Maternity Care (call after delivery)
  - iii. Detoxification Admissions (available **In Network only**)
- B. How to give Concurrent Notice. You must contact us at 1-800-380-3530 extension 3 within 48 hours (or as soon as reasonably possible) after you begin receiving these services. You must provide us with your name, MVP ID number, your Provider's name and address, services you are receiving, dates of service and your diagnosis.
- C. MVP's Response to Concurrent Notice. MVP will provide you with a written notice confirming your call.
- Covered Services that require Concurrent Notice Review are marked in **bold** throughout this Contract.
4. Concurrent Review. Concurrent Review means MVP's review of a request to extend a course of treatment beyond the period of time or number of treatments approved under paragraphs 1 or 2, to determine whether such services continue to be Medically Necessary Covered Services.
- A. Concurrent Review is our Concurrent Review to determine whether it is Medically Necessary for you to continue receiving the following inpatient-based services.
- i. Inpatient Services, including Emergency Inpatient Admissions, Inpatient Maternity and Newborn Care, and Detoxification Admissions
  - ii. Skilled Nursing Facility Services
  - iii. Hospice Services

Covered Services that require Length of Stay Review are marked in **bold** throughout this Contract

- B. Getting Length of Stay Review. MVP will contact your Provider. You must ensure that your Provider gives us the clinical information needed to conduct this review before the end of each period for which your benefits were approved.
  
- C. Review of Ongoing Outpatient and Professional Services is our review to determine whether the following ongoing services are Medically Necessary.
  - i. Home Health Agency Services
  - ii. Chiropractic Treatment
  - iii. Mental Health and Substance Abuse Services
  
- D. Getting Review of Ongoing Outpatient and Professional Services.
  - i. Home Health Agency Services. You must ensure that your Provider calls MVP's Utilization Management Department at 1-800-380-3530 extension 3 and gives the necessary clinical information to conduct the review.
  
  - ii. Chiropractic Treatment. You must ensure that your Provider completes a written Chiropractic Treatment Plan that includes a request for a specific number additional of visits and submits it to [Landmark] for review at [1-800-638-4557] phone, [800-599-8350] fax, or [Landmark Healthcare, 1750 Howe Avenue, Sacramento, California 95825] address. The Chiropractic Treatment Plan must be submitted to [Landmark] at least 15 days before the additional proposed services are to be provided.
  
  - iii. Mental Health and Substance Abuse Services. You must ensure that your Provider completes a written Outpatient Treatment Report that includes a request for a specific number additional of visits and submits the treatment plan to [PrimariLink] for review at [1-800-320-5895] phone, [(802) 258-3749] fax, or [PO Box 803, Brattleboro, Vermont 05302] address. The Outpatient Treatment Report must be submitted to [PrimariLink] at least 15 days before the additional proposed services are to be provided.
  
- E. MVP's Response to Concurrent Review.
  - i. Urgent Matters
    - a. If all necessary information is received at the time of the concurrent review, we will notify you and your Provider, in writing and your provider by telephone, of our decision within 24 hours after the review. If we deny Benefits as a result of our review, we will not provide any Benefits after the date that you get notice of our decision. You must then pay all Charges.

b. If all necessary information is not received at the time of the concurrent review request, we will deny Benefits. If we deny Benefits, we will not provide Benefits after the date that you get notice of our decision. You must then pay all Charges.

ii. Non-Urgent Matters

a. Pre-service.

(i) If all necessary information is received at the time of the concurrent review and services have not yet been provided to you, we will notify you of our decision within three (3) working days. Except in cases involving Mental Health Services or Substance Abuse Services, in the event of an adverse determination, we will also notify your Provider by telephone of our decision. If we deny Benefits, you must pay all Charges.

(ii) If all necessary information is not received at the time of the Concurrent Review, we will notify you and your Provider within five (5) days after the review of any necessary information that is needed to complete the review. You and your Provider will have 45 days from the receipt of our notice to provide us with the missing information. In such cases, we will notify you and your Provider, in writing, of our decision within three (3) working days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner. If we deny Benefits, you must pay all Charges.

b. Post Service.

(i) If all necessary information is received at the time of the review and services have already been provided to you, we will notify you of our decision within thirty (30) working days. If we deny Benefits, you must pay all Charges.

(ii) If all necessary information is not received at the time of the Concurrent Review, we will notify you and your Provider within five (5) days after the review of any necessary information that is needed to complete the review. You and your Provider will have 45 days from the receipt of our notice to provide us with the missing information. In such cases, we will notify you and your Provider, in writing, of our decision within fifteen (15) days after: (a) our receipt of the

missing information; or (b) the expiration of your time to provide the missing information, whichever is sooner. Except in cases of missing information, MVP's time to conduct this review shall not exceed a total of thirty (30) days. If we deny Benefits, you must pay all Charges.

- F. Failure to give Concurrent Notice or get Concurrent Review. If you fail to give Concurrent Notice or get Concurrent Review when required, MVP will reduce payment of any otherwise payable Benefit to fifty percent (50%) of the Allowable Charge if the information was not reasonably available to you. Additionally, if we conduct Retrospective Review and determine that any admission or service whether received in Network or Out of Network, was not Medically Necessary, we will not provide Benefits.
5. Retrospective Review. Retrospective review means our review, after services have been provided to you, to determine whether such services are Medically Necessary Covered Services and whether and to what extent Benefits are payable.
- A. When Retrospective Review is Required. We conduct Retrospective Review on all claims.
  - B. How to get Retrospective Review.
    - i. In Network Services. When you get Covered Services In Network, the Preferred Provider will submit your claim and bill MVP directly.
    - ii. Out of Network Services. When you get Covered Services Out of Network, in most cases, a Non-Preferred Provider will bill you directly. In some cases, you must pay a Non-Preferred Provider and request reimbursement from MVP. In either case, you must then submit your claim to MVP by following the Claims Submission instructions below. In some cases, the Non-Preferred Provider will bill MVP directly. In such cases, either you or the Non-Preferred Provider must submit a claim to MVP by following the Claims Submission instructions below.
    - iii. Claim Submission.
      - a. Submit your properly completed claims form to MVP. You may request claim forms by calling MVP's Member Services Department at (888) MVP-MBRS. You may also request or download claim forms by visiting MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com).
      - b. Mail your properly completed claim forms with any bills and receipts by first class mail, postage prepaid, to MVP at:

MVP Health Insurance Company  
P.O. Box 1076  
Schenectady, NY 12301-1076

- c. You must mail your properly completed claim forms to MVP within **twenty-four (24) months**, or as soon thereafter as is reasonably possible, of your receipt of the Non-Preferred Provider's bill.
  - C. MVP's Response to Retrospective Review. If all necessary information is received at the time of the claim submission, we will notify you of any adverse determination, in writing, within 30 days after our receipt of the claim. If all necessary information is not received at the time of the claim, we will notify you and your Provider within 5 days after our receipt of the claim of any missing information that is needed to decide the claim. You and your Provider will have 45 days from receipt of our notice to provide us with the missing information. In such cases, we will notify you of any adverse determination, in writing, within 30 days after: (a) our receipt of the missing information; or (b) the expiration of your time to provide us with the missing information, whichever is sooner. Except in cases of missing information, MVP's time to conduct Retrospective Review shall not exceed a total of fifteen (15) days.
6. Individual Case Benefit Management. If your Provider recommends an alternate setting or treatment as appropriate for your condition, at our discretion, we may provide Benefits for alternative settings or treatment even if we do not usually cover them under this Contract. Our decision to cover alternate care in one case does not obligate us to provide the same benefits again. We will only provide Benefits for alternative settings or treatment:
  - A. if the alternative services are Medically Necessary;
  - B. if we did not cover the alternative services you would get Covered Services; and
  - C. you agree in writing to a case management plan, to abide by MVP Protocols for Case Management and, if requested to waive specific Benefits for Covered Services in lieu of alternative services.
7. Right to File a Grievance. If you disagree with our decisions under this Section, you may file a Grievance as described in Section Nineteen.

## **SECTION SIX - COVERED HOSPITAL INPATIENT SERVICES**

1. **Inpatient Services are subject to Length of Stay Review**. Your Benefits will be reduced to 50% of the Allowable Charge if we do not get the information needed to conduct Length of Stay Review. We will only provide Benefits if a Covered Service is Medically Necessary.
2. Inpatient Services. To get Benefits for Inpatient Services, you must be a registered inpatient in the Hospital and be under the care of a licensed physician. We will provide benefits for up to 365 days per Single Confinement per Contract Year for the following when provided

to you in a Hospital. You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

- 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. This means supplies and equipment used in and provided by the Hospital when performing Diagnostic Services ordered by a physician to determine a definite condition or disease. Diagnostic Services includes radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scans, electroencephalograms (EEG), electrocardiograms (ECG), organ scans, allergy testing (percutaneous, intracutaneous, patch and RAST testing) and other medical and surgical diagnostic services;
- G. Therapeutic Services. Therapeutic Services means:
  - i. Radiation Therapy. This means the use of x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes for treatment of disease;
  - ii. Chemotherapy. This means prevention of the development, growth, or multiplication of malignant diseases by chemical or biological agents, and includes growth cell stimulating factor injections taken as part of a chemotherapy regimen;
  - iii. Cancer Hormone Therapy. This means a treatment method altering hormone levels to combat cancer growth;
  - iv. Dialysis. This means 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;
  - v. Infusion Therapy. This means treatment of disease by continuous injection of curative agents; and

- vi. Inhalation Therapy. This means inhalation of medicine, water vapor and/or gases to treat impaired breathing.
  - H. Therapeutic items used in and provided by the Hospital when performing Therapeutic Services, such as prescribed drugs, medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items;
  - I. Equipment, and supplies in connection with oxygen, anesthesia, and pathology services;
  - J. Laboratory services; and
  - K. Medical and surgical supplies.
3. Skilled Nursing Facility Care. Care that is most appropriately provided in a Skilled Nursing Facility, but at MVP's discretion is provided on an inpatient basis in a Hospital, may be covered under your Skilled Nursing Facility Benefits.
  4. Maternity Care. **Concurrent Notice is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not give Concurrent Notice.** We provide benefits for Inpatient Services to a covered mother for childbirth for at least 48 hours after a non-caesarean delivery or for at least 96 hours after a cesarean delivery in a Hospital or birthing center. The attending physician, with the mother or mother's designated representative, may decide to discharge the mother sooner. We will also provide benefits for Inpatient Services for pregnancy and complications of pregnancy. You must pay any applicable Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.
  5. Newborn Care. We will provide Benefits for Inpatient Services and routine inpatient nursery care and examinations for a covered newborn child for at least 48 hours after a non-caesarian delivery or for at least 96 hours after a caesarian delivery in a Hospital or birthing center. The attending physician, with the newborn's mother or the newborn's designated representative, may decide to discharge the newborn sooner. Subject to the requirements set forth in Section Three, paragraph 4(B), we will also provide Benefits for a covered newborn from the moment of birth through 31 days after birth for Covered Services for sickness, injury, and medically diagnosed congenital defects or birth abnormalities, or any combination of these, and Well Child Care. You must pay any applicable Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge
  6. Breast Cancer Care. We will provide Benefits for Inpatient Services in connection with an inpatient Hospital stay following a mastectomy, lymph node dissection or lumpectomy for the treatment of breast cancer. We will provide Benefits for physical complications

of mastectomy, including lymphedema. We will provide Benefits for Inpatient Services in connection with an inpatient Hospital stay following reconstruction of the breast on which a mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. These surgical services will be performed in the manner that your attending physician, in consultation with you, determines is appropriate. Benefits shall include coverage of routine costs for patients who participate in approved cancer clinical trials as required by Vermont law. You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

We will provide Benefits for breast prostheses required as a result of covered Breast Cancer Care. You must pay any applicable Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

7. Physical Rehabilitation Care. **Prior Authorization is required except when such care is immediately preceded by an inpatient Hospital stay. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** We will provide Benefits for up to 30 days per Contract Year for Inpatient Services only when such services are Acute Services provided by a Preferred facility licensed to provide inpatient physical rehabilitation services or by a unit of a Preferred Hospital designated as providing such services. **In Network Only. Subject to Annual Benefit Maximum.** You must pay any applicable Deductible and Coinsurance.
8. Mental Health and Substance Abuse Services:
  - A. Mental Health Services. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** We will provide Benefits for Inpatient Services and Mental Health Services for Mental Health Conditions only when such services are provided in a mental health facility qualified pursuant to rules adopted by the secretary of human services or in an institution approved by the secretary of human services and such facility or institution provides a mental health treatment program pursuant to a written plan. The facility must also be a MVP Preferred Provider. **In Network Only.** You must pay any applicable Deductible and Coinsurance.
  - B. Substance Abuse Services. **Prior Authorization is not required for Detoxification Admissions. You must give Concurrent Notice. Your Benefits will be reduced to 50% of the Allowable Charge if you do not give Concurrent Notice. Prior Authorization is required for all other Inpatient Substance Abuse Services, including rehabilitation. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** We will provide Benefits for Inpatient Services and Substance Abuse Services only when such services are provided pursuant to a written treatment plan in an institution approved by the secretary of human services that

provides a program for the treatment of alcohol or substance dependency. The institution must also be a MVP Preferred Provider. **In Network Only.** You must pay any applicable Deductible and Coinsurance.

9. Clinical Trials for Cancer Patients. We will provide coverage for routine costs for patients who participate in approved cancer clinical trials.
  - A. **In-Network.** Coverage is considered In-Network only if conducted under the auspices of the following cancer care providers ("Cancer Care Providers"): Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, and approved clinical trials administered by a hospital and its affiliated, qualified cancer care providers.
  - B. **Out-of-Network.** Coverage is available only if:
    - (i) The Member provides Notification to MVP prior to participation in the clinical trial;
    - (ii) No clinical trial is available at the Vermont or New Hampshire Cancer Care Providers listed in paragraph A above;
    - (iii) The Member has completed a clinical trial at one of the Vermont or New Hampshire Cancer Care Providers listed in paragraph A above and that provider determines that a subsequent clinical trial related to the original diagnosis is available outside of the health benefit plan's network and determines participation in that clinical trial would be in the best interest of the patient, even if a comparable clinical trial is available at that time under; or
    - (iv) MVP has already approved a referral of the patient to an out-of-network cancer care provider and an out-of-network clinical trial becomes available and the patient's Cancer Care Provider determines participation in that clinical trial would be in the best interest of the patient, even if a comparable clinical trial is available at the Vermont or New Hampshire Cancer Care Providers listed in paragraph A above

If you participate in an Out-of-Network clinical trial, you will be required to get routine follow-up care In-Network, unless the cancer care provider determines this would not be in your best interest.

## **SECTION SEVEN – COVERED OUTPATIENT SERVICES**

1. Outpatient Services. We will provide Benefits for the following Outpatient Services. Such services must be provided to you in the outpatient department of a Hospital or in a free standing facility. We will only provide benefits if a Covered Service is Medically Necessary.

- A. Pre-admission testing. We will provide benefits for tests given to you before your admission to a Hospital if:
- i. Your physician has ordered the tests; and
  - ii. An operating room and inpatient bed at the Hospital have been reserved.
  - iii. Surgery occurs within seven (7) days of the tests.

You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

- B. Outpatient Surgery. **Notification is required.** Surgery means generally accepted invasive, operative, and cutting procedures. This includes, but is not limited to specialized instrumentation, endoscopic examinations, and correction of fractures and dislocations, and the pre- and post-operative care usually rendered in connection with such procedures. Sterilization is included. You must pay any applicable Deductible and Coinsurance or Copayment. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

C. Therapeutic Services

- i. Radiation Therapy. This means the use of x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes for treatment of disease.
- ii. Chemotherapy. This means prevention of the development, growth, or multiplication of malignant diseases by chemical or biological agents, and includes growth cell stimulating factor injections taken as part of a chemotherapy regimen.
- iii. Cancer Hormone Therapy. This means a treatment method altering hormone levels to combat cancer growth.
- iv. Dialysis. This means 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. Alternatively, Dialysis may be provided at home. If provided at home, MVP will provide Benefits for the reasonable rental cost of equipment, as determined by us, plus Medically Necessary supplies for home dialysis treatment when ordered by your physician. MVP will not provide benefits for any furniture, electrical or other fixtures or plumbing to perform the dialysis treatments at home. For outpatient or home-based Dialysis to be covered, the treatments must be provided, supervised or arranged by your physician, and you must be a

registered patient of an MVP approved kidney diseases treatment center. Benefits for Dialysis will continue until your MVP coverage is terminated.

- v. Infusion Therapy. This means treatment of disease by continuous injection of curative agents.
- vi. Inhalation Therapy. This means inhalation of medicine, water vapor and/or gases to treat impaired breathing.
- vii. Items used in and provided by the Hospital or facility when performing Therapeutic Services, such as prescribed drugs, medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items.

You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge. Therapeutic Services will be covered in full if you are enrolled in a chronic care management program.

- D. Diagnostic Services means services ordered by a physician to determine a definite condition or disease. Diagnostic Services includes radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scans, EEGs, ECGs, organ scans, allergy testing and other medical and surgical diagnostic services. You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

E. Outpatient Mental Health and Substance Abuse Services

- i. Mental Health Services. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** Services must be provided by a Preferred Hospital or a Preferred facility that is a licensed or certified mental health provider. **In Network Only.** You must pay any applicable Deductible and Coinsurance or Copayment. Mental Health Services will be covered in full if you are enrolled in a chronic care management program.
- ii. Substance Abuse Services. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** Services must be provided by a Preferred Hospital or a Preferred facility that is a licensed or certified substance abuse provider. **In Network Only.** You must pay any applicable Deductible and Coinsurance or Copayment. Substance Abuse Services will be covered in full if you are enrolled in a chronic care management program.

- F. Mammography Screenings. We will provide Benefits for mammography screening for occult breast cancer performed in the outpatient department or ambulatory surgery department of a hospital or other facility, subject to the following limits:
- i. Upon the recommendation of a physician at any age;
  - ii. once every two (2) years, or more frequently upon the recommendation of a physician, for members under age 50; and
  - iii. once each year for members age 50 or older.

Covered in full. **In Network Only.**

- G. Diagnostic Screening for Prostate Cancer. We will provide Benefits for diagnostic screening for prostate cancer subject to the following limits.
- i. Standard diagnostic testing, including a digital rectal examination and a prostate specific antigen test, at any age for men having a prior history of prostate cancer; and
  - ii. An annual standard diagnostic examination, including a digital rectal examination and a prostate specific antigen test, for men age fifty (50) and over who are not symptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.

**In Network Only.**

- H. Laboratory Services. You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.
- I. Cardiac Rehabilitation Care. We will provide Benefits for up to 36 visits per Contract Year only when such services are Acute Services and are provided by a Preferred Hospital or Preferred Facility. **In Network Only. Subject to Annual Benefit Maximum.** You must pay any applicable Deductible and Coinsurance.

## **SECTION EIGHT – COVERED SKILLED NURSING FACILITY SERVICES**

1. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization. Skilled Nursing Facility Services are also subject to Concurrent Review. Your Benefits will be reduced to 50% of the Allowable Charge if we do not get the information needed to conduct Concurrent Review.** We will only provide Benefits if a Covered Service is Medically Necessary. **In Network Only. Subject to Annual Benefit Maximum.**

2. What is a Skilled Nursing Facility (SNF)? – A Skilled Nursing Facility is a licensed facility that provides 24 hour inpatient skilled nursing care and related services. It is certified as a participating SNF by Medicare or accredited as an SNF by the Joint Commission on Accreditation of Healthcare Organizations. A SNF is not, other than occasionally, a place that provides minimal, custodial, ambulatory or part-time care services. The SNF must be a Preferred Provider.
3. Conditions For Skilled Nursing Facility Services. We will provide Benefits for Skilled Nursing Facility Care if:
  - A. You are under the care of a licensed physician;
  - B. You have been in a Hospital within twenty eight (28) days immediately preceding admittance to the Skilled Nursing Facility; and
  - C. You would otherwise need further Inpatient Services.
4. Skilled Nursing Facility Services. We will provide Benefits for the inpatient Skilled Nursing Facility Services listed below for up to 120 days per Contract Year. You may not select the day or days for which we will provide benefits. We will provide benefits for the day you are admitted. We will not provide benefits for the day you are discharged. If you are admitted and discharged on the same day, we will provide benefits for that day.
  - A. Room and board in a semiprivate room.
  - B. Skilled nursing care.
  - C. Drugs, medications, supplies and equipment used in and furnished by the SNF.
  - D. Other services provided by the SNF that would be covered if you were an inpatient in a Hospital.

You must pay any applicable Deductible and Coinsurance.

#### SECTION NINE – SPECIAL COVERED SERVICES

1. Home Health Agency Services. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization. Home Health Agency Services are also subject to Concurrent Review. Your Benefits will be reduced to 50% of the Allowable Charge if we do not get the information needed to conduct Concurrent Review.** We will only provide benefits if a Covered Service is Medically Necessary. **In Network Only. Subject to Annual Benefit Maximum.**
  - A. What is a Home Health Agency? A Home Health Agency is an organization licensed or certified by Medicare to operate as a home health agency. The Home Health Agency must be a Preferred Provider.

- B. Conditions for Home Health Agency Services. We will provide Benefits for Home Health Agency services if:
- i. The services are supervised by a Preferred physician under a written treatment plan.
  - ii. The services are provided by a Preferred home health agency.
  - iii. Without these services you would need to be admitted to a Hospital or Skilled Nursing Facility.
  - iv. You or your designated representative consent in writing to the treatment plan.
- C. Home Health Agency Services. We will provide Benefits for up to 200 visits per Contract Year for the services listed below.
- i. Part time or intermittent skilled nursing care by or under the supervision of a registered nurse.
  - ii. Part time intermittent home health aide services, provided that such services consist primarily of caring for the patient and do not include Custodial Care.
  - iii. Therapy Services if provided by Home Health Agency personnel. This means Acute Services, limited to physical therapy, occupational therapy, and speech therapy.
  - iv. Medical supplies and drugs prescribed by a Preferred Physician 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.

You must pay any applicable Deductible and Coinsurance.

2. Non-Emergency Ambulance Services. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** We will provide benefits for Hospital, municipal, professional, or licensed voluntary Ambulance Services when used locally to transport a Member to and from a Hospital, between Hospitals, and between a Hospital and a Skilled Nursing Facility. We will only provide benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.
3. Hospice Services. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization. Hospice Services are also subject to Concurrent Review. Your Benefits will be reduced to 50% of the Allowable Charge if we do not get the information needed to conduct Concurrent**

**Review.** We will only provide Benefits if a Covered Service is Medically Necessary. **In Network Only.**

A. What is a Hospice? Hospice is an organization engaged in providing services to terminally ill persons. It must be federally certified to provide hospice services or accredited as a hospice by the Joint Committee of Accreditation of Health Care Organizations. The Hospice must be a Preferred Provider.

B. Conditions for Hospice Services.

We will provide benefits for Hospice Services under the following conditions.

- i. A Preferred physician certifies and MVP agrees that your terminal illness has a prognosis of 6 month life expectancy or less; and
- ii. The Hospice Services are supervised by a Preferred physician under a written Hospice Care plan; and
- iii. You consent to the written Hospice care plan.

C. Hospice Services. We will provide Benefits for the Hospice Services listed below:

- i. Up to 210 days of inpatient Hospice Services in a Preferred Hospice or Preferred Hospital.
- ii. Skilled nursing visits - up to 2 visits per day.
- iii. Home health aide visits - up to 100 hours per month for personal care services only.
- iv. Continuous care - up to 5 days or 120 hours for the Member's continuous care in his or her home.
- v. Social service visits - up to 6 visits before the Member's death and up to 2 visits following the Member's death. Social service visits include counseling and emotional support, assessment of social and emotional factors related to the Member's condition, assistance in resolving problems, assessment of financial resources and use of available community resources.
- vi. Respite Care - up to 72 hours per month. Respite care relieves the Member's family or caregivers by providing temporary relief from the duties of caring for the Member's illness.

D. Hospice Services are available only once per each Member's lifetime.

You must pay any applicable Deductible and Coinsurance.

4. Transplant Services/Donor Costs. We will provide Benefits for human organ and bone marrow transplant services only when you get such services through a Participating Specialty Network Transplant Provider. The donor and the recipient must pay any applicable Deductible and Coinsurance. **Specialty Network Only.** You may ask if a Provider is a Participating Specialty Network Transplant Provider by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

MVP will also provide Benefits for live donors for otherwise Covered Services provided in connection with a covered transplant procedure ("Donor Benefits"). These Donor Benefits are available only when the recipient of the transplant is an MVP Member who is receiving a covered transplant procedure and when the donor has met all criteria established by the Participating Specialty Network Transplant Provider.

Subject to the limitations set forth below, MVP will also provide Benefits for donor expenses for complications arising from a covered transplant procedure; provided that such complications arose within ninety (90) days from the date of the transplant ("Complications Benefits"). If a donor's complications arise after more than ninety (90) days from the date of the transplant, MVP will not provide any Complications Benefits.

Donor Benefits and Complications Benefits will be provided only up to the recipient Member's coverage limitations and after payment of the recipient Member's expenses; provided that for a non-MVP Member donor who has other HMO or insurance coverage, MVP will provide Complications Benefits only as follows: (1) MVP will provide Complications Benefits as the primary carrier for up to one hundred eighty (180) days from the date of the transplant; (2) MVP will provide Complications Benefits only as the secondary carrier after one hundred eighty (180) days from the date of the transplant. If the non-MVP Member donor does not have other HMO or insurance coverage, MVP will continue to provide Complications Benefits as the primary carrier beyond one hundred eighty (180) days, but only up to the recipient Member's coverage limitations and after payment of the recipient Member's expenses. Donor Benefits and Complications Benefits are not available if the donor is an MVP Member, but the recipient is not.

5. Bariatric Surgery. We will provide Benefits for Bariatric Surgery only when such Bariatric Surgery is performed at a Specialty Network Bariatric Surgery Hospital by a Specialty Network Bariatric Surgery Provider. You must pay any applicable Deductible and Coinsurance. You may ask if a Hospital or a Provider is a Specialty Network Provider by calling MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277). **Specialty Network Only.**

**SECTION TEN - COVERED EMERGENCY SERVICES  
AND URGENTLY NEEDED CARE**

1. Emergency Services.
  - A. **Prior Authorization is NOT required for Emergency Services. If your condition is not an Emergency Medical Condition, you must pay all Charges.**
  - B. Emergency Services. We will provide Benefits for Emergency Services only if your condition is an Emergency Medical Condition. We will only provide benefits if a Covered Service is Medically Necessary.
  - C. You, your Provider, or a member of your family must call MVP at 1-888-MVP-MBRS within 48 hours, or as soon as reasonably possible, after receiving Emergency Services.

You must pay any applicable Deductible and Coinsurance. You will not have to pay this Deductible and Coinsurance if you are admitted to a Hospital right away. However, you must pay the Deductible and Coinsurance for Hospital inpatient services. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

2. Emergency Ambulance Services. We will provide Benefits for Ambulance Services, when used for an Emergency Medical Condition. We will only provide Benefits for transportation to the nearest appropriate facility. We will not provide Benefits for Ambulance Services if you could have safely ridden in a private car, whether or not one was available. We will only provide benefits if a Covered Service is Medically Necessary. You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.
3. Urgently-Needed Care. We will provide benefits for this service provided by a Participating or a Non-Participating Provider.
  - A. Urgently-Needed Care provided by a Participating Provider means Medically Necessary Covered Services to treat an illness or condition that if not treated within 24 hours presents a serious risk of harm.
  - B. Urgently-Needed Care provided by a Non-Participating Provider means Medically Necessary Covered Services to screen and stabilize a condition that if not treated within 24 hours presents a serious risk of harm, so that you can be safely transported to a Participating Provider; provided that such services were received because you were unable to get services from a Participating Provider.
  - C. You, your Provider, or a member of your family must call MVP at 1-888-MVP-MBRS within 48 hours, or as soon as reasonably possible, if you were admitted after receiving Urgently-Needed Care.

- D. You must pay any applicable Deductible and Coinsurance. You will not have to pay such Coinsurance if you are admitted to a Hospital right away. However, you must pay the Coinsurance for Hospital inpatient services. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non- Preferred Provider's Charge.

#### **SECTION ELEVEN – COVERED PREVENTIVE CARE**

1. Covered Services. We will provide Benefits for the following Preventive Care. These services must be provided at the office of a Preferred Provider. They do not need to be Medically Necessary. **In Network Only**. However, if preventive care services are not available in network, services may be obtained out-of-network, and will be covered in full.
- A. Well Child Care. We will provide Benefits for Well Child Care for Dependent children from the date of birth to attainment of age 19. 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. Services not described above and services which exceed the frequency levels described above are not covered under Well Child Care. **In Network Only**.
- B. Preventive Dental Care for Children. We will provide benefits for the following Dental Services for MVP Members to age 19 when such services have been recommended, approved and certified as necessary and reasonable by a licensed dentist and rendered by a licensed dentist:
- i. Dental Services. One initial oral examination per child; periodic oral examinations once every six months; bitewing x-rays, once every six months; full mouth x-rays and panoramic x-rays, once every 36 months; routine cleaning, scaling and polishing of teeth, once every six months; fluoride treatments, once every six months; pulp vitality testing, as needed; diagnostics casts as needed; sealants, once per tooth per child up to age 16; space maintainers and recementation thereof, as needed; intra-oral and periapical x-rays, as needed.
  - ii. You must pay the Copayment listed on your Copayment Schedule.
  - iii. You may see the licensed dentist of your choice to receive the benefits described in this paragraph B. Your provider may require you to pay for the services at the time rendered in which case you should submit the claim to

MVP Health Care, P.O. Box 763, Schenectady, NY 12301 and you will be reimbursed in full, less your applicable Copayment. You may get a claim form by calling the MVP Member Services Department at 1-888-MVP-MBRS. Claims for Dental Services must be filed as soon as reasonably possible, but not later than one year after the service is performed. Claims filed later than one year from the date of service will not be covered.

iv. In addition to those listed in Section Fifteen, the following Dental Services are also excluded from coverage: Services which are not approved by the Council of Dental Therapeutics of the American Dental Association; Coverage of hospitalization for any dental procedures; Implantation or pharmacological regimens; and Drugs obtainable with or without a prescription, when prescribed or recommended by a dentist.

C. Annual Adult Health Evaluations. We will provide Benefits for one visit per Contract Year for periodic routine physical examinations and immunizations for covered persons age 19 and older. **In Network Only. Subject to Annual Benefit Maximum.**

D. Mammography Screenings. We will provide Benefits for mammography screening for occult breast cancer performed in the outpatient department or ambulatory surgery department of a hospital or other facility, subject to the following limits:

- i. Upon the recommendation of a physician at any age;
- ii. once every two (2) years, or more frequently upon the recommendation of a physician, for members under age 50; and
- iii. once each year for members age 50 or older.

Covered in full. **In Network Only.**

E. Gynecological Health Care Services – We will provide Benefits for 2 visits per Contract Year for this service. Gynecological health care services means preventive and routine reproductive health and gynecological care. Such services include annual screening, annual cervical cytology screening, contraceptive services, counseling and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. **In Network Only.** You must pay the applicable Copayment. **Subject to Annual Benefit Maximum.** Annual Cervical Cytology Screening is covered in full.

F. Diagnostic Screening for Prostate Cancer. We will provide Benefits for this service subject to the following limits:

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

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

**In Network Only.**

**SECTION TWELVE – COVERED PROFESSIONAL CARE AND SERVICES**

1. Covered Services. We will provide Benefits for the following services. We will only provide Benefits if a Covered Service is Medically Necessary.
  - A. Provider Office Visits. We will provide benefits for the examination, diagnosis, and treatment of an injury, illness or condition and laboratory services provided at the time of such visit. Coverage includes injections given during a covered office visit, including desensitization treatments to alleviate allergies. Whether you get services In Network or Out-of-Network, you must pay the applicable Copayment. **Subject to Deductible.**
  - B. Maternity Care.
    - i. In-Network and Out-of-Network Maternity Care.
      - a. We will provide Benefits for the initial visit to confirm a pregnancy. The visit must be to a Preferred Provider. You must pay the applicable Copayment.
      - b. We will provide Benefits for prenatal and postnatal office visits to a Preferred Provider and for delivery. These services are covered in full.
      - c. You must pay the applicable Copayment for all other Covered Services related to Maternity Care. This includes diagnostic testing performed during prenatal and postnatal office visits.
      - d. MVP will reimburse up to \$40 for Lamaze and up to \$25 for parenting classes. A Contract of completion is required to receive reimbursement.
  - C. Consultations. We will provide Benefits for inpatient or office consultations by Providers when requested by your attending physician for the evaluation of your condition. A written report must be given to your Provider. You must pay any applicable Deductible and Coinsurance.
  - D. Second Surgical Opinions. We will provide Benefits for a second surgical opinion when your Provider has made a recommendation on the need for covered elective Surgery. You do not have 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. If you get services in a Preferred Provider's Office, you must pay the applicable Copayment. The specialist who gives the second opinion must not perform the Surgery. You must pay any applicable Deductible. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

- E. Mental Health Services. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** We will provide Benefits for Mental Health Services only when such services are provided by a licensed or certified mental health professional who is a Preferred Provider. **In Network Only. You must pay the applicable Copayment.** Mental Health Services will be covered in full if you are enrolled in a chronic care management program.
- F. Substance Abuse Services. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** We will provide Benefits for Substance Abuse Services only when such services are provided by a substance abuse counselor or other person approved by the secretary of human services who is a Preferred Provider. **In Network Only.** You must pay the applicable Copayment. Substance Abuse Services will be covered in full if you are enrolled in a chronic care management program.
- G. Chiropractic Treatment. **Prior Authorization is required if you use more than eight Chiropractic Treatment visits in any one Contract Year. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** We will provide Benefits for clinically necessary chiropractic services. The services must be provided by a Preferred licensed chiropractic physician. Services are for treatment of conditions related to subluxations, joint dysfunctions, and neuromuscular and skeletal disorders. We will not provide Benefits for:
- i. Adjunctive therapies, except physiotherapy modalities and rehabilitative exercises when used in conjunction with other, covered, chiropractic treatment; and
  - ii. Treatment of any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs.

**In-Network Only.** You must pay the applicable Copayment.

- H. Diabetes Equipment, Supplies and Treatment. We will provide Benefits for equipment, supplies, and outpatient self-management training and education. This includes medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if such

equipment, supplies and training are prescribed by a Preferred licensed, health care professional legally authorized to prescribe such items. We will provide Benefits for the self-management training and education. This includes medical nutrition therapy, described above only if provided by a Preferred certified, registered, or licensed health care professional with specialized training in the education and management of diabetes.

i. In-Network

- a. Diabetes Equipment and Supplies. You must pay the applicable Coinsurance per each 30-day supply. **In-Network Diabetes equipment and supplies are not subject to Deductible.**
- b. Diabetes Treatment. If you get Services in a Preferred Provider's office, you must pay the applicable Copayment. Otherwise, you must pay Deductible and Coinsurance.

ii. Out of Network.

- a. Diabetes Equipment and Supplies. You must pay the Non-Preferred pharmacy or Non-Preferred Supplier's Charge. You must then submit a claim for Retrospective Review as described in Section Five of this Contract.
- b. Diabetes Treatment. You must pay the applicable Coinsurance. You must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

I. Inpatient Medical Care. We will provide Benefits for medical services rendered when you are receiving Inpatient Services in: (1) a Hospital or Skilled Nursing Facility; (2) a Preferred mental health care facility or institution for the treatment of alcohol or substance dependency; or (3) a Preferred physical rehabilitation facility. We will only provide Benefits for one visit per day per Provider. We will not provide Benefits for Inpatient Medical Care in connection with Surgery or Maternity Care because services are covered by a global fee. You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

J. Office Surgery. **Prior Authorization is not required when Surgery is performed in a Provider's office.** We will provide benefits for Surgery and surgical care rendered in a Provider's office. This includes surgery and surgical care for abortion and sterilization. You must pay any applicable Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

- K. Breast Cancer Care. We will provide Benefits for mastectomy and treatment of physical complications of mastectomy such as lymphedema, lymph node dissection, or lumpectomy for the treatment of breast cancer. Following a covered mastectomy, we will provide Benefits for all stages of reconstruction of the breast on which the mastectomy was performed. We will also provide benefits for surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined appropriate by your Provider, in consultation with you. Benefits shall include coverage of routine costs for patients who participate in approved cancer clinical trials as required by Vermont law. If you get Services in a Preferred provider's office, you must pay the applicable Copayment. Otherwise, you must pay Deductible and Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

We will also provide Benefits for breast prostheses required as a result of covered Breast Cancer Care. You must pay any applicable Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge. **Breast Prostheses are not subject to Deductible.**

- L. Anesthesia Services. We will provide Benefits for consultation before anesthesia is given, administration of anesthesia during covered surgery or maternity care, and the Provider's services during and after such covered surgery or maternity care. We will not provide anesthesia for services not covered under this Contract. You must pay any applicable Deductible and Coinsurance.
- M. Laboratory Services. We will provide Benefits for Laboratory Services provided in a Provider's office. If you get Laboratory Services in a Preferred Provider's office, the services are covered in full. If you get Laboratory Services in a Non-Preferred Provider's office, you must pay any applicable Deductible and Coinsurance. You must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.
- N. Diagnostic Services. Diagnostic Services means services ordered by a physician to determine a definite condition or disease. Diagnostic Services includes radiology and imaging services, x-rays, ultrasounds, diagnostic nuclear medicine, MRIs, CAT scans, electroencephalograms (EEG), electrocardiograms (ECG), organ scans, allergy testing (percutaneous, intracutaneous, patch and RAST testing) and other medical and surgical diagnostic services. We will provide Benefits for Diagnostic Services provided in a Provider's office, including allergy testing. If you get Diagnostic Services in a Preferred Provider's office, your must pay the applicable Copayment. If you get Diagnostic Services in a Non-Preferred Provider's office, you must pay any applicable Deductible and Coinsurance. You must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge.

- O. Medical Foods. We will provide Benefits for low protein modified food products and medical foods prescribed by a Preferred Provider and obtained from a Preferred pharmacy or a Preferred supplier for use under the direction of a Preferred physician for the medically necessary dietary treatment of an inherited metabolic disease. A low protein modified food product must be specifically formulated to have less than one gram of protein per serving. A medical food means an amino acid modified preparation. **In-Network Only.** You must pay any applicable Deductible and Coinsurance. Benefits are limited to \$2,500 per Contract Year. **Subject to Annual Benefit Maximum.**
- P. Craniofacial Disorders. We will provide Benefits for Preferred Provider services for diagnosis and treatment. This includes surgical and non-surgical procedures of a musculoskeletal disorder that affects any bone or joint in the face, neck or head. Such disorder must be the result of accident, trauma, congenital defect, developmental defect, or pathology. Surgical procedures require a second opinion as set forth in paragraph 1(D) above. **Prior Authorization is required for surgical procedures. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** We will not provide Benefits for the diagnosis and treatment of dental conditions or disorders. We will not provide Benefits for dental pathology primarily affecting the gums, teeth, or alveolar ridge. We will also not provide Benefits for prescription or non-prescription drugs prescribed or recommended by a dentist. **In-Network Only.** You must pay the Copayment or Deductible and Coinsurance amounts applicable to the particular services you get.
- Q. Therapy Services. We will provide Benefits for Physical Therapy, Speech Therapy and Occupational Therapy for a combined total of up to thirty (30) visits per Contract Year. Such services must be Acute Services provided by the outpatient department of a Hospital, at a properly licensed facility, or at a properly licensed Provider's office. You may get this Benefit on an In Network basis, an Out of Network basis, or any combination thereof. We will not provide Benefits for more than thirty (30) visits in any one Contract Year. **In Network Only. Subject to Annual Benefit Maximum.** You must pay any applicable Deductible and Coinsurance. Physical Therapy Services will be covered in full and need not be an Acute condition if you are enrolled in a chronic care management program.
- R. Transplant Services/Donor Costs. **Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** We will provide Benefits for organ and bone marrow Transplant Services. This includes transplant surgeries only when such services are obtained through MVP's Specialty Network. You may get a description of this Network by calling the MVP Member Services Department at 1-888-MVP-MBRS. MVP will also provide Benefits for live donor medical expenses up to your coverage limitations and after payment of your Benefits. The cost of outpatient drugs associated with these services will not be covered. We will provide Benefits to live donors as follows:

- i. If we cover both the recipient and the donor, each receives benefits under his or her own Contract;
- ii. If we cover the recipient, but not the donor, both get Benefits under the recipient's Contract (Benefits available to the recipient will be paid first);
- iii. Benefits are available if we cover the donor, but not the recipient.

You must pay the Deductible and Coinsurance amounts applicable to the particular services received. **MVP Specialty Network Only.**

- S. **Durable Medical Equipment. Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** Durable Medical Equipment means equipment which is primarily and customarily used only for a medical purpose. Such equipment is appropriate for use in the home, and is designed for prolonged and repeated use. It is generally not useful to a person in the absence of an illness, injury or condition. Durable medical equipment includes, but is not limited to wheelchairs, hospital beds, walkers, traction equipment, and respirators.

We will provide Benefits for the purchase or rental, repair or replacement of Durable Medical Equipment. The option of whether to rent or purchase authorized Durable Medical Equipment is at the sole discretion of MVP. The total rental benefits may not exceed our Allowable Charge for the purchase of the equipment. You must pay the applicable Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge. **Any amounts paid as the difference between the Non-Preferred Provider's Charge and the Allowable Charge for Durable Medical Equipment do not apply to any Annual Out of Pocket Maximum. Durable Medical Equipment is not subject to Deductible. Durable Medical Equipment and External Prosthetic Devices and ostomy supplies are subject to combined In Network and Out of Network per Member Lifetime Maximum Benefit.**

Durable Medical Equipment will be covered in full if you are enrolled in a Chronic Care Management Program.

- T. **External Prosthetic Devices. Prior Authorization is required. Your Benefits will be reduced to 50% of the Allowable Charge if you do not get Prior Authorization.** External Prosthetic Devices are devices that replace all or part of a body organ or that replace all or some of the functions of a permanently inoperative and/or malfunctioning external body part. Examples of such devices are artificial limbs and breast prostheses.

We will provide Benefits for the purchase, repair and replacement of covered External Prosthetic Devices, and for medical appliances, including external breast prostheses for Members who received covered Breast Cancer Care, and ostomy supplies. Replacement of external breast prostheses are covered once every two

Contract Years, if replacement is Medically Necessary. Custom prosthetics will not be covered if a standard device exists, unless a custom device is Medically Necessary. You must pay the applicable Coinsurance. If you get services Out of Network, you must also pay the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge. **Any amounts paid as the difference between the Non-Preferred Provider's Charge and the Allowable Charge for External Prosthetic Devices do not apply to any Annual Out of Pocket Maximum. External Prosthetic Devices are not subject to Deductible. Durable Medical Equipment, External Prosthetic Devices and Ostomy Supplies are subject to a combined In Network and Out of Network per Member Lifetime Maximum Benefit.**

- U. Allergy Services. We will provide benefits for diagnosis and treatment of allergies by Participating Providers, including test and treatment materials.
- V. Basic Infertility Services. Infertility is the inability of a couple to conceive after one year of unprotected intercourse. We will provide the following benefits for basic infertility services. Medically Necessary Phase 1 and Medically Necessary Phase 2 services must be completed before moving on to Phase 3 services.

**Phase 1:**

History and Physical of partners who are MVP members; Clinical assessment for ovulatory dysfunction **or** documented history of amenorrhea or oligomenorrhea; Education of both partners regarding infertility; Semen analysis; Laboratory screenings for prolactinemia, thyroid disease, polycystic ovary disease, androgen excess, etc. as clinically indicated; Cervical cultures and Post coital exam

**Phase 2:**

Endometrial biopsy; Testis biopsy (if medically indicated); Hysterosalpinogram; and Pelvic ultrasound

**Phase 3**

Diagnostic Laparoscopy; Laparoscopy/Tubal Surgery/Exploratory Laparotomy or other surgical procedure to correct female infertility due to pelvic diseases such as adhesions or endometriosis; and Varicocele surgery or other surgical procedure to correct male infertility except when the infertility diagnosis is due to a previous sterilization procedure.

- W. Dental Services. Except as provided in Section Twelve, Paragraph 1(P) (Craniofacial Disorders) and for accidental injury to sound, natural teeth provided within 12 months of the accident or when a claim is made within 12 months of the date of the accident establishing that it is Medically Necessary for the dental services to be provided more than 12 months of the date of the accident and provided further that the Member must be covered under this Contract when services are provided, and except for dental services necessary due to congenital disease or anomaly, we will not provide Benefits for dental services. **Services provided pursuant to this**

**exception are subject to Pre-Service Review.** Call [MVP] at [1-800-568-0458]. This includes, but is not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, bony impacted teeth, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, dental implants, and prosthetic restoration of dental implants.

## **SECTION THIRTEEN - PRESCRIPTION DRUG COVERAGE**

### 1. In-Network and Out of Network Prescription Drug Benefits.

#### A. In-Network Benefits.

In order to get the In-Network Benefits for prescription drugs as described herein, your prescription must be written by a Preferred Provider or a Non-Preferred Provider who is authorized to write prescriptions, and you must fill the prescription at a Preferred pharmacy.

You must present your MVP ID card, prescription and pay the applicable Copayment to the Preferred pharmacy. You may request a copy of MVP's directory of Preferred pharmacies or inquire whether a particular pharmacy is a Preferred pharmacy by calling MVP's Member Services Department at 1-800-318-8575 or by visiting MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com).

#### B. Out-of-Network Benefits.

If you fill the prescription at a Non-Preferred pharmacy, you must pay the pharmacy's Charge and follow the instructions set forth in Paragraph 7(B)(3) of this Section. MVP will reimburse you up to the amount we would otherwise have paid had the prescription been filled at a Preferred pharmacy.

### 2. Generally. Medically Necessary prescription drugs are covered up to a thirty (30) day supply. Prescriptions that require the mixing of two or more ingredients must contain at least one ingredient that requires a prescription. Prescription contraceptives and prescription contraceptive devices approved by the Federal Food and Drug Administration are covered subject to the applicable Copayment in this Section. You may get one Vacation Supply per Contract Year. This means that you may receive up to a 90 day supply one time per Contract Year. You must pay the applicable multiple Copayment for a Vacation Supply. **Copayments for Prescription Drugs do not count toward Annual Out of Pocket Maximums.**

#### A. Tier One – Generic Formulary Drugs. Subject to paragraph D below, each prescription for a generic drug (except generic drugs excluded under MVP's Drug Formulary) is subject to a \$10.00 Copayment (or cost, whichever is less) per prescription item.

- B. Tier Two –Brand Formulary Drugs. Subject to paragraph D below, each prescription for a brand name drug (except brand name drugs excluded under MVP’s Drug Formulary) is subject to A \$30.00 Copayment (or cost, whichever is less) per prescription item.
- C. Tier Three – Non-Formulary Drugs. Subject to paragraph D below, each prescription for a drug that is excluded under MVP’s Drug Formulary is subject to \$50.00 Copayment (or cost, whichever is less) per prescription item.

Please see below for more information on MVP’s Drug Formulary.

- D. If your prescribed dosage is not commercially available, you may be required to make more than one Copayment. For example, if your prescription drug is available only in 20 milligram and 30 milligram doses and your Provider prescribes 50 milligrams, you may be required to make one payment for the 20 milligram dosage and a second payment for the 30 milligram dosage.
3. Mail Order Pharmacy. MVP will provide benefits for certain prescription drugs obtained from MVP’s mail order pharmacy program, as described below.
- A. Only drugs approved by MVP for mail order may be obtained through the mail order pharmacy program. You may get a copy of the list of drugs approved for mail order or inquire whether a particular drug is an approved maintenance drug by calling MVP’s Member Services Department at 1-800-318-8575. You may also visit MVP’s web site at [www.mvphealthcare.com](http://www.mvphealthcare.com) and enter the name of a drug to determine whether it is approved for mail order or to request a copy of the list of drugs approved for mail order. MVP notifies Preferred Providers, in writing, when we add new drugs to the list of drugs approved for mail order or delete previously approved drugs from the list of drugs approved for mail order. MVP provides at least 30 days prior written notice to affected Members when we delete previously approved drugs from the list. MVP also provides notice of new drugs added to the list in MVP’s member newsletter or similar communication. If MVP does not provide the 30 day prior written notice specified above and you attempt to have your prescription filled in accordance with this Section, MVP will provide full coverage for a three (3) day supply. You must then contact the Provider who wrote the prescription to change your prescription. You may also file a claim for benefits by following the instructions in Paragraph 7 of this Section.
  - B. Each mail order for prescription drugs must be for up to a ninety (90) day supply.
  - C. Each mail order for prescription drugs, except contraceptives, shall be reviewed for Medical Necessity.

- D. Each mail order for prescription drugs is subject to a Copayment. The Copayment for the ninety (90) day mail order supply is two (2) times the applicable Copayment for a thirty (30) day supply.
- E. 90-Day Supply Benefits from Participating Retail Pharmacy. You may also be able to obtain 90-Day Supply Benefits as described herein from a Participating Retail Pharmacy. You may inquire whether a particular Participating Retail Pharmacy has agreed to provide 90-Day Supply Benefits by calling MVP's Member Services Department at 1-800-318-8575.
- F. How to Use the Mail Order Program.
  - i. New Prescriptions. You must complete a Mail Order Pharmacy Form. You may request a copy of the Form by calling MVP's Member Services Department at 1-800-318-8575. You may also visit MVP's web site at [www.mvphealthcare.com](http://www.mvphealthcare.com) to download the Form or request a copy. Complete and sign the Form and attach the 90-day prescription with your check or credit card number for your Copayment. Then, mail everything to the address listed on the Form.
  - ii. Refills. When you need to refill a prescription, you may
    - a. Refill By Phone. Call the number listed on your order form. Have your prescription number, name, address and credit card information available to make your payment.
    - b. Refill By Mail. Complete the order form enclosed with your most recent delivery form and, if your health has changed, update your health profile. Complete the refill section, enclose your check or credit card number for your payment and mail it to the address listed on the delivery form.
- 4. Pharmacy and Therapeutics Committee. MVP's Pharmacy and Therapeutics Committee, which includes physicians, pharmacists and other health care professionals, evaluates prescription drugs and determines which drugs MVP will approve for coverage. The list of approved drugs is called the Formulary. Drugs that MVP has not approved for coverage are called Non-Formulary Drugs. At least two drugs in each therapeutic class will be included on the Formulary unless there are clinically equivalent over-the-counter products readily available. MVP's Pharmacy and Therapeutics Committee reviews and must approve new drugs prior to such new drugs being included on the Formulary.
  - A. Getting Formulary Information. At any time, you may get a copy of the Formulary, inquire whether a particular drug is listed on the Formulary, or inquire whether a particular drug requires Prior Approval by calling MVP's Member Services Department at 1-800-318-8575. You may also visit MVP's web site at

[www.mvphealthcare.com](http://www.mvphealthcare.com) and enter the name of a drug to determine whether it is listed on MVP's Formulary or to request a copy of the Formulary.

- B. Changes to the Formulary. MVP notifies Preferred Providers, in writing, when we add new drugs to the Formulary or delete previously approved drugs from the Formulary. MVP provides at least 30 days prior written notice to affected Members when we delete previously approved drugs from the Formulary. MVP also provides notice of new drugs added to the Formulary in MVP's member newsletter or similar communication.
  - C. If MVP does not provide the 30 day prior written notice specified in paragraph B above and you attempt to have your prescription filled in accordance with this Section, MVP will provide full coverage for a three (3) day supply. You must then contact the Provider who wrote the prescription to change your prescription. You may also file a claim for benefits by following the instructions in Paragraph 7 of this Section.
5. Prescriptions that require the mixing of two or more ingredients must contain at least one ingredient that requires a prescription. However, we will not provide benefits for a compounded product that exists in a comparable commercially available form.
6. In addition to the Exclusions Section of your Contract, the following items are excluded from coverage.
- A. Any drugs, including vitamins that, by federal law, do not require a prescription, even if one is written, provided that insulin shall be covered as described in your Contract.
  - B. Drugs used in connection with Non-Covered Services.
  - C. Refills needed because the Member lost or misused his or her supply, even if ordered by a participating physician.
  - D. Drugs for cosmetic reasons, including those intended to improve your appearance, such as:
    - i. Products to grow or regain hair.
    - ii. Products to prevent skin wrinkling.
    - ii. Products to affect the color, tone or texture of the skin.
  - E. Any refill in excess of the amount specified by the prescription.
  - F. Any refill dispensed more than one year from the date the prescription was written.

- G. Drugs prescribed for uses and conditions other than those approved by the U.S. Food and Drug Administration.
- H. Medical and non-medical prescription drug supplies, devices and equipment except contraceptive devices. For example, therapeutic devices or appliances, infertility medications (oral and injectable), standard cosmetic drugs, allergy sera.
- I. Experimental or Investigational Drugs (unless directed to be covered pursuant to Independent External Appeal). This term means drugs that are either not generally accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by medical or scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

7. Filing Claims for Prescription Drug Benefits

- A. Prescription Filled by Preferred Retail or Mail Order Pharmacy. When your pharmacy fills your prescription, you must pay the applicable Copayment to the pharmacy. The pharmacy will then submit a claim to MVP for payment. If MVP determines that the claim is for Medically Necessary Covered Services, MVP approves the claim and reimburses the pharmacy.
- B. Prescription Not Filled by Retail Pharmacy in accordance with this Section. If your pharmacy does not charge you in accordance with this Section, you must follow the instructions in Paragraph 7(B)(i) OR Paragraph 7(B)(ii) OR Paragraph 7(B)(iii) to file a claim for benefits.
  - i. You may decline to pay the pharmacy's Charge for the prescription and follow the instructions below:
    - a. Your Preferred Provider who wrote the prescription must submit a Pre-Service claim to MVP by following the instructions given to the provider by MVP; OR
    - b. You must call MVP's Member Services Department at 1-800-318-8575 and make a benefit inquiry. To expedite matters, you should call within one day of your visit to the pharmacy; AND
    - c. You or a Non-Preferred Provider who wrote the prescription must submit a Pre-Service claim to MVP by following the instructions set forth below:

You or your Non-Preferred Provider must submit a Non-Medical Pre-Service Claim Form to MVP. You may request a copy of the form by calling Member Services or download the form from

MVP's web site. You must fax or mail the completed form to MVP at the fax number or address indicated on the form.

MVP will respond to the Pre-Service claim as described in the Utilization Management Section of your Contract. If MVP denies the claim, we will send you and your Provider a written adverse determination notice explaining why the claim was denied. You may then make a grievance as described in the Grievances and Independent External Review Section of your Contract.

2. If you decline to pay the pharmacy's Charge for the prescription and the matter is Urgent or involves Urgently-Needed Care, you must follow the instructions below:
  - a. Your Preferred Provider who wrote the prescription must submit an Urgent Pre-Service claim to MVP by following the instructions given to the Provider by MVP; or
  - b. You or the Non-Preferred Provider who wrote the prescription must call MVP's Member Services Department at 1-800-318-8575 and provide your name, the name of the drug requested, your pharmacy, the name of the prescribing provider, a description of your condition and a description of the circumstances that make the claim Urgent.

MVP will respond to the claim as described in the Utilization Management Section of your Contract. If MVP denies the claim, we will send you and your Provider a written adverse determination notice explaining why the claim was denied. You may then make a grievance as described in the Grievances and Independent External Review Section of your Contract.

3. You may pay the pharmacy's Charge for the prescription and submit a completed Claim Form for Retrospective Review. You must also have the pharmacist sign the claim form and attach the original receipt for the prescription. Mail the claim form to the address listed on the form.

You may get claim forms by calling MVP's Member Services Department at 1-800-318-8575. You may also visit MVP's web site at [www.myphealthcare.com](http://www.myphealthcare.com) to download the claim form or to request a copy of the claim form.

Claim Forms for Retrospective Review must be filed as soon as reasonably possible, but not later than one year from the date that the prescription was filled. Claims filed later than one year from the date the prescription was filled will be denied.

MVP will respond to claims for Retrospective Review as described in the Utilization Management Section of your Contract of Coverage. If MVP denies your claim, we will send you a written adverse determination notice explaining why the claim was denied. You may then make a grievance as described in the Grievances and Independent External Review Section of your Contract.

- C. Prescription Not Filled By Mail Order Pharmacy in accordance with this Section. If the pharmacy does not charge you in accordance with this Section, you must follow the procedures described in Paragraph 7(B)(i) OR Paragraph 7(B)(ii) above in order to file a claim for benefits.

## **SECTION FOURTEEN - CHRONIC CARE MANAGEMENT PROGRAM**

1. Introduction. This section describes MVP's Chronic Care Management Program, which includes Disease Management (DM) programs for asthma, diabetes, low back pain, heart disease and depression. By participating in a Chronic Care Management Program, you will be able to reduce your health care costs. The goal of this program is to:
- restore members to their highest level of functioning;
  - minimize negative effects of the condition; and
  - prevent future complications.

To accomplish the Goals of the Chronic Care Management Program requires the involvement of Members, Providers and MVP.

- A. Members. Members receive health risk appraisals ("HRA's"), individualized education and health coaching, and useful tools to aid in managing their condition.

Through self-management support and education on guideline recommendations, members are provided the knowledge and skills to proactively manage their condition. Each program offers telephonic health coaching to members identified as high-risk. Health coaching reinforces the care plans developed by the member's providers and empowers the member to bring about personal change and engage the health care system in a more constructive manner.

Health coaching techniques utilize patient centric strategies to achieve agreed upon goals. The member's stage of change is assessed for each undesirable behavior that may worsen the member's condition (e.g. smoking or obesity).

Based on the level of readiness to change, specific behaviors are selected and improvement goals are set. These goals as well as the results of the HRA survey help the program health coach to individualize the telephonic education and support. Health coaching topics may vary between disease states as outlined below:

### Diabetes

Members identified as high-risk from complications of their diabetes are offered one-on-one telephonic health education and coaching by registered nurses with expertise in diabetes. Although the one-on-one education is tailored to the individual's needs, the importance of the following topics are stressed with each member: getting an A1c, LDL, microalbumin and dilated eye exam test and the recommended results for each, medication use, making important lifestyle changes such as diet, exercise, stress reduction, smoking cessation, daily foot care and recognition of depression.

### Heart Disease

After an acute Cardiovascular event, individuals often feel overwhelmed by the amount of information they receive and the fact that their lifestyles may need to change dramatically. In addition to supporting the recovery and follow-up care, the Cardiac Care Program health coach helps to piece together the information, clarify any misconceptions and coach the individual through behavior change and related psychosocial factors. Positive reinforcement by the health coach motivates the member to sustain beneficial changes. Through learning techniques members are able to gain a better understanding of how they can prevent or modify risk factors and the impact on their future health. After discharge from the program members have the knowledge and tools to carry on the learned behaviors and lead a heart-healthy life.

### Low Back Pain

Members' scores in each of the eight functional areas on the disease-specific HRA help the program health coach to individualize the telephonic education and support. The health coach develops an individualized plan of care with the member and coaches them on each call to achieve the goals that have been set. Topics reviewed with members include anatomy of the back, exercise, proper body mechanics, diet and weight and barriers to adherence to recommended care and behavior change. The program health coach also screens members for depression and other behavioral health issues such as stress since these conditions are correlated with back pain and can worsen one's level of pain.

### Depression

Health coaching for the Depression Care Program is carried out by a Master's-Prepared Certified Social Worker (CSW) who:  
Educates the member on depression and how it is treated;  
Encourages adherence to prescribed treatment plans including medications and psychotherapy;

Helps the member identify his/her personal health concerns and set goals;  
Identifies barriers to personal goals and methods for overcoming them. Progress toward goals will be reviewed during each call;  
Teaches problem-solving skills;  
Helps the member recognize triggers and symptoms of depression; and  
Ensures the member attends follow-up visits with their provider(s).

### Asthma

Although the one-on-one education and health coaching is tailored to the individual's needs, the importance of the following topics are stressed with each member:

Appropriate medication usage including long term control medications;  
Indications of poor asthma control;  
Identification and control of asthma triggers;  
Following a written treatment plan;  
Smoking cessation if applicable;  
Lifestyle changes such as diet, exercise and stress reduction;  
Recognition of depression and treatment if appropriate; and  
Use of a peak flow meter (PFM) and diary (upon request MVP will send a PFM free of charge).

**B. Providers.** MVP supports providers in chronic care management to assure patient needs are met and that care is delivered appropriately. This goal is achieved through providing education and decision support tools and facilitating the adoption of clinical information systems. This includes:

- Involvement of the physician in identifying eligible patients for programs and encouraging participation;
- Coordination among various specialty providers and PCPs to assure continuity of care;
- Encouraging written treatment plans and that these are communicated to the patient;
- Providing feedback on performance related to process and outcome measures; and
- Creating financial incentives for establishing chronic care management systems, improving health outcomes and quality of care.

**C. MVP.** In addition to supporting Members and Practitioners as outlined above, MVP has developed the following to achieve the goals of the Chronic Care Management Program:

- Physician Quality Improvement Manual;
- Patient-Specific Reports;
- Physician Performance Reports and Financial Incentives; and
- Partnering With Practices.

2. Participation in Programs. To find out if you are eligible to participate in MVP's Chronic Care Management Program, call MVP's Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

By participating in MVP's Chronic Care Management Program, Copayments and Coinsurance payments for Benefits will be waived.

## **SECTION FIFTEEN – EXCLUSIONS**

These exclusions are in addition to those described in other sections of this Contract.

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

- A. A private room, unless it is Medically Necessary. If you stay in a private room when it is not Medically Necessary, you must pay the difference between the charge for the private room and the charge for a semi-private room;
- B. Any inpatient days that are mostly for Custodial Services or social programs;
- C. Any inpatient days that are mostly for diagnostic purposes, such as x-rays, laboratory tests, or physical checkups, unless Medically Necessary;
- D. An inpatient stay while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available to you;
- E. Any inpatient services for dental services, except as specifically provided in Section Twelve, paragraph 1(P) (Craniofacial Disorders);
- F. Any charges because you did not leave your room at the discharge time;
- G. Any services provided by a private duty nurse, unless Medically Necessary and prior approved by MVP;
- H. Any non-medical items including, but not limited to, telephone, television, beauty and barber services, guest trays, guest services and accommodations; and

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

- A. Services Starting Before Coverage Begins. We will not provide Benefits for any services you get:
  - 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, Contract, program or plan.

If the service is not covered and is not required to be covered under any other health benefits Contract, program or plan, MVP will provide Benefits beginning on your Effective Date only if you comply with the terms of this Contract.

- B. Non-Covered Services. We will not provide Benefits for any services not listed in this Contract as a Covered Service. We will not provide Benefits for any service that is related to services not covered under this Contract. We will not provide Benefits for services in excess of any limitations or maximums described in this Contract.
- C. Non-Medically Necessary Services. We will not provide Benefits for any services that are not Medically Necessary.
- D. Non-Provider Services. We will not provide Benefits for any services provided by a person or entity that we do not approve for the given service or who is not defined as a Provider. We 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-Preferred Provider Services for In-Network Only Services. We will not provide Benefits for In Network Only Services if such services are provided by a Non-Preferred Provider.
- F. Non-Standard Allergy Services. We will not provide Benefits for non-standard allergy services. This includes, but is not limited to, skin titration, cytotoxicity testing, and treatment of non-specific candida sensitivity and urine autoinjections.
- G. Advanced Infertility Services. We will not provide Benefits for any advanced services for or related to artificial means to induce pregnancy. This includes, but is not limited to, artificial insemination, in vitro fertilization and embryo transplantation, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and drugs used in connection with such procedures, cryopreservation and storage of sperm, eggs, or embryos, intracytoplasmic sperm injection (ICSI), sperm storage, sperm banking, donor costs, surrogate parenting, acrobeads sperm assay, hamster egg penetration test, hypo-osmotic swelling test, retrieval of sperm through electrostimulation, preimplantation genetic diagnosis and gender selection, and drugs used in connection with such services.
- H. Alternative Services. We will not provide Benefits for alternative or complementary health services, products, remedies, treatments and therapies. This includes, but is not limited to, biofeedback (except for treatment of urinary incontinence), massage therapy, hypnosis and hypnotherapy, homeopathy, primal therapy, chelation therapy, carbon dioxide therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, aroma therapy, hair analysis, thermograms and thermography, yoga, meditation, and recreational therapy and any related diagnostic testing.
- I. Aviation. We will not provide Benefits for any illness, injury, or condition that is a direct result of air travel, except when you are a fare paying passenger on a commercial airline scheduled flight.

- J. Blood Products. We will not provide Benefits for charges for whole blood, blood plasma, packed blood cells, or other blood products or derivatives if a volunteer blood replacement program is available. If a program is not available, we will provide benefits if billed by a Preferred Provider. We will provide Benefits for autologous blood donations when they are Medically Necessary. We will provide Benefits for administration and processing charges.
- K. Certification Examinations. Except as specifically provided in Section Eleven, paragraph 1(C) (Annual Adult Health Evaluations), we will not provide Benefits for any services related to routine physical examinations, immunizations and/or testing to certify health status. This includes, but is not limited to, examinations required for school, employment, insurance, marriage, divorce, adoption, custody, divorce, medical research, licensing, insurance, travel, camp, or sports.
- L. Communication Devices. We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of devices for speaking, listening, or otherwise communicating. This includes, but is not limited to, telecommunication devices for the deaf (TDDs), teletype machines (TTYs), and services for evaluation, fitting, or modification of such devices.
- M. Consultations. We will not provide Benefits for consultations except when they are between Providers. Such Providers must attach a written report to your medical record.
- N. Cosmetic Services and Surgery. We will not provide Benefits for any services or surgery that are mostly meant to improve your appearance. This includes but is not limited to, plastic surgery and scar repair or revision. We will provide Benefits for services for reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part. This includes breast reconstruction and symmetry surgery as described in Section Six, paragraph 6 and Section Twelve, paragraph 1(K) (Breast Cancer Care). We 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. Please see Section Three paragraphs 2(C)(vi) and 4(B) for more information about covered newborn children.
- O. Court-Ordered Services. We will not provide Benefits for 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 for legal actions.
- P. Criminal Behavior. We will not provide Benefits for any services related to an illness, injury or condition arising out of your participation in a felony, riot or insurrection. The felony, riot, or insurrection will be determined by the law of the state where the criminal behavior occurred.

- Q. Custodial Services. We will not provide Benefits for this service or for bed rest or convenience reasons.
- R. Dental Services. Except as provided in Section Twelve, paragraph 1(P) (Craniofacial Disorders), we will not provide Benefits for dental services. This includes, but is not limited to, dental services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, bony impacted teeth, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, dental implants, and prosthetic restoration of dental implants. We will not provide Benefits for dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge. We will not provide Benefits for inpatient or outpatient services for dental services unless such services are Medically Necessary and precertified by MVP.
- S. Dietician Services. Except as specifically provided, we will not provide Benefits for dietician services, homemaker services, home delivered meals, or other food or food-related services.
- T. Disposable Medical Supplies. Except as otherwise specifically provided in this Contract (for example under Diabetic Treatment, Supplies and Equipment, and Allergy Services), we will not provide Benefits for non-medically necessary disposable medical supplies. This includes, but is not limited to diapers, chux, sponges, syringes, needles, incontinence pads, reagent strips, catheters, elastic support stockings, compressive garments, dressings, and bandages.
- U. Educational Services. We will not provide Benefits for services required to determine appropriate educational placements or services or for other educational testing. We will not provide Benefits for special education and related services, and assistive technology devices and assistive technology services determined to be needed as a result of such educational evaluations. This includes, but is 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. However, Educational Services provided in connection with Chronic Care Management Programs will be covered.
- V. Employer Services. We will not provide Benefits for any services furnished by a medical department or clinic provided by your employer.
- W. Experimental or Investigational Services. Except as specifically provided in this paragraph, we will not provide Benefits for services which we determine are Experimental or Investigational Services. We will provide Benefits for Experimental or Investigational Services if we determine: (a) that the proposed service has demonstrated promise in treating the underlying condition through a Phase III or Phase IV clinical trial sanctioned by the United States Food and Drug

Administration; and (b) that an expert panel with quality assurance and technology assessment expertise has reviewed the proposed service and deemed it appropriate. Phase I and II clinical trials, whether or not sanctioned by the United States Food and Drug Administration, are excluded. MVP will also provide Benefits for routine patient care costs, but only to the extent required by applicable law. MVP will also provide benefits for routine patient care costs for patients who participate in cancer clinical trials.

- X. Exploratory Counseling. We will not provide Benefits for exploratory counseling for personal growth and development or other similar reasons.
- Y. Family Services. We will not provide Benefits for services provided by your immediate family.
- Z. Foot Care. We will not provide Benefits for routine or palliative foot care. This includes but is not limited to any services in connection with corns, callouses, flat feet, fallen arches, weak feet, toenails, chronic foot strain, or symptomatic complaints of the feet. We will provide Benefits for Medically Necessary foot care.
- AA. Free Services. We will not provide Benefits for any services provided to you without charge or services that would normally be provided without charge.
- BB. Government Benefits. We will not provide Benefits for any services for which benefits are available to you under any federal, state, or local government program, except Medicaid, but including Medicare to the extent it is your primary payor. 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.
- CC. Government Hospital. We will not provide Benefits for services you get in any hospital or other facility or institution which is owned, operated or maintained by the Veteran's Administration, the federal government, or any state or local government, or the United States Armed Forces. However, we will provide Benefits for otherwise covered services in such hospital, facility or institution if the conditions of coverage described in Section Ten (Covered Emergency Services and Urgently Needed Care) are satisfied or for otherwise covered services provided for non-military service related conditions.
- DD. Home Modifications and Fixtures. We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of home modifications and fixtures. For example: 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, home appliances, 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.

- EE. Late Submitted Charges. We will not provide Benefits for charges for services rendered by Preferred Providers which are submitted to MVP more than one hundred eighty (180) days, or as soon thereafter as is reasonably possible, after the date of service. We will not provide Benefits for charges for services rendered by Non-Preferred Providers which are submitted to MVP more than twenty-four (24) months, or as soon thereafter as is reasonably possible, after the date of service.
- FF. Manipulative Medicine Services. We will not provide Benefits for manipulative medicine services performed by a provider other than a licensed chiropractic physician. This includes but is not limited to doctors of osteopathy
- GG. Ophthalmic Services. We will not provide Benefits for vision correction or accommodations or for the expense of purchasing corrective lenses.
- HH. Outside the United States. Except for Emergency Services, we will not provide Benefits for services accessed outside the United States and its possessions or the countries of Canada and Mexico.
- II. Military Service-Connected Illnesses, Injuries and Conditions. We will not provide Benefits for any services in connection with any military service-connected illness, injury, or condition if the Veteran's Administration is responsible for providing such services.
- JJ. No-Fault Automobile Insurance and MedPay. We will not provide Benefits for any service that is covered by mandatory automobile no-fault benefits or applied to any no-fault deductible, for any service that is covered by MedPay or for any service that is covered by similar policies or programs. This exclusion applies even if you do not make a proper or timely claim for benefits available to you under such policy or program or if you fail to appear at any hearing. We will also not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you get money from that lawsuit and have repaid the medical expenses you received payment for under such policy or program.
- KK. Orthotic Devices for Feet. We will not provide Benefits for orthotic devices. This includes, but is not limited to, custom made shoes, orthopedic shoes, arch supports, elastic support stockings and shoe inserts, or for services for evaluation, fitting, or modification of such devices.
- LL. Personal Hygiene and Comfort and Convenience Items and Services. We will not provide Benefits for the purchase, rental, repair, replacement or maintenance of personal hygiene or comfort and convenience items or provider services. This includes, but is not limited to, massage services, spa services, and other provider services, central or unit air conditioners, air or water purifiers, waterbeds, furniture

such as reclining chairs, massage equipment, radio, telephone, television, beauty and barber services, commodes, hypoallergenic bedding, mattresses, waterbeds, dehumidifiers, humidifiers, hygiene equipment, saunas, whirlpool baths, exercise or physical fitness equipment, emergency alert systems and equipment, handrails, heat appliances, and business or vehicle modifications, or for services for evaluation, fitting or modification of such items.

- MM. Private Duty Nursing. We will not provide benefits for this service.
- NN. Reversal of Elective Sterilization. We will not provide Benefits for this service.
- OO. Self-Help Education and Training. Except as specifically provided, we will not provide Benefits for biofeedback, self-diagnosis, self-treatment or self-help training and/or materials. However, Self-Help Education and Training Services provided in connection with Chronic Care Management Programs will be covered.
- PP. Smoking and Caffeine Cessation Services. We will not provide Benefits for programs and services to help you stop smoking or alleviate caffeine dependence.
- QQ. Special Charges. We will not provide Benefits for 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.
- RR. Support Therapies. Except as provided in Section Nine, paragraph 3 (Hospice Services), we will not provide Benefits for support therapies. This includes, but is 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.
- SS. Terminated Coverage. Except as provided in Section Seventeen (Termination of Your Coverage), we will not provide Benefits for any services provided after the termination date of your coverage under this Contract.
- TT. Transsexual Surgery and Related Services. We will not provide Benefits for any services related to or leading up to transsexual surgery. This includes but is not limited to, hospital services, hormone therapies, procedures, treatments or related services designed to alter the physical characteristics of your biologically determined gender to those of another gender.
- UU. Travel and Transportation Costs. Except as specifically provided, we will not provide Benefits for this service or related expenses such as meals and lodging.
- VV. Unlicensed Provider. We will not provide Benefits for services provided by an unlicensed Provider or for services that are outside of a Provider's scope of practice.

- WW. Vision and Hearing Examinations, Therapies and Supplies. We will not provide Benefits for any services related to eye or hearing examinations for prescribing, fitting, determining the need for, or provision of eyeglasses, lenses, frames, contact lenses, or hearing aids. We will not provide Benefits for vision or hearing therapy or training, vision perception training or orthoptics. We will not provide Benefits for the correction of refractive errors by means of any surgical or other procedures, including radial keratotomy. We will not provide Benefits for services for disorder of vision correction or accommodations. However, we will provide Benefits for Medically Necessary eye and ear care.
- XX. Weight Loss Services. We will not provide Benefits for any services or programs in connection with weight reduction, dietary control, dietary supplements and replacements, and exercise classes. However; we will provide Benefits for surgical weight loss procedures pursuant to Section Nine above. This includes, but is not limited to, gastric stapling, gastric by-pass, and gastric bubble. We will provide Benefits for Medically Necessary Covered Services for the treatment of morbid obesity. Morbid obesity is defined as having a body mass index greater than 40 or a body mass index greater than 35 with at least 2 severe comorbidities such as diabetes and heart disease. MVP will also provide benefits for Weight Loss Services provided in connection with Chronic Care Management Programs (such services will be covered in full).
- YY. Wigs. We will not provide Benefits for wigs. This includes toupees, hair pieces, hair transplants, hair extensions or similar hair items. We will not provide Benefits for any products or services to promote hair growth.
- ZZ. Workers' Compensation. Except for sole proprietors and partners who are not voluntarily covered under a workers' compensation insurance policy, we will not provide Benefits for any service for which you have received or are eligible to get benefits under a workers' compensation act or similar law or for services which are the subject of a controverted Workers' Compensation claim or case. This exclusion applies even if you do not get such benefits because you did not submit a proper or timely claim for benefits or because you fail to appear at a hearing. We will also not provide Benefits even if you bring a lawsuit against the person who caused your illness, injury or condition and even if you get money from that lawsuit and you have repaid the medical expenses you received payment for under the workers' compensation act or similar law.

## SECTION SIXTEEN - PREMIUMS

1. Amount of Premiums – The premiums for this contract are approved by the Vermont Department of Banking, Securities, Insurance and Health Care Administration. The approved premium will be charged for the period for which it has been approved, unless an increase or decrease has been approved by the Vermont Department of Banking, Securities, Insurance and Health Care Administration and we provide you with the notice described in paragraph 2 below.
2. Change in Premiums – The premiums for this Contract will change each year based on the attained age of the Subscriber and his or her Dependents. The change will be made on the Contract renewal date. We will give you at least 30 days prior written notice of any increase or decrease in the premiums.
3. Payment of Premiums – The Subscriber, on behalf of himself/herself and his or her Dependents, is responsible for timely payment of all premiums due under this Contract. You will not become covered under this contract until the first premium has been paid to us. All premiums for this contract are due and payable in advance on or before the last day of each prior month (the “Premium Due Date”).
  - A. Misstatement of Age. If the age of a Member has been misstated on the application for this Contract, the Subscriber shall be responsible for the difference between premiums paid and premiums owed had the Member’s age been correctly stated. This provision shall not limit MVP’s rights under any other section of this Contract or applicable law.
4. Grace Period. Notwithstanding paragraph 3 above, MVP will allow you thirty (30) days from the missed Premium Due Date for all premiums except for the first premium (the “Grace Period”). If MVP does not receive your payment within the Grace Period, then your coverage will automatically terminate as of the missed Premium Due Date. If this Contract is terminated for any reason, you will continue to be held liable for all premium payments due and unpaid before the termination. In the event that you do not pay these premiums, MVP shall be entitled to all remedies provided for in law and equity.
  - A. Special Rule for Children Covered Pursuant to Qualified Medical Support Orders – If we do not receive your payment on or before the Premium Due Date, we will send a termination notice to both of the child’s parents and all other persons or agencies identified in the Medical Support Order. If we receive the required premium payment within forty-five (45) days of the termination date specified in the notice, we will reinstate coverage effective from the termination date.
5. Reinstatement. MVP, in its sole discretion, may accept premium payments after expiration of the Grace Period and allow for reinstatement of your Contract. In the event that MVP does allow for reinstatement, your Contract will begin again upon your payment of the appropriate premium subject to the following limitations:

- A. MVP may accept the premium without a new enrollment application. If MVP does not ask for a new enrollment application, this Contract will be reinstated on the date MVP accepts your premium.
- B. MVP may ask for a new enrollment application or conditionally accept premium payment. If this happens, the Contract will begin again, with a new Effective Date, when one of the following happens:
  - i. When the enrollment application is approved by MVP; or
  - ii. Forty-five (45) days after the premium is paid unless MVP notifies you that we will have disapproved your new enrollment application within that timeframe.

## **SECTION SEVENTEEN - TERMINATION OF YOUR COVERAGE**

This Section describes how your coverage may terminate. When your coverage terminates, it stops at 12:00 midnight on the termination date. You may be eligible for Benefits after termination as described below.

1. Automatic Termination. Your coverage will automatically terminate in the event of any of the following:
  - A. On Your Death. If you have individual coverage, your coverage will automatically terminate on the date of your death. If you have two person or family coverage, coverage will automatically terminate on the date of your death, or the date to which your premium is paid, whichever is sooner. Your Spouse or Dependents must immediately notify us of your death.
  - B. Dissolution of Marriage or Civil Union. If you become divorced, or your marriage or civil union is annulled or otherwise legally dissolved, your Spouse's coverage will automatically terminate on the date of dissolution, or the date to which your premium is paid, whichever is sooner. You must immediately notify us of any such dissolution.
  - C. Termination of Coverage of a Child. Your child's coverage under this Contract will automatically terminate on the last day of the month following the earliest of the following dates, or the date to which your premium is paid, whichever is sooner: (a) the child reaches age 19 and is claimed on a tax return as a dependent of a resident of another state; (b) the child marries; (c) the child is no longer chiefly dependent upon you for support and maintenance; or (d) upon termination of your civil union, in which case coverage for the child of such civil union spouse will be terminated. If your child is covered pursuant to Section Three, paragraph 2(B), the child's coverage will automatically terminate on the earliest of the date the child is no longer incapable of self-sustaining employment, is no longer disabled, or is no

longer chiefly dependent upon you for support and maintenance. You must immediately notify us when your child is no longer eligible for coverage.

- i. Special Rule for Children Covered Pursuant to Qualified Medical Support Orders. We will not terminate the coverage of a child required to be covered pursuant to a qualified medical support order until we are provided satisfactory written proof that:
  - a. The order is no longer in effect, or
  - b. The child is or will be enrolled in comparable coverage through another insurer which will take effect not later than the date coverage under this Contract would terminate.

You must immediately notify us of these circumstances. In such instances, the child's coverage will terminate on the last day of the month following the date of the event described in subparagraph a or b, or the date to which your premium is paid, whichever is sooner

2. MVP's Termination of Your Coverage. MVP may terminate your coverage for the following reasons. We will give you 30 days prior written notice:
  - A. Fraud or Misrepresentation. MVP will immediately void your coverage for any fraud or material misrepresentation made by you when you enrolled or when you filed any claim under this Contract. MVP is entitled to recover from you charges for Benefits provided.
  - B. Withdrawal from the Applicable Market. We withdraw from the market as permitted by Vermont law and regulation. We will give you 180 days prior written notice.
  - C. Regulatory. Any reason found to be acceptable to the Vermont Department of Banking, Insurance, Securities and Health Care Administration., authorized by the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations thereunder.
3. Your Option to Terminate Coverage. You may terminate your coverage at any time by giving us 30 days prior written notice.
4. Obligations on Termination. Except as specifically provided in paragraph 5 below, once your coverage ends, MVP will not provide any more Benefits except for Covered Services received before termination.
5. Benefits After Termination. If you are Totally Disabled on the date your coverage terminates, and such Total Disability occurred before your coverage terminated, we will continue to provide Benefits for otherwise covered services which are directly related to the

illness, injury or condition causing the Total Disability. This extension of Benefits will continue until the earliest of: (1) the date you are no longer Totally Disabled; or (2) twelve months from the date your coverage would otherwise have terminated. However, we will not provide more Benefits than would otherwise have been provided if your coverage under this Contract had not been terminated and we will not provide Benefits for any services covered or required to be covered under any other insurance plan, Contract or contract.

- A. Other than Individual Coverage. If you have coverage other than individual coverage under this Contract, this extension of Benefits covers only the member with the Total Disability. MVP will terminate the coverage of other family members who were covered under this Contract as of the termination date.
  - B. Other Exceptions – If your coverage under this Contract was terminated for Fraud or Misrepresentations, we will not provide this extension of benefits.
6. MVP's Right to Recover. If we incorrectly provide Benefits after your coverage or this Contract has been terminated, MVP may recover from you the charges for Benefits provided.

#### **SECTION EIGHTEEN -- THIRD PARTY LIABILITY AND RIGHTS OF REPAYMENT**

1. Introduction. If MVP provides benefits to a Member for an injury, illness, or condition for which a third party is or may be responsible, then MVP retains the right to be repaid the full cost of all benefits provided by MVP that are for or related to the injury, illness or condition. MVP may recover the full cost of all benefits provided by MVP without regard to any fault by the Member.
2. Right to Subrogation. When MVP has provided benefits as described above and the Member has not yet recovered such costs from the third party, MVP is subrogated to the Member's rights of recovery against any third party for the full cost of benefits. MVP may proceed against any third party without the consent of the Member.
3. Right to Reimbursement. When MVP has provided benefits as described above and the Member or Member's representative has recovered such costs from the third party, MVP is entitled to reimbursement from the Member for the full cost of benefits. As a condition of coverage under this Contract, each Member hereby grants to MVP: (1) an assignment of the proceeds of any settlement, judgment, benefits under any automobile policy or other coverage, or any other payment received by the Member, to the extent of the full cost of all benefits provided by MVP; and (2) a first priority lien against the proceeds of any settlement, verdict, judgment, benefits under any automobile policy or other coverage, insurance proceeds, or any other payment received by the Member, to the extent of the full cost of all benefits provided by MVP.

4. Sources of Payment. MVP's rights apply to any payments made to or on behalf of a Member from third-party sources. This includes, but is not limited to: (1) payments made by a tortfeasor or any insurance company on behalf of such third-party tortfeasor, (2) any payments or awards under Medpay or an uninsured or underinsured motorist automobile policy, (3) any worker's compensation or disability award or settlement, (4) medical payments coverage under any automobile policy, (5) premises or homeowners medical payments coverage or premises or homeowners insurance coverage, (6) any other payments from a source intended to compensate a Member for injuries resulting from alleged negligence of a third party. No court costs may be deducted from MVP's recovery without MVP's prior written consent.
5. Cumulative Rights. MVP may choose to exercise either or both rights.
6. Member's Obligations.
  - A. Promptly notify MVP when notice is given to any third party to pursue a claim for injuries, illnesses or conditions that may be the legal responsibility of a third party.
  - B. Cooperate with MVP to protect MVP's rights to reimbursement and subrogation, including:
    - i. signing and delivering, within 30 days of a reasonable request to do so, any documents needed to secure MVP's subrogation claim, to protect MVP's right to reimbursement, or to effect the assignment or lien described in paragraph 3 above;
    - ii. providing any relevant information;
    - iii. getting the consent of MVP before releasing any party from liability for payment of medical expenses;
    - iv. taking such other actions as may be needed to assist MVP in making a full recovery of the cost of all benefits provided; and
    - v. not taking any action that prejudices MVP's rights to reimbursement or subrogation, including but not limited to making any settlement or recovery which specifically attempts to reduce or exclude the full cost of benefits provided by MVP.
7. Consequence of Failure to Comply. If the Member fails to comply with the requirements of paragraph 6, a Member shall be responsible for all benefits provided by MVP in addition to costs and interest incurred by MVP in getting repayment. Your future benefits may be reduced or withheld to recover monies owed to us.

## **SECTION NINETEEN – GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW**

1. Grievances. A grievance means a written or verbal complaint submitted to MVP by or on behalf of a Member expressing dissatisfaction regarding the availability, delivery or quality of health care services, claims payment, handling or reimbursement for health care services, or expressing dissatisfaction regarding matters governed by or related to this Contract. It includes requests that MVP change decisions that services are not Medically Necessary or are not Covered Services. You, your appointed representative (such as a family member, friend, or lawyer), or a Provider acting for you, may submit a grievance. You must call MVP at 1-888-MVP-MBRS in order to appoint a representative. Your decision as to whether or not to submit a grievance has no effect on your rights to any other benefits under this Contract. 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 grievance. First Level Grievances are mandatory. This means that you must commence and complete a First Level Grievance before you may seek any other internal or external remedy, including Independent External Review or court action.
  
2. Grievance Reviewers.
  - A. First Level Grievances. Medical grievances are reviewed by one of MVP's medical directors. Non-medical grievances are reviewed by a member of MVP's administrative staff. This person has the necessary education and experience to resolve the matter. First level grievances are reviewed by persons who were not involved in making the initial decision and who are not subordinate to such persons.
  
  - B. Second Level Grievances. Second level grievances are reviewed by a panel comprised of MVP senior medical and administrative staff and/or board members. This panel has the necessary education, training and experience to resolve the matter. The medical staff participating in at least one level of grievance review will have appropriate training and experience in the field of medicine involved in the particular grievance. Such staff will be actively practicing in the same or similar specialty and typically treat the condition or provide the service that is the subject of the grievance. Alternatively, MVP may use independent organizations to provide medical specialists practicing in the same or similar specialty as consultants for a grievance. Second level grievances are reviewed by persons not involved in making the initial decision or the first level grievance decision and who are not subordinate to such persons. More information about the panel reviewing your grievance is included in MVP's written response to the grievance.
  
3. Information Reviewed. MVP will review all comments, documents, records and other information you provide, without regard to whether such information was submitted or considered when making the initial decision or any first level grievance decision. Grievances are reviewed without regard to the initial decision or any first level grievance decision.

4. Time Limit for Submitting a First Level Grievance. You must submit a grievance within 180 days of receiving our decision regarding the matter that is the subject of the grievance. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral grievance by calling MVP at 1-888-MVP-MBRS. You may submit a written grievance to MVP Health Plan, Inc., 625 State Street, Schenectady, New York 12305.

5. MVP's Response to First Level Grievances. MVP will respond to grievances as follows:

A. Grievances related to Emergency Services or Urgently-Needed Care and in cases where:

- i. application of the time periods described in subparagraph B below:
  - a. could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or
  - b. would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or
- ii. a physician with knowledge of your medical condition determines that a Prior Authorization, concurrent review or prior approval request is urgent.

MVP will notify you of our decision within 24 hours after our receipt of the grievance. In cases involving mental health conditions, a licensed mental health review agent will make a decision within 24 hours of the date the grievance is submitted. You will be notified of our decision by telephone and in writing.

B. All other Grievances. MVP will notify you of our decision within 15 days after our receipt of the grievance. In cases involving Mental Health or Substance Abuse Services, a licensed mental health review agent will make a decision within 10 days of the date the grievance is submitted. You will be notified of our decision in writing.

C. If you are not satisfied with MVP's decision in response to your First Level Grievance, you may, in addition to any other legal remedy available to you:

- i. Proceed directly to Independent External Review, as described in paragraph 11 below; or
- ii. Commence a Voluntary Second Level Grievance with MVP as described in paragraph 7 below. If you do so, your time to commence court action

will not start until you receive MVP's response to the Voluntary Second Level Grievance.

D. Additional Provisions.

- i. MVP waives any right to assert that you failed to exhaust administrative remedies because you did not elect to make a Voluntary Second Level Grievance.
- ii. MVP agrees that any statute of limitations or other defense based on timeliness is tolled during the time that your Voluntary Second Level Grievance is pending.
- iii. No fees or costs are imposed on you as part of the Mandatory First Level or Voluntary Second Level Grievance.

6. Time Limit for Submitting a Voluntary Second Level Grievance. In cases not involving Mental Health or Substance Abuse Services, if you are not satisfied with MVP's decision in response to the first level grievance, you may submit a second level grievance. If you proceed, you are not required to make a Voluntary Second Level Grievance in order to pursue any external remedy that may be available to you. You must submit this grievance within 90 days of receiving our decision in response to the first level grievance. You should describe the reasons why you disagree with the decision and provide any further information you think is relevant. You may submit an oral grievance by calling MVP at 1-888-MVP-MBRS. You may submit a written grievance to MVP Health Plan, Inc., 625 State Street, Schenectady, New York 12305. As described in paragraph ii, second level grievances are reviewed by a panel. You also have the right to appear before the panel to discuss your grievance. If you cannot appear before the panel in person, you may communicate with the panel by conference call or other appropriate technology. For cases involving Mental Health or Substance Abuse Services, please see paragraph 9 below.

7. MVP's Response to Voluntary Second Level Grievances. MVP will respond to second level grievances as follows.

A. Grievances related to Emergency Services or Urgently Needed Care and in cases where:

- i. application of the time periods described in subparagraph B below:
  - a. could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously jeopardize your life or health or your ability to regain maximum function; or

- b. would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or
- ii. a physician with knowledge of your medical condition determines that a Prior Authorization, concurrent review or prior approval request is urgent.

MVP will notify you of our decision within 48 hours after our receipt of the grievance. You will be notified of our decision by telephone and in writing.

- B. All other Grievances. MVP will notify you of our decision within 15 days after our receipt of the grievance. You will be notified of our decision in writing.

If you are not satisfied with MVP's decision in response to your Second Level Grievance, you may, in addition to any other legal remedy available to you, proceed directly to Independent External Review as described in paragraph 11 below.

- 8. Review of First Level Grievance Decisions in Cases Involving Mental Health or Substance Abuse Services. If you are not satisfied with the decision in response to the first level grievance, you, your provider, or your authorized representative may submit an appeal to the Independent Panel of Mental Health Care Providers established by the Vermont Department of Banking, Securities, Insurance and Health Care Administration. You must contact the Vermont Department of Banking, Securities, Insurance and Health Care Administration at 1-800-631-7788 for assistance in submitting this appeal.

- 9. Independent External Review.

- A. You have the right to an "independent external review" of certain first or second level grievance decisions made by MVP. An independent external review is an independent review of our decision by a third party known as an independent review organization. Independent review organizations are selected by the Vermont Department of Banking, Securities, Insurance and Health Care Administration and must not have any conflict of interest associated with the review. You may have the right to an expedited external review if the subject of the review concerns an emergency medical condition, emergency services, or urgently needed care. The timeframes for expedited external reviews are shorter than the timeframes for standard external reviews.
- B. You must request this review within 90 days of receiving MVP's first level or second level adverse decision. To request an independent external review, you must call the Vermont Department of Banking, Securities, Insurance and Health Care Administration at 800-631-7788.
- C. You may request an independent external review only if the service that is the subject of the review is a Covered Service.

- D. You may not request an external review unless we have issued a first level grievance decision. This means that you must complete MVP's first level grievance process before requesting an external review.
  - E. To be eligible for external review, the first or second level grievance decision must be based on a decision that the requested service is not Medically Necessary, is Experimental or Investigational, is an off-label use of a drug, or is a service involving a medically-based decision that a condition is preexisting, or that we have limited your selection of a provider in a manner inconsistent with the terms of this Contract or applicable laws and regulations. You do not have the right to external review of any other decisions, even if those other decisions affect your eligibility or benefits.
10. Effect of Review Organization's Decision; Coverage. The decision of the review organization is binding on MVP. If the organization decides in our favor, we will not change our decision or provide benefits for the service that is the subject of the review. If the organization decides in your favor, we will provide benefits subject to all other terms and conditions of this Contract. We will not provide benefits for any service that is not a Covered Service. In addition, this section does not change any Copayment, Coinsurance, or Deductible.

## **SECTION TWENTY -- EFFECT OF MEDICARE**

When you become eligible for Medicare, you must enroll in Part B and notify MVP in writing. Medicare then becomes your Primary Plan. We will not provide Benefits for any service or care for which benefits are payable under Medicare. When you are eligible for Medicare, we will reduce our 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 premiums or other charges for Medicare; or you get services at a hospital or from a provider that cannot bill Medicare.

1. Medicare as Primary Plan/MVP as Secondary Plan.

You must follow Medicare's rules and the terms of this Certificate. You must pay all Deductible, Copayments, Coinsurance, and, when using Non-Preferred Providers, the difference, if any, between the Allowable Charge and the Non-Preferred Provider's Charge, before MVP will provide Benefits.

The Benefits provided by MVP will be reduced to provide Benefits only to the extent not provided by Medicare.

2. MVP as Primary Plan/Medicare as Secondary Plan.

If 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, MVP will not reduce this Certificate's benefits, and we will provide benefits before Medicare pays, during the waiting period (this means that Medicare is the Secondary Plan during this

waiting period). We will also provide benefits before Medicare pays during the coordination period with Medicare. After the waiting period, Medicare will pay its benefits before we provide benefits under this Certificate (this means that Medicare is the Primary Plan after this waiting period).

The benefits provided by Medicare will be reduced to provide benefits only to the extent not provided by MVP.

3. Recovery of Overpayment. If we provide more Benefits than we should have, we have the right to recover the overpayment from you or from any other person, insurance company, agency or organization. You must cooperate with us to recover the overpayment.

### **SECTION TWENTY-ONE -- GENERAL PROVISIONS**

1. Assignment. Only you are eligible for benefits under this Contract. You cannot assign your right to any benefits due under this Contract to any person, corporation or other organization, your right to collect for those benefits, or your right to bring legal action against us. Any such assignment shall be null and void and, at our option, may result in termination of your coverage.
2. Notices. Any notice that we give you will be mailed to you at your address as it appears in our records. You must notify MVP of any change of address right away. All notices to MVP must be mailed, postage prepaid, registered or certified mail, return receipt requested, or personally delivered to us at 625 State Street, Schenectady, New York 12305.
3. Your Medical Records. To provide benefits, it may be necessary to get your medical records from providers who treated you. Providing Benefits includes determining your eligibility, conducting utilization management, processing your claims, reviewing grievances involving your care, and quality assurance and quality improvement reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Contract, you automatically authorize each and every Provider to:
  - A. disclose to MVP all facts about your care, treatment, and condition to assist us in providing Benefits;
  - B. give MVP reports about your care, treatment and condition; and
  - C. permit MVP to review and copy your records.

At any time we request, you will give us a signed authorization to get your records for these purposes. We have the right to deny benefits under this Contract if you refuse to give us such authorization. We will maintain your medical records in accordance with state and federal confidentiality laws. You automatically authorize us to give your medical records to

the Vermont Department of Banking, Securities, Insurance and Health Care Administration or other quality oversight organizations. **This disclosure excludes the release of any information about previously administered tests for HIV antibodies, T-Cell counts, AIDS or ARC.**

4. Changes to this Contract.
  - A. We may change the terms of this Contract and change or eliminate any of the benefits if approved by the Vermont Department of Banking, Insurance Securities and Health Care Administration. We will give you at least 30 days prior written notice of a change.
  - B. This Contract may not be modified, amended or changed, except in writing, and signed by our Chief Executive Officer.
5. Time to File Claims. Claims for services rendered by Preferred Providers under this Contract must be submitted to us for payment within 180 days after the date of service. Claims for services rendered by Non-Preferred Providers must be submitted to us for payment within twenty four (24) months after the date of service, or as soon thereafter as is reasonably possible.
6. Who Receives Payment Under this Contract. Payments for Covered Services provided by a Preferred Provider will be made by us directly to the provider. When services are provided by a Non-Preferred Provider, you or the Provider must submit a claim to MVP. Payments may be made to you or to the Provider. See Section Five.
7. Legal Action. You may not start a legal action against us prior to exhausting the first level grievance process outlined in Section Nineteen. You must start any lawsuit against us within 3 years from the date we made a first level grievance decision. Service or process must be made upon an officer of MVP at 625 State Street, Schenectady, New York 12305 or otherwise in accordance with state or federal law.
  - A. Physical Examination. MVP may require you to have a physical exam as often as necessary about any injury or illness which results in a claim made under this Contract. MVP may also have the right and opportunity to make an autopsy in the case of death, where it is not prohibited by law. Such exams and autopsy will be at MVP's cost.
  - B. Examination Under Oath. MVP shall have the right and opportunity to examine under oath the Covered Person for whom claim is made when and so often as we may reasonably require during the pendency of such claim made under this Contract.
  - C. Choice of Law. In any dispute between you and MVP, Vermont or federal law, as appropriate, shall be applied to determine your rights.

8. Venue for Legal Action. You must start any lawsuit against us in a court in Vermont. You agree not to start a lawsuit against us in a court located anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action we bring against you.
9. MVP's Relationship with Providers. MVP and Preferred Providers have an independent contract relationship. Providers are not agents or employees of MVP and MVP is not an agent or employee of any Provider. This Contract does not require any particular Provider to accept you as a patient and we do not guarantee such acceptance by any particular Provider. Preferred and Non-Preferred Providers are solely responsible for all services rendered or not rendered to Members.

MVP does not control the treatment or other professional actions of providers. MVP's decisions relate only to whether we will provide benefits under this Contract and are not a substitute for the professional judgment of your Provider. Further, the persons making these decisions for MVP do not get incentives to limit or deny benefits and are not paid based upon the quantity or type of such decisions.

10. Identification Cards. Possession of a card confers no automatic right to benefits. To be eligible for benefits, you must be listed on a completed enrollment form submitted to and accepted by us and your premiums must be paid in full. We may terminate your Coverage if you allow another person to wrongfully use an MVP identification card.
11. Construction and Interpretation of this Contract. Subject to any rights you have to dispute a determination of coverage or benefits under this Contract, MVP determines whether and to what extent Members are entitled to coverage and benefits and to construe disputed or unclear terms under this Contract. This means that even if a Provider provides, prescribes or recommends a service, MVP still determines whether benefits for the service are available under this Contract. In the event of any dispute or question concerning enrollment, eligibility, coverage, or other terms and conditions, this Contract controls over other sources of general information issued by MVP.
12. Furnishing Information. You must, within 30 days of our request, provide us with all information and records that we may need to perform our obligations under this Contract. In the event of a dispute concerning the provision or denial of benefits, MVP may require that a Member be examined, at MVP's expense, by a provider designated by MVP.
13. Inability to Provide Service. In the event of circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of our offices, a significant part of our network, or entities with whom MVP has arranged for services, and our ability to provide benefits under this Contract is delayed or becomes impossible, we will not be liable for such delay or failure, except to refund unearned premiums. We are required only to make a good faith effort to provide or arrange for the provision of benefits.

14. Recovery of Overpayments. If we make a payment to you in error, we will tell you and you must return the amount of the overpayment to us within 60 days. If we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we make to you.
15. Nonwaiver of Our Rights. We may choose not to enforce certain terms or conditions of your Contract. This does not mean we give up the right to enforce these terms or conditions later.
16. Time Limit on Certain Defenses. After 3 years from the effective date of this Contract, no misstatements, except fraudulent misstatements, made by the Subscriber or his or her Dependents in the enrollment application for this Contract, shall be used to void this Contract or used as a basis to deny a claim after the expiration of such 3 year period.
17. Choice of Law. Unless federal law applies, this Contract is subject to the laws of Vermont.
18. Severability. If any provisions of your Contract are declared invalid or illegal for any reason, the remaining terms and provisions will remain in full force and effect.
19. Entire Contract. The Member's enrollment/change forms, this Contract, and any riders, amendments, endorsements, and schedules delivered with this Contract or added thereafter shall constitute the entire agreement between MVP and the Member, and shall supersede any prior arrangements, agreements, negotiations, and discussions between the parties, whether written or oral.