EXHIBIT 3

NEW YORK STATE OF OPPORTUNITY. | Department of Civil Service

ANDREW M. CUOMO
Governor
LOLA W. BRABHAM
Commissioner

August 18, 2020

Ms. Kelly Smith
Senior Vice President, Chief of Sales
MVP Health Plan, Inc.
625 State St.
Schenectady, N.Y. 12305

VIA U.S. POSTAL MAIL & ELECTRONIC MAIL:
KSmith@mvphealthcare.com

RE: Clarification Request #1 - Solicitation entitled "Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

Dear Ms. Smith:

On July 27, 2020, MVP Health Plan Inc. (MVP) submitted a proposal in response to the Department of Civil Service's above Solicitation. Upon review, the Joint Labor Management Committee (JLMC) identified the following sections of your proposal that require clarification:

Administrative Proposal:

1. **Attachment 8, Item #1:** MVP states that it is required to comply with the New York State Department of Financial Services Model Audit Rule (MAR). What were the results of the 2019 MAR audit?

2. **Attachment 8, Item #1:** MVP states that it undergoes a yearly SSAE 18/SOC 1 type 2 audit. It states that the most recent audit was "signed off" in November 2019. Please provide the results of this audit.

3. **Attachment 8, Item #1:** MVP states that the 2020 audit is in process. When does MVP expect that this audit will be completed?

4. **Attachment 8, Item #1:** MVP identifies several audits which appear to examine various financial controls. Please provide information about what data security controls are in place at MVP and how those controls map to this response.

5. **Page 22, Subcontractors:** MVP indicates eviCore's contract for radiology services was renewed for 1/1/20. What is the duration of that contract?

Similarly, what is the duration of the Magellan contract? Please confirm MVP will notify the JLMC of any changes to subcontractors that occur after submission of its proposal and prior to the end of contract with the Department.

6. **Page 134, Vendor Responsibility:** Please confirm MVP will submit all necessary Vendor Responsibility documents for Optum and American Specialty Health Management as soon as possible.

Technical Proposal:

1. **Page 15, Section 5.1:** Please confirm MVP's understanding that the Department requires the Medicare enrollment file to be submitted weekly, not monthly.

2. **Page 15, CMS Star Ratings:** MVP's CMS Star Ratings for Medicare Part C and Medicare Part D coverage have each declined by a half of a point last year, and the overall Star Rating for the product has decreased from 4.5 to 4.0 over the previous two years. Please provide an explanation for the decline in ratings.

3. **Page 22, Telemedicine:** MVP states it is currently negotiating a one-year contract renewal for 2021. Please follow-up with confirmation when an agreement is reached. Also, the contract with Upstate Concierge Management is scheduled to terminate on March 15, 2021. Does MVP expect to extend the contract through 2021?

4. **Page 27, Section 5.3:** Can MVP please provide the JLMC with dummy login credentials in order to access the member portal?

5. **Page 34, C. Counties/Rating Regions - NYSHIP Region 058 Rochester:** Please confirm MVP is proposing to add Chemung and Schuyler counties in Region 058 for 2021.

6. **Page 34, C. Counties/Rating Regions - NYSHIP Region 060 East:** The following counties appear to be missing for the Commercial *Choices* Page for Region 060 (Columbia, Fulton, Greene, Hamilton and Montgomery) Please confirm. If confirmed, please update the Commercial *Choices* page and submit to the JLMC. If not confirmed, please note the requirement to have identical Commercial and MAP service areas.

7. **Page 35, Schedule M:** Please confirm this is the schedule M filed with and accepted by the New York State Department of Financial Services. If it is not, please provide the appropriate document.

8. **Page 39, Provider Access Report:** MVP is presenting a Preferred Provider Network that offers $0 copays for office visits and specialist visits. Please provide an estimated count of each specialist type by county that would qualify for this Network.

9. **Page 700, I. Prescription Drug Benefit:** The Commercial Formulary chart indicates that MVP is proposing a "Closed" formulary. The Commercial *Choices* page indicates an "incented" formulary. Please clarify which is correct.

10. **Page 1282, L. 2021, Benefit Chart:** Confirm the Preferred Provider Network at $0 copay applies to office visits and specialty providers.

11. **Page 1285, Benefits Chart:** The document lists a change in prescription drug coverage, but the copays listed are the same as those for 2020. Please clarify if there is a change in 2021. In addition, please clarify if there is a change to Fertility Drug coverage in 2021.

12. **Page 1307, Summary of Benefits and Coverage (SBC):** The SBC indicates a $0 copay for Tier 1 generic drugs for all three categories (e.g. retail, mail order, and specialty), but the Tier 1 copay is listed as $10 in MVP's Benefit Chart on page 1285. Please clarify the correct copay.

13. **Page 1309, Summary of Benefits and Coverage:** Per the SBC, the Inpatient Rehabilitation benefit is 30 days per calendar year, but the coverage is 60 days per calendar year for combined therapies. Please submit corrected copy.

14. **Page 1315, M. Communications Materials:** Please describe what criteria is used to establish a Preferred Provider. How will members be made aware of the Preferred Provider Network? Additionally, confirm this network is an HMO product and does not constitute a PPO or EPO with out-of-network coverage.

15. **Page 1332, Schedule of Benefits:** This document indicates a $0 copay for Tier 1 drugs, but the Tier 1 copay is listed as $10 in MVP's Benefit Chart on page 1285. Please identify the correct copay and submit updated copies of the corrected documents.

16. **Page 1335, Letter of Notice:** This document indicates that MVP is still in the process of completing the 2021 MAP bid to CMS and benefits could be subject to change. Please submit documentation when approved.

17. **Page 1336, M. Side-by-Side Comparison of Benefits Changes 2020 to 2021 – Commercial:** MVP indicates that Diagnostic Laboratory services are "Covered in Full", but also states there's a $0 co-payment per visit at a preferred provider facility. Is there a difference in cost sharing for Diagnostic Laboratory services between preferred providers and non-preferred providers?

18. **Page 1338, M. Side-by-Side Comparison of Benefits Changes 2020 to 2021 – Commercial:** MVP appears to have included commercial services that did not change from 2020 to 2021. In the future, please include only the benefits that have changed.

19. **Page 1338, M. Communication Materials - Side-by-Side Comparison of Benefits Changes 2020 to 2021 - Commercial:** The Side-by-Side Comparisons should include a $0 copay for dependents to age 26 for office visits. Please correct and resubmit this document.

20. **Page 1338, M. Communication Materials - Side-by-Side Comparison of Benefits Changes 2020 to 2021 - Commercial:** The change in copay for Telemedicine should be added to the Side-by-Side Comparison. Where in the certificate is this copay indicated?

21. **Page 1339, M. Side-by-Side Comparison of Benefits Changes 2020 to 2021 – Commercial:** The header for the 2020 plan on this page is labeled "MVP HMO 25/40", while the commercial plan is labeled "MVP HMO 25/25" everywhere else. Please confirm if this is a typo. If it is not a typo, please provide the correct Side-by-Side Comparison for the appropriate plan comparison.

22. **Page 1340, M. Side-by-Side Comparison of Benefits Changes 2020 to 2021 - MAP:** MVP appears to have included MAP services that did not change from 2020 to 2021. In the future, please include only the benefits that have changed.

23. **Page 1348, P. NYSHIP Communications:** This document appears to be directed to all state employees, and not just to existing MVP enrollees. Please confirm this communication will only be distributed to existing MVP NYSHIP enrollees.

24. **Page 1361, P. NYSHIP Communications:** Please confirm the Preferred Provider Network of $0 copay applies to office visits and specialty providers.

25. **Page 1361, P. NYSHIP Communications:** The SBC indicates a $25 copay for the 1st diagnostic visit for a maternity visit. This is not indicated in other documents. Please confirm this is correct information and if it is new information, add it to the Side-by-Side Comparison.

26. **Page 1364, Q. *Choices* - Commercial:** Please confirm the Preferred Provider Network $0 copay benefit applies to office visits and specialty providers.

27. **Page 1364, Q. *Choices* - Commercial:** *Choices* indicates weight loss/bariatric surgery covered in full, with approval, at a Centers of Excellence. Is this a new benefit? If so, please add it to the Side-by-Side Comparison and submit.

28. **Page 1372, Q. *Choices* - MAP:** Regarding Inpatient Mental Health for MAP, there is a 190-day lifetime limit in a psychiatric facility. Please explain how this is consistent with the Mental Health Parity Addiction and Equity Act (MHPAEA). Are lifetime limits for this benefit allowed under the Patient Protection and Affordable Care Act (PPACA)?

29. **Certificate of Coverage, Schedule of Benefits, NYSHIP Eligibility Rider and other documents marked as "Draft":** Please confirm that finalized versions of all documents submitted as "Draft" and "Pending" will be distributed to the JLMC as soon as they are available.

30. There are co-insurances listed in the Evidence of Coverage for the MAP that appear to be new but are not listed on the Side-by-Side Comparison for MAP and are not reflected on the *Choices*- MAP page. They include Medicare Part B drugs and some other Medicare covered items. Please explain and correct the Side-by-Side and other benefit charts as appropriate.

A response to this request is due no later than August 25, 2020. Please email your response to DCSProcurement@cs.ny.gov. We look forward to your timely response and advancing to the next stage of the solicitation process.

Sincerely,

[redacted]

James DeVan
Director
Employee Benefits Division

NYSHIP 2021 Clarifying Questions

August 25, 2020

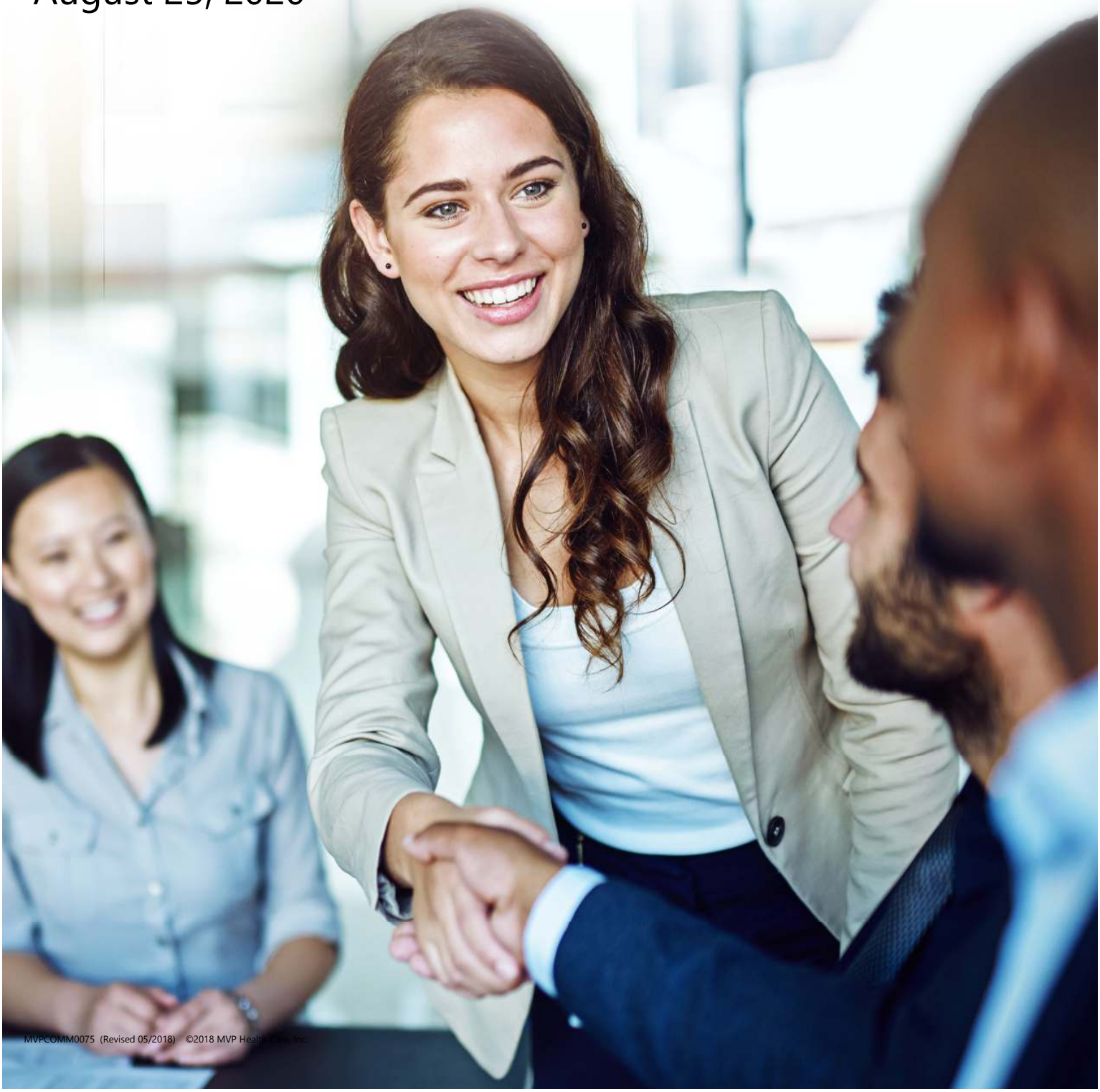


Table of Contents

NYSHIP Clarifying Questions Response

Administrative Proposal:

1. ***Attachment 8, Item #1*: MVP states that it is required to comply with the New York State Department of Financial Services Model Audit Rule (MAR). What were the results of the 2019 MAR audit?**

   The results of the MAR audit attestation submitted to New York State reported that no material weaknesses were identified. Please refer to **Attachment 1**--attestation that was submitted on 4/1/2020.

2. ***Attachment 8, Item #1*: MVP states that it undergoes a yearly SSAE 18/SOC 1 type 2 audit. It states that the most recent audit was "signed off' in November 2019. Please provide the results of this audit.**

   THIS INFORMATION IS CONSIDERED PROPRIETARY AND CONFIDENTIAL MVP requests that this response and all the information contained herein be afforded confidential treatment and be excepted from disclosure to the extent available pursuant to NY Public Officers Law S. 87(2)

   [redacted]

3. ***Attachment 8, Item #1: MVP states that the 2020 audit is in process. When does MVP expect that this audit will be completed?***

   MVP plans to obtain the signoff of the 2020 SSAE 18/SOC 1 type 2 from our external auditors on, or around, 12/1/2020.

4. ***Attachment 8, Item #1: MVP identifies several audits which appear to examine various financial controls. Please provide information about what data security controls are in place at MVP and how those controls map to this response.***

   MVP's SOC report contains the ITGC's that were tested.

5. ***Page 22, Subcontractors*: MVP indicates eviCore's contract for radiology services was renewed for 1/1/20. What is the duration of that contract? Similarly, what is the duration of the Magellan contract? Please confirm MVP will notify the JLMC of any changes to subcontractors that occur after submission of its proposal and prior to the end of contract with the Department.**

   - The eviCore contract was renewed thru 12/31/20.

- The current Magellan contract has a three-year term. It became effective on 1/1/2019 is set to expire on 12/31/2021.

MVP confirms that we will notify the JLMC of any changes to subcontractors that occur after submission of its proposal and prior to the end of contract with the Department.

6. ***Page 134, Vendor Responsibility*: Please confirm MVP will submit all necessary Vendor Responsibility documents for Optum and American Specialty Health Management as soon as possible.**

- Please find Optum's Vendor Responsibility questionnaire enclosed as **Attachment 3**.
- American Specialty Health (ASH) has confirmed that they have received and finalized the site requests for the NYS Vendor Responsibility questionnaire, which should take about a week to receive. As soon as they send us the PDF of the certificate we will forward on to the Department.

Technical Proposal:

1. **Page 15, Section 5.1: Please confirm MVP's understanding that the Department requires the Medicare enrollment file to be submitted weekly, not monthly.**

   Confirmed—MVP will submit the Medicare enrollment file weekly.

2. **Page 15, CMS Star Ratings: MVP's CMS Star Ratings for Medicare Part C and Medicare Part D coverage have each declined by a half of a point last year, and the overall Star Rating for the product has decreased from 4.5 to 4.0 over the previous two years. Please provide an explanation for the decline in ratings.**

   MVP Health Care's 2020 Part C and Part D summary STAR ratings each dropped a ½ STAR for the 2020 CMS STAR ratings, causing the plan to drop a ½ STAR on the overall rating for our HMO plan. MVP maintained 4.5 STARS for this plan for several years.

   Many factors contribute to a plan decreasing or increasing its overall STAR rating, including, but not limited to: a decrease in performance on the individual measures; a change in the measure thresholds (cut point) that negatively affect the plan's rating; and the calculations for improvement measures and the reward factor.

   Several of these factors contributed to MVP's HMO plan dropping from 4.5 to 4.0 stars. Specifically, the plan experienced loss of points in several areas, including:

   · For both Part C and Part D, MVP experienced a decline in ratings on several HEDIS measures as well as on some of the CAHPS survey measures.

   · MVP experienced an additional loss of points on some HOS survey measures, appeals' measures, and call center measures.

   · Points lost for the above measures were augmented due to variations in measure cut points and the measures being heavily weighted.

Remediation plans have been put in place for each measure where points were lost. MVP expects to see an improvement to our score for the 2021 CMS STAR ratings.

3. **Page 22, Telemedicine: MVP states it is currently negotiating a one-year contract renewal for 2021. Please follow-up with confirmation when an agreement is reached. Also, the contract with Upstate Concierge Management is scheduled to terminate on March 15, 2021. Does MVP expect to extend the contract through 2021?**

   It is now confirmed that the agreement to extend AmWell through 2021 has been signed. For UCM, MVP expects to extend the current agreement through 2021.

4. **Page 27, Section 5.3: Can MVP please provide the JLMC with dummy login credentials in order to access the member portal?**

   A dummy account has been created to allow the member portal to be experienced. While there are no claims attached to this account, the navigation, fields, and general functionality of the portal will be accessible. The email address tied to the account is currently set to one of our IT Analysts, but this can be updated after you login. Please feel free to reach out to Alex Miller if you have any questions or encounter any issues: almiller@mvphealthcare.com.

   Website: https://wwwacc.mvphealthcare.com
   Username: JDOE1234
   Password: NYS1234!
   Security Question: What was your high school mascot?
   Security Answer: Fish

5. **Page 34, C. Counties/Rating Regions - NYSHIP Region 058 Rochester: Please confirm MVP is proposing to add Chemung and Schuyler counties in Region 058 for 2021.**

   MVP confirms that we are proposing to add Chemung and Schuyler counties in Region 058 for 2021.

6. **Page 34, C. Counties/Rating Regions - NYSHIP Region 060 East: The following counties appear to be missing for the Commercial Choices Page for Region 060 (Columbia, Fulton, Greene, Hamilton, and Montgomery) Please confirm. If confirmed, please update the Commercial Choices page and submit to the JLMC. If not confirmed, please note the requirement to have identical Commercial and MAP service areas.**

   Columbia, Fulton, Greene, Hamilton, and Montgomery counties are still a part of our offering for NYSHIP Region 060 East and they have been added back to the Choices Page – Commercial Plan.

   Please refer to **Attachment 4**—for an updated *Choices Page – Commercial Plan*.

7. **Page 35, Schedule M: Please confirm this is the schedule M filed with and accepted by the New York State Department of Financial Services. If it is not, please provide the appropriate document.**

Please find attached the filed **Schedule M** submitted and accepted by NYS Department of Financial Services – **Attachment 5.**

8. **Page 39, Provider Access Report: MVP is presenting a Preferred Provider Network that offers $0 copays for office visits and specialist visits. Please provide an estimated count of each specialist type by county that would qualify for this Network.**

Please find a listing of Preferred Provider Facilities attached as **Attachment 6**--*MVP Preferred Provider Facilities Directory*. This details the Preferred Provider facilities which can also be found on our website at https://www.mvphealthcare.com/wp-content/uploads/download-manager-files/MVPCOMM0140_PreferredProviderFacilitiesDirectory_202002.pdf. Please note that the list is subject to change and that members should always check *MVP's Find a Doctor* search tool for the most current listing.

A breakdown by NYSHIP code and Preferred Provider Facility type is listed below.

060
Ambulatory – 10
Laboratory – 25 (all multi-location)
Radiology – 16

058
Ambulatory – 5
Laboratory – 25 (all multi-location)
Radiology – 4

360
Ambulatory – 2
Laboratory – 25 (all multi-location)
Radiology – 2

330
Ambulatory – 17
Laboratory – 25 (all multi-location)
Radiology – 16

340
Ambulatory – 11
Laboratory – 25 (all multi-location)
Radiology – 17

MVP's preferred provider facilities (PPF) benefit helps members save money on laboratory, radiology, and ambulatory/outpatient services. Medically necessary and covered services are covered in full ($0) when performed at a designated MVP preferred provider facility. The PPF benefit is not applicable to these services for PCP or Specialist office visits and would be subject to the plan's $25 co-payment.

9. **Page 700, I. Prescription Drug Benefit: The Commercial Formulary chart indicates that MVP is proposing a "Closed" formulary. The Commercial Choices page indicates an "incented" formulary. Please clarify which is correct.**

MVP offers a closed formulary. **Attachment 4**--the *Choices Page – Commercial Plan* has been updated to reflect formulary type.

10. Page 1282, L. 2021, Benefit Chart: Confirm the Preferred Provider Network at $0 copay applies to office visits and specialty providers.

MVP's preferred provider facilities (PPF) benefit helps members save money on laboratory, radiology, and ambulatory/outpatient services. Medically necessary and covered services are covered in full ($0) when performed at a designated MVP preferred provider facility. The PPF benefit is not applicable to these services for PCP or Specialist office visits and would be subject to the plan's $25 co-payment.

11. Page 1285, Benefits Chart: The document lists a change in prescription drug coverage, but the copays listed are the same as those for 2020. Please clarify if there is a change in 2021. In addition, please clarify if there is a change to Fertility Drug coverage in 2021.

The prescription coverage for Tier 1 has been updated to reflect $0 copayment in the member cost column on the *Commercial Benefits Chart*. Please refer to **Attachment 7**--*Commercial Benefits Chart*.

There is no change to the Fertility Drug coverage from 2020 to 2021. No documents have been updated for this benefit.

12. Page 1307, Summary of Benefits and Coverage (SBC): The SBC indicates a $0 copay for Tier 1 generic drugs for all three categories (e.g. retail, mail order, and specialty), but the Tier 1 copay is listed as $10 in MVP's Benefit Chart on page 1285. Please clarify the correct copay.

The *Commercial Benefits Chart* has been updated to reflect a $0 co-payment for tier 1 Rx. Please refer to **Attachment 7** reflecting the change.

13. Page 1309, Summary of Benefits and Coverage: Per the SBC, the Inpatient Rehabilitation benefit is 30 days per calendar year, but the coverage is 60 days per calendar year for combined therapies. Please submit corrected copy.

The Inpatient Rehabilitation benefit is 60 days, combined therapies. The following documents have been updated to reflect this benefit: **Attachment 8**--Certificate of Coverage (Commercial) with [and without] Rx, **Attachment 9**--Draft NYSHIP Summary of Benefits and Coverage without Rx, **Attachment 10**--Draft NYSHIP Summary of Benefits and Coverage with Rx, **Attachment 11**--Schedule of Benefits without Rx, **Attachment 12**--Schedule of Benefits with Rx, and **Attachment 4**--Choices page – Commercial Plan.

The *Certificate of Coverage[Commercial] with [and without] Rx*, the *Draft NYSHIP Summary of Benefits and Coverage without Rx*, the *Draft NYSHIP Summary of Benefits and Coverage with Rx*, the *Schedule of Benefits without Rx*, and the *Schedule of Benefits with Rx* have also been updated to reflect the correct Rehabilitation Services benefit (PCP, Specialist, and Outpatient Facility) which is 30 visits per Calendar Year, combined therapies. This was previously misstated as 30 visits per condition, per Plan year, combined therapies. The *Choices page – Commercial Plan* correctly stated this benefit and was not updated for the Outpatient setting. Please note that the *Certificate of Coverage[Commercial] with [and without] Rx*, the *Draft NYSHIP Summary of Benefits and Coverage without Rx*, the *Draft NYSHIP Summary of Benefits and Coverage with Rx*, the *Schedule of Benefits without RX*, and the *Schedule of Benefits with Rx*, are still pending approval. Once these are approved, we will provide updated versions to the JLMC.

14. **Page 1315, M. Communications Materials: Please describe what criteria is used to establish a Preferred Provider. How will members be made aware of the Preferred Provider Network? Additionally, confirm this network is an HMO product and does not constitute a PPO or EPO with out-of-network coverage.**

    Providers who were selected to be a preferred provider offer services with low member abrasion and competitive rates for the region(s)/county(ies) they serve. For Ambulatory Surgical Centers, a team of Network Managers reviewed the relative cost of each surgery center and manually reviewed the list to ensure that common procedures completed in an Ambulatory Surgical setting had an option for a preferred provider (i.e. Ortho, GI, etc.). A team from the Network Department selected several ambulatory surgical locations to ensure network adequacy in all regions and these centers also have a competitive rate for the region/county.

    MVP's laboratory network is a semi-closed panel. MVP has identified labs who offer high quality and low member abrasion. MVP has also created a network of labs in the Capital region (ULN) that offer high quality services to members. A team of Network Managers reviewed the relative cost of each lab with consideration of draw stations, inclusion in ULN, and common specialty lab tests that are billed. Labs outside of ULN were required to have a rate that is better than regional average for lab services and fewer than 3 member complaints over the past 3 years for the relevant population. A review of the draw stations by county was completed to ensure adequate coverage.

    For Radiology services, the provider needed to offer a full suite of radiology services, the facility cost was required to be better than the regional average, and the facility was required to have fewer than 3 member complaints for the past 3 years for the relevant population. Specialists with radiology in their office were *not* considered. MVP ensured there was coverage across rate regions by considering counties and some providers have multiple sites across counties. Additionally, the current contract language required us to include two hospitals as well.

    MVP intends to let members know about the Preferred Provider Facility benefit by providing a copy of the *Preferred Provider Facilities Directory* and the *Preferred Provider Facilities Flyer* to members upon request, in an electronic packet, and/or as a part of the required October mailing submission as well.

    The *2021 NYSHIP Custom Packets* has been updated to include the *Preferred Provider Facilities Flyer*. Please refer to **Attachment 13**—*Preferred Provider Facilities Flyer and* **Attachment 14**—*Updated NYSHIP* Custom Packets.

    We are also confirming that this listing adheres to the HMO network and does not constitute a PPO or EPO plan with out-of-network coverage.

15. **Page 1332, Schedule of Benefits: This document indicates a $0 copay for Tier 1 drugs, but the Tier 1 copay is listed as $10 in MVP's Benefit Chart on page 1285. Please identify the correct copay and submit updated copies of the corrected documents.**

    The *Commercial Benefits Chart* has been updated to reflect a $0 co-payment for Tier 1 Rx while the *Schedule of Benefits with Rx* remains unchanged. Pleaser refer to **Attachment 7** which has been updated.

16. **Page 1335, Letter of Notice: This document indicates that MVP is still in the process of completing the 2021 MAP bid to CMS and benefits could be subject to change. Please submit documentation when approved.**

    MVP is still awaiting approval from CMS on our 2021 MAP bid. We will submit documentation as soon as approval is received.

17. **Page 1336, M. Side-by-Side Comparison of Benefits Changes 2020 to 2021 - Commercial: MVP indicates that Diagnostic Laboratory services are "Covered in Full", but also states there's a $0 co-payment per visit at a preferred provider facility. Is there a difference in cost sharing for Diagnostic Laboratory services between preferred providers and non-preferred providers?**

    There is no difference in member responsibility for diagnostic laboratory services between a preferred provider facility or a non-preferred provider facility since the benefit is covered in full regardless.

18. **Page 1338, M. Side-by-Side Comparison of Benefits Changes 2020 to 2021 - Commercial: MVP appears to have included commercial services that did not change from 2020 to 2021. In the future, please include only the benefits that have changed.**

    In future RFPs we will not include benefits that have not changed in the Side-by-Side Comparison of Benefit Changes - Commercial.

19. **Page 1338, M. Communication Materials - Side-by-Side Comparison of Benefits Changes 2020 to 2021 - Commercial: The Side-by-Side Comparisons should include a $0 copay for dependents to age 26 for office visits. Please correct and resubmit this document.**

    The *Side by Side Comparison of Benefit Changes 2020-2021 – Commercial* Plan has been updated to reflect the $0 co-payment for dependents to age 26 for Primary Care visits. Please refer to **Attachment 15** for updated document.

20. **Page 1338, M. Communication Materials - Side-by-Side Comparison of Benefits Changes 2020 to 2021 - Commercial: The change in copay for Telemedicine should be added to the Side-by-Side Comparison. Where in the certificate is this copay indicated?**

    The telemedicine benefit change has been added to **Attachments 15--***Side by Side Comparison of Benefit Changes 2020-2021 – Commercial Plan* at the bottom of page 1339. The telemedicine benefit is not reflected on the certificate but can be found on both Schedule of Benefits, *without and with Rx,* respectively. Please refer to **Attachments 11 & 12** reflecting changes made.

21. **Page 1339, M. Side-by-Side Comparison of Benefits Changes 2020 to 2021 - Commercial: The header for the 2020 plan on this page is labeled "MVP HMO 25/40", while the commercial plan is labeled "MVP HMO 25/25" everywhere else. Please confirm if this is a typo. If it is not a typo, please provide the correct Side• by-Side Comparison for the appropriate plan comparison.**

This is indeed a typo at the header of page 1339 and has been updated on the *Side by Side Comparison of Benefit Changes 2020-2021 – Commercial Plan*. Please refer to **Attachment 15** for a copy of updated document.

22. Page 1340, M. Side-by-Side Comparison of Benefits Changes 2020 to 2021 - MAP: MVP appears to have included MAP services that did not change from 2020 to 2021. In the future, please include only the benefits that have changed.

In future RFPs we will not include benefits that have not changed in the Side-by-Side Comparison of Benefit Changes - MAP.

23. Page 1348, P. NYSHIP Communications: This document appears to be directed to all state employees, and not just to existing MVP enrollees. Please confirm this communication will only be distributed to existing MVP NYSHIP enrollees.

The *NYSHIP 2021 Cover Letter* and *2021 NYSHIP Custom Packets* have been updated to address MVP enrollees and we confirm that they are only sent to existing MVP NYSHIP enrollees.

Additionally, it is MVP's intention to update the NYSHIP Communications with NYSHIP-specific information that is current for 2021. These documents are not yet ready for review. Once they are ready, MVP will send a copy of the revised custom packet to the JLMC.

Refer to **Attachment 16—*Revised NYSHIP 2021 Cover Letter***.

24. Page 1361, P. NYSHIP Communications: Please confirm the Preferred Provider Network of $0 copay applies to office visits and specialty providers.

MVP's preferred provider facilities (PPF) benefit helps members save money on laboratory, radiology, and ambulatory/outpatient services. Medically necessary and covered services are covered in full ($0) when performed at a designated MVP preferred provider facility. The PPF benefit is not applicable to these services for PCP or Specialist office visits and would be subject to the plan's $25 co-payment.

No document updates have been made.

25. Page 1361, P. NYSHIP Communications: The SBC indicates a $25 copay for the 1st diagnostic visit for a maternity visit. This is not indicated in other documents. Please confirm this is correct information and if it is new information, add it to the Side-by-Side Comparison.

This is not a new benefit and has appeared on previous years' *Summary of Benefits* documents. The diagnostic visit is not a true 'Maternity' visit. It is the visit to determine if the individual is pregnant and therefore does not fall under the Pre-Natal Care preventive benefit and would incur a primary care co-payment. No documents have been updated.

26. Page 1364, Q. Choices - Commercial: Please confirm the Preferred Provider Network $0 copay benefit applies to office visits and specialty providers.

MVP's preferred provider facilities (PPF) benefit helps members save money on laboratory, radiology, and ambulatory/outpatient services. Medically necessary and covered services are covered in full ($0) when performed at a designated MVP preferred provider facility. The PPF benefit is not applicable to these services for PCP or Specialist office visits and would be subject to the plan's $25 co-payment.

No document updates have been made.

27. Page 1364, Q. Choices - Commercial: Choices indicates weight loss/bariatric surgery covered in full, with approval, at a Centers of Excellence. Is this a new benefit? If so, please add it to the Side-by-Side Comparison and submit.

The weight loss/bariatric surgery coverage is not a new benefit. This was not listed as category for input on the *Choices* page for 2020 and was not called out previously. This procedure does require prior authorization but would follow the outpatient or inpatient benefits if approved and it would be considered in-network. The *Choices Page – Commercial* Plan has thereby not been updated.

28. Page 1372, Q. Choices - MAP: Regarding Inpatient Mental Health for MAP, there is a 190-day lifetime limit in a psychiatric facility. Please explain how this is consistent with the Mental Health Parity Addiction and Equity Act (MHPAEA). Are lifetime limits for this benefit allowed under the Patient Protection and Affordable Care Act (PPACA)?

There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a *psychiatric unit* of a general hospital. We can confirm that this is the exact language provided from CMS in their model notices and is therefore compliant with Federal regulations, including ACA regulations.

29. Certificate of Coverage, Schedule of Benefits, NYSHIP Eligibility Rider and other documents marked as "Draft": Please confirm that finalized versions of all documents submitted as "Draft" and "Pending" will be distributed to the JLMC as soon as they are available.

As soon as the documents are approved, we will remove the "draft" and "pending" from them and distribute the updated documents to the JLMC.

30. There are co-insurances listed in the Evidence of Coverage for the MAP that appear to be new but are not listed on the Side-by-Side Comparison for MAP and are not reflected on the Choices- MAP page. They include Medicare Part B drugs and some other Medicare covered items. Please explain and correct the Side-by-Side and other benefit charts as appropriate.

As a clarification please note that the coinsurances are the same as last year. There are no new coinsurances or amounts for 2021. Part B drugs remain a 20% co-insurance.

Attachments

MVP HEALTH CARE
625 State Street, PO Box 2207
Schenectady, NY 12301-2207
mvphealthcare.com

Management's Report of Internal Control over Financial Reporting

Management of MVP Health Plan, Inc. (the Company) is responsible for establishing and maintaining adequate internal control over statutory financial reporting. The Company has established an internal control system designed to provide reasonable assurance regarding the fair presentation of statutory financial reporting. The Company developed its own internal framework for evaluating the effectiveness of internal control over statutory financial reporting. The Company's framework includes the identification and evaluation of the Company's internal control environment and areas of potential material internal control risk, documentation of existing internal controls, monitoring and testing of those key controls, documentation of remedial actions planned or taken, if any, and communication of the findings of the evaluation by the Company's senior management to the Audit Committee of the Board of Directors.

Management conducted an assessment of the effectiveness, as of December 31, 2019, of the Company's internal control over statutory financial reporting, which included identifying, reviewing, monitoring and testing significant internal controls over statutory financial reporting. Based on our assessment under the above described approach and through diligent inquiry, management has concluded that the Company's internal control over statutory financial reporting is effective to provide reasonable assurance regarding the reliability of financial reporting and the preparation of statutory financial statements as of December 31, 2019.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Projections of any evaluation of effectiveness to future periods are also subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Based on management review of internal controls, there were no unremediated material weaknesses as of December 31, 2019 identified as part of the Company's internal control structure over the statutory financial statements for the year ended December 31, 2019.

[redacted]

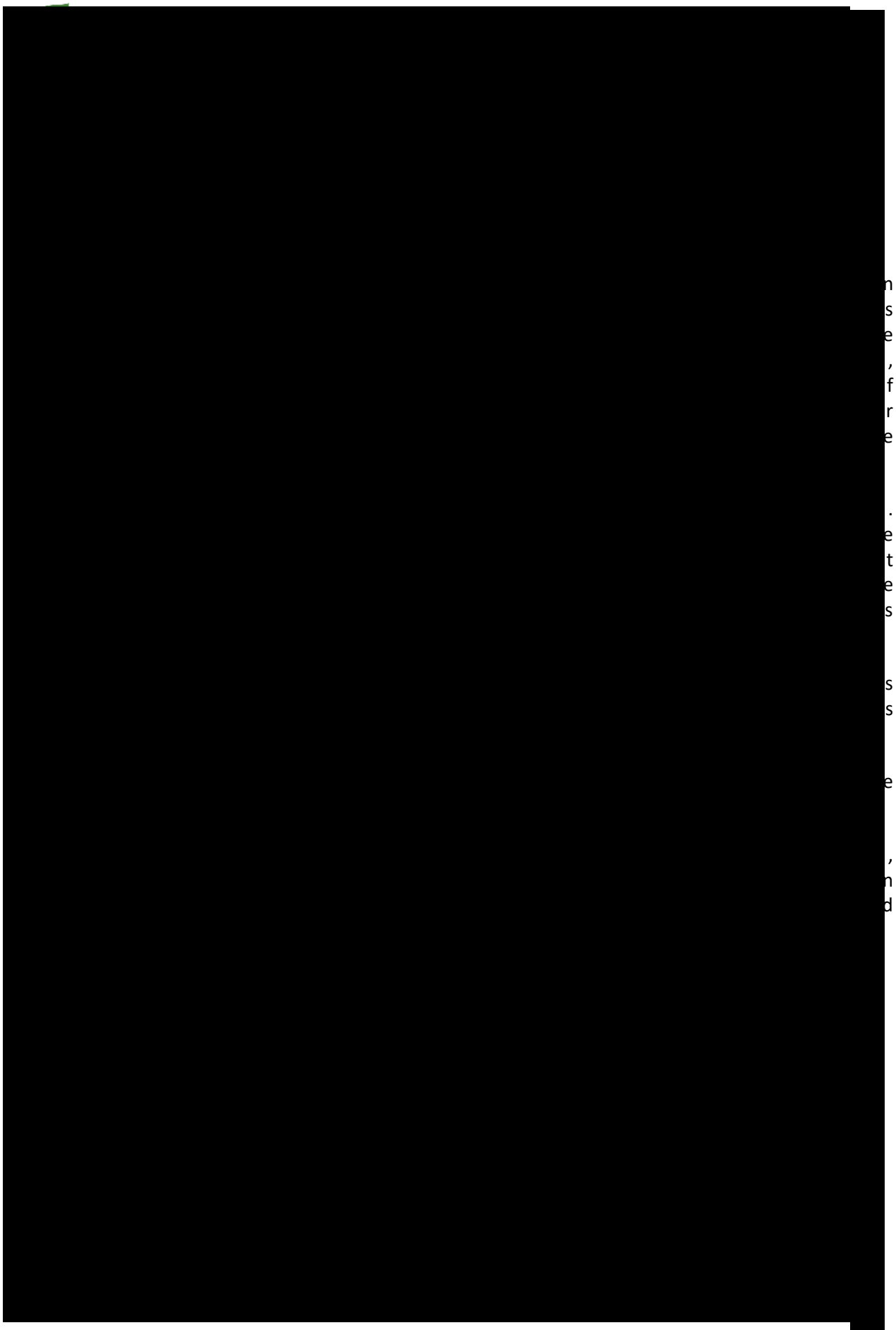
Christopher Del Vecchio
Chief Executive Officer

Date 4/1/2020

[redacted]

Karla Austen
Chief Financial Officer

3/31/2020
Date



Printed By: Lindsey Streefland
Date Printed: Aug 24, 2020

Vendor Responsibility For-Profit v2 Form

Status: Certified
Note: The content of any attached documents will not print with this page. To view or print an attached document, you must open it separately by clicking the corresponding hyperlink in the 'Uploaded Files' section of a question.

Basic Vendor Data

Entity Information

Legal Business Entity Name:	OPTUMHEALTH CARE SOLUTIONS INC
TIN (EIN or SSN):	411591944
Vendor ID:	1100167597
Principal Place of Business:	11000 OPTUM CIRCLE Eden Prairie, MN 55344 USA
Telephone:	1-800-888-2998

Business Entity Information

Business Type:	For-Profit
Business Activity:	Non-Construction

Authorized Contacts

Name:	Sarey Phang	**Address:**	11000 Optum Circle Eden Prairie, MN 55344 United States
Title:	Compliance Director, Optum Legal, Compliance, & Re		
Telephone:	(952)205-6253		
Email:	sarey_j_phang@optum.com		

I. Legal Business Entity Information

1.0 Legal Business Entity type - Check appropriate box and provide additional information:

- ○ Corporation (including PC)
- ◉ Limited Liability Company (LLC or PLLC)
- ○ Limited Liability Partnership
- ○ Limited Partnership
- ○ General Partnership
- ○ Sole Proprietor
- ○ Other

Date of Organization

12/14/2017

1.1 Was the Legal Business Entity formed or incorporated in New York State?

- ○ Yes
- ◉ No

Indicate jurisdiction where the Legal Business Entity was formed or incorporated:

- ◉ USA
- ○ Other

State

Delaware

Attach a Certificate of Good Standing from the applicable jurisdiction or provide an explanation if a Certificate of Good Standing is not available:

Select method for providing this information:

- ○ Enter Below
- ◉ Attach Document(s)
- ○ Attach Document(s) with Explanation

Uploaded Files

OptumHealth Care Solutions LLC-NY-Certificate of Standing-Foreig.pdf 113K

1.2 Is the Legal Business Entity publicly traded?

- ○ Yes
- ◉ No

1.3 Does the Legal Business Entity have a DUNS Number?

- ○ Yes
- ◉ No

1.4 If the Legal Business Entity's Principal Place of Business is *not* in New York State, does the Legal Business Entity maintain an office in New York State?

Note: Select "N/A" if Principal Place of Business is in New York State.

- (●) Yes
- ( ) No
- ( ) N/A

Provide the address and telephone number for one office loacted in New York State:

Address Line

505 Boices Lane

City

Kingston

State

NY

Zip Code

12401

Telephone

845-382-7500

1.5 Is the Legal Business Entity a New York State certified Minority-Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), New York State Small Business (SB), or federally certified Disadvantaged Business Enterprise (DBE)?

- ( ) Yes
- (●) No

1.6 Identify Officials and Principal Owners, if applicable.

Note: If more than four (4) Officials or Principal Owners need to be listed, select "Attach Document" as the response.

If applicable, reference to relevant SEC filing(s) containing the required information is optional.

Select method for providing this information:

- (●) Enter Below
- ( ) Attach Document(s)

Name

UnitedHealth Group

Title

UnitedHealth Group

% of Ownership (Enter 0%, if not applicable)

100

Add another?

- ( ) Yes
- (●) No

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

II. Reporting Entity Information

2.0 The Reporting Entity for this questionnaire is:

(Note: Select only one)

- (●) Legal Business Entity
- ( ) Organizational Unit within and operating under the authority of the Legal Business Entity

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

III. Leadership Integrity

Within the past five (5) years, has any current or former Reporting Entity Official or any individual currently or formerly having the authority to sign, execute or approve bids, proposals, contracts or supporting documentation on behalf of the Reporting entity with any government entity been:

3.0 Sanctioned relative to any business or professional permit and/or license?

- ○ Yes
- ◉ No
- ○ Other

3.1 Suspended, debarred or disqualified from any government contracting process?

- ○ Yes
- ◉ No
- ○ Other

3.2 The subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation for any business-related conduct?

- ○ Yes
- ◉ No
- ○ Other

3.3 Charged with a misdemeanor or felony, indicted, granted immunity, convicted of a crime or subject to a judgment for:

a. Any business-related activity; or
b. Any crime, whether or not business-related, the underlying conduct of which is related to truthfulness?

- ○ Yes
- ◉ No
- ○ Other

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

IV. Integrity - Contract Bidding

Within the past five (5) years, has the Reporting Entity:

4.0 Been suspended or debarred from any government contracting process or been disqualified on any government procurement, permit, license, concession, franchise or lease, including, but not limited to, debarment for a violation of New York State Workers' Compensation or Prevailing Wage laws or New York State Procurement Lobbying Law?

- ○ Yes
- ◉ No

4.1 Been subject to a denial or revocation of a government prequalification?

- ○ Yes
- ◉ No

4.2 Been denied a contract award or had a bid rejected based on a non-responsibility finding by a government entity?

- ○ Yes
- ◉ No

4.3 Had a low bid rejected on a government contract for failure to make good faith efforts on any Minority-Owned Business Enterprise, Women-Owned Business Enterprise or Disadvantaged Business Enterprise goal or statutory affirmative action requirements on a previously held contract?

- ○ Yes
- ◉ No

4.4 Agreed to a voluntary exclusion from bidding/contracting with a government entity?

- ○ Yes
- ◉ No

4.5 Initiated a request to withdraw a bid submitted to a government entity in lieu of responding to an information request or subsequent to a formal request to appear before the government entity?

- ○ Yes
- ◉ No

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

V. Integrity - Contract Award

Within the past five (5) years, has the Reporting Entity:

5.0 Been suspended, cancelled or terminated for cause on any government contract including, but not limited to, a non-responsibility finding?

- ○ Yes
- ◉ No

5.1 Been subject to an administrative proceeding or civil action seeking specific performance or restitution in connection with any government contract?

- ○ Yes
- ◉ No

5.2 Entered into a formal monitoring agreement as a condition of a contract award from a government entity?

- ○ Yes
- ◉ No

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

VI. Certification/Licenses

Within the past five (5) years, has the Reporting Entity:

6.0 Had a revocation, suspension or disbarment of any business or professional permit and/or license?

- ○ Yes
- ◉ No

6.1 Had a denial, decertification, revocation or forfeiture of New York State certification of Minority-Owned Business Enterprise, Women-Owned Business Enterprise or federal certification of Disadvantaged Business Enterprise status for other than a change ownership?

- ○ Yes
- ◉ No

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

VII. Legal Proceedings

Within the past five (5) years, has the Reporting Entity:

7.0 Been the subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation?

- ○ Yes
- ◉ No

7.1 Been the subject of an indictment, grant of immunity, judgment or conviction (including entering into a plea bargain) for conduct constituting a crime?

- ○ Yes
- ◉ No

7.2 Received any OSHA citation and Notification of Penalty containing a violation classified as serious or willful?

- ○ Yes
- ◉ No

7.3 Had a government entity find a willful prevailing wage or supplemental payment violation or any other willful violation of New York State Labor Law?

- ○ Yes
- ◉ No

7.4 Entered into a consent order with the New York State Department of Environmental Conservation, or received an enforcement determination by any government entity involving a violation of federal, state or local environmental laws?

- ○ Yes
- ◉ No

7.5 Other than the previously disclosed:

a. Been subject to fines or penalties imposed by government entities which in the aggregate total $25,000 or more; or
b. Been convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any government entity?

- ○ Yes
- ◉ No

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

VIII. Financial and Organizational Capacity

8.0 Within the past five (5) years, has the Reporting Entity received any formal unsatisfactory performance assessment(s) from any government entity on any contract?

- ○ Yes
- ◉ No

8.1 Within the past five (5) years, has the Reporting Entity had any liquidated damages assessed over $25,000?

- ○ Yes
- ◉ No

8.2 Within the past five (5) years, have any liens or judgments (not including UCC filings) over $25,000 been filed against the Reporting Entity which remain undischarged?

- ○ Yes
- ◉ No

8.3 In the last seven (7) years, has the Reporting Entity initiated or been the subject of any bankruptcy proceedings, whether or not closed, or is any bankruptcy proceeding pending?

- ○ Yes
- ◉ No

8.4 During the past three (3) years, has the Reporting Entity failed to file or pay any tax returns required by federal, state or local tax laws?

- ○ Yes
- ◉ No

8.5 During the past three (3) years, has the Reporting Entity failed to file or pay any New York State unemployment insurance returns?

- ○ Yes
- ◉ No

8.6 During the past three (3) years, has the Reporting Entity had any government audit(s) completed?

- ○ Yes
- ◉ No

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

IX. Associated Entities

This section pertains to any entity(ies) that either controls or is controlled by the Reporting Entity.

(See definition of "Associated Entity" for additional information to complete this section.)

9.0 Does the Reporting Entity have any Associated Entities?

Note: The response must be "Yes," if the Reporting Entity is either:

- An Organizational Unit; or
- The entire Legal Business Entity which controls, or is controlled by, any other entity(ies).

○ Yes
◉ No

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

X. Freedom of Information Law (FOIL)

10.0 Indicate whether any information supplied herein is believed to be exempt from disclosure under the Freedom of Information Law (FOIL).

Note: A determination of whether such information is exempt from FOIL will be made at the time of any request for disclosure under FOIL.

- ○ Yes
- ◉ No

Last Modified: Aug 24, 2020
Modified By: Lindsey Streefland

Certification

The undersigned: (1) recognizes that this questionnaire is submitted for the express purpose of assisting New York State government entities (including the Office of the State Comptroller (OSC)) in making responsibility determinations regarding award or approval of a contract or subcontract and that such government entities will rely on information disclosed in the questionnaire in making responsibility determinations; (2) acknowledges that the New York State government entities and OSC may, in their discretion, by means which they may choose, verify the truth and accuracy of all statements made herein; and (3) acknowledges that intentional submission of false or misleading information may result in criminal penalties under State and/or Federal Law, as well as a finding of non-responsibility, contract suspension or contract termination.

The undersigned certifies that he/she:

- is knowledgeable about the submitting Business Entity's business and operations;
- has read and understands all of the questions contained in the questionnaire;
- has reviewed and/or supplied full and complete responses to each question;
- to the best of his/her knowledge, information and belief, confirms that the Business Entity's responses are true, accurate and complete, including all attachments, if applicable;
- understands that New York State government entities will rely on the information disclosed in the questionnaire when entering into a contract with the Business Entity; and
- is under an obligation to update the information provided herein to include any material changes to the Business Entity's responses at the time of bid/proposal submission through the contract award notification, and may be required to update the information at the request of the New York State government entities or OSC prior to the award and/or approval of a contract, or during the term of the contract.

Legal Business Name:	OPTUMHEALTH CARE SOLUTIONS INC
Certifier's Name:	Sarey Phang
Certifier's Title:	Director, Compliance
Certification Date:	Aug 24, 2020

MVP - Co cial

Character count: 4248 out of 4250

Commercial

Office Visits	$25/$0 children per visit [1]
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$25 per visit
Diagnostic/Therapeutic Services	
Radiology	$0/$25 per visit [2]
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	$25 per visit
Radiation	$25 per visit
Chemotherapy	$25 per visit
Dialysis	$25 per visit
Women's Health Care/Reproductive Health	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Breastfeeding Services and Equipment [3]	No copayment
External Mastectomy Prosthesis [4]	50% coinsurance

Family Planning Services [5]	$25 per visit
Infertility Services [5]	$25 per visit
Contraceptive Drugs [6]	No copayment [7]
Contraceptive Devices [6]	No copayment [7]
Inpatient Hospital Surgery	No copayment
Physician	
Facility	
Outpatient Surgery	
Hospital	$25 per visit
Physician's Office	$25 per visit
Outpatient Surgery Facility	$0/$25 per visit [2]
Emergency Department	$75 per visit (waived if admitted)
Urgent Care Facility	$25 per visit
Ambulance	$50 per trip
Telemedicine	No copayment
Outpatient Mental Health	$25 per visit, unlimited
Individual	
Group	
Inpatient Mental Health	No copayment, unlimited
Outpatient Drug/Alcohol Rehab [8]	$25 per visit, unlimited
Inpatient Drug/Alcohol Rehab [8]	No copayment, unlimited

Durable Medical Equipment	50% coinsurance
Prosthetics	50% coinsurance
Orthotics	50% coinsurance
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient	No copayment, 60 days, combined
Outpatient Physical or Occupational Therapy	$25 per visit, 30 visits max combined
Outpatient Speech Therapy	$25 per visit, 30 visits max combined
Diabetic Supplies [9]	$25 per boxed item, 31-day supply
Retail	
Mail Order	
Insulin and Oral Agents [9]	$25 per boxed item, 31-day supply
Retail	
Mail Order	
Diabetic Shoes	50% coinsurance, unlimited pairs when medically necessary
Weight Loss/Bariatric Surgery	Covered in full at Center of Excellence with approval
Hospice	No copayment, 210 days max
Skilled Nursing Facility	No copayment, 45 days max per calendar year
Prescription Drugs	
Retail	$0 Tier 1/$30 Tier 2/$50 Tier 3, 30-day supply
Mail Order	$0 Tier 1/$75 Tier 2/$125 Tier 3, up to 90-day supply

Additional Prescription Drug Related Information	If a brand-name drug is requested over the prescribed generic, you pay the difference between the cost of the two drugs plus the Tier 1 copayment. This includes fertility, injectable, self-injectable meds and enteral formulas. Approved generic contraceptive drugs, devices and those without a generic equivalent are covered at 100% under retail and mail order.
Specialty Drugs	Retail covered as noted. 30-day supply limit. Prior auth may be required. 30-day supply through Specialty Pharmacy. Members are required to use Caremark Specialty.
Additional Benefits	
Annual Out-of-Pocket Maximum (In-Network Benefits)	$6,350 Individual/$12,700 Family per year
Dental	$25 preventive visit (to age 19)
Vision	$25 per exam every 24 months (routine only)
Hearing Aids	Not covered
Out of Area	Emergencies only
Additional Benefits HMOs (as applicable)	
Plan Highlights for 2021	$0 PCP visits to age 26, $0 Telemedicine, $0 Tier 1 generic drugs (retail & mail order). $0 copayment Preferred Provider Facility: laboratory, radiology, & ambulatory/outpatient surgery services. $600 in Wellness Rewards.
Participating Physicians	MVP provides services through 44,400+ physicians and practitioners throughout its service area.
Affiliated Hospitals	MVP members are covered at participating hospitals where their MVP physician has admitting privileges. Members may be directed to other hospitals to meet special needs when medically necessary upon prior approval from MVP.

Pharmacies and Prescriptions	Virtually all pharmacy chain stores and many independent pharmacies within the MVP service area participate. MVP also offers mail-order service for select maintenance drugs. We offer a closed formulary.
Medicare Coverage	Medicare-primary NYSHIP enrollees must enroll in MVP Preferred Gold, MVP's Medicare Advantage Plan. Some copayments may vary from the MVP HMO plan's copayments.

Plan Mailing Ad res

Name: MVP Health Care

Address: P.O. Box 2207
625 State Street

City: Schenectady

State: NY

Zip: 12301-2207

Additional Addresses

Information Numbers

Customer Service: 1-888-MVP-MBRS (687-6277)

TTY: 1-800-662-1220

Website

www.mvphealthcare.com

Important Note: Only participating providers in the c unties listed below are part of this HMO's network within NYSHIP.Please be sure to check before receiving care that your provider participates with this HMO's NYSHIP network.

NYSHIP Code number 058

A IPA HMO serving individuals living or working in the following select counties:

Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming and Yates

NYSHIP Code number 060

A IPA HMO serving individuals living or working in the following select counties:

Albany, Columbia, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington

NYSHIP Code number 330

A IPA HMO serving individuals living or working in the following select counties:

Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga and Tompkins

NYSHIP Code number 340

A IPA HMO serving individuals living or working in the following select counties:

Dutchess, Orange, Putnam, Rockland, Sulliv Ulster d Westchester

NYSHIP Code number 360

A IPA HMO serving individuals living or working in the following select counties:

Clinton, Essex, Franklin and St. Lawrence

Comments for DCS

Footnotes:

1. children (newborn up to age 26)
2. $0 copayment at Preferred Provider Facilities which can be located at https://www.mvphealthcare.com/members/find-a-doctor or call 888.687.6277.
3. Refer to the Certificate of Coverage for requirements/provider specs regarding Breastfeeding Services & Equipment.
4. Contact MVP for additional information regarding prior auths, quantity limits, participating providers, etc.
5. Refer to Certificate Of Coverage for requirements regarding Infertility Services.
6. Over-the-counter contraceptives are not covered.
7. Brand-name contraceptives with generic equivalents require member payment of the difference in cost between the generic and brand-name drugs, plus the Tier 1 copayment.
8. Refer to Certificate of Coverage for requirements regarding Substance Use Disorder.
9. Refer to Certificate of Coverage for requirements regarding Diabetic Supplies.
10. Refer to Certificate of Coverage for requirements regarding Wellbeing Rewards.
11. Prior authorization may be required.

MVP HEALTH PLAN, INC.

N.Y. SCHEDULE M

Section 4408-a of the Public Health Law requires all health maintenance organizations to establish and maintain a grievance procedure. Article 49 of the Public Health Law requires HMOs to establish a utilization review procedure to evaluate whether a health care treatment is medically necessary. Article 49 also allows for enrollees to have EXTERNAL appeals under certain circumstances.

Tables 1, 2 and 3 should not include grievances under Medicare Cost Contracts, Medicare Risk Contracts, Medicare Plus Choice Contracts or Medicaid Contracts.

Table 1: Section 4408-a Grievances

	1 Pending as of 12/31/18	2 Filed in 2019	3 Closed in 2019 (Whether Filed in 2018 or Earlier) Col. 4 + Col. 5	4 Closed in 2019 Resulting in a Reversal (in Whole or in Part) of HMO's Original Determination	5 Closed in 2019 in Which the HMO's Original Determination Was Upheld	6 Pending on 12/31/19 Col. 1 + Col. 2 - Col. 3
1. Actual number	2	125	120	32	88	7
2. Number per 1,000 members (a)	0.0	1.4	1.3	0.4	1.0	0.1

(a) For all tables the number per 1,000 members, excluding Medicare and Medicaid members, should be based on the number of members as of June 30, 2019. The number per 1,000 members should be carried to one decimal point, e.g. "3.6".

(1) State the number of members at June 30, 2019, as shown in the June 2019 Data Requirements, excluding Medicare and Medicaid members 90,218

MVP HEALTH PLAN, INC.

N.Y. SCHEDULE M (continued)
Table 2: Utilization Review Appeals

	1 Pending as of 12/31/18	2 Filed in 2019	3 Closed in 2019 (Whether Filed in 2019 or Earlier) Col. 4 + Col. 5	4 Closed in 2019 Resulting in a Reversal (in Whole or in Part) of HMO's Original Determination	5 Closed in 2019 in Which the HMO's Original Determination Was Upheld	6 Pending on 12/31/19 Col. 1 + Col. 2 - Col. 3
1. Actual number	2	342	339	159	180	5
2. Number per 1,000 members (a)	0.02	3.79	3.76	1.76	2.00	0.06

Table 2a. Appeals of expedited utilization review appeals closed in 2018 (These should NOT be reported in Table 2 above).

1. Please state the number of expediated utilization review appeals reported as closed in the 2018 Schedule M which were appealed in a timely manner in 2019		1
Of the above, please state:	(2) the number reversed in 2019	0
	(3) the number upheld in 2019	1
	(4) the number stilling pending at 12/31/2019	0

Table 3: External Appeals

	1 Pending as of 12/31/18	2 Filed in 2019	3 Closed in 2019 (Whether Filed in 2019 or Earlier) Col. 4 + Col. 5	4 Closed in 2019 Resulting in a Reversal (in Whole or in Part) of HMO's Original Determination	5 Closed in 2019 in Which the HMO's Original Determination Was Upheld	6 Pending on 12/31/19 Col. 1 + Col. 2 - Col. 3
1. Actual number	0	20	19	5	14	1
2. Number per 1,000 members (a)	0.0	0.2	0.2	0.1	0.2	0.0

(a) For all tables the number per 1,000 members, excluding Medicare and Medicaid members, should be based on the number of members as of June 30, 2019, as shown in the June 2019 Data Requirements. The number per 1,000 members should be carried to one decimal point, e.g., "3.6".

Name.....and telephone number.....of HMO contact person regarding this schedule.

Contact Person Last Name	First Name	Middle Name	Phone Number
Stasik	Denise	Michele	518-386-7684

MVP Preferred Provider Facilities

For NY Individual Non-Standard plans, NY Small Group plans, and most NY Large Group plans.

MVP's preferred provider facilities can help you save money on ambulatory/outpatient surgery, laboratory, and radiology services. If you have a deductible, medically necessary and covered services at one of these facilities are covered in full once your deductible is met. If your plan is not subject to a deductible, medically necessary and covered services at MVP preferred provider facilities are covered in full from day one!

Table of Contents

Updates to the preferred provider facilities listing are made on an ongoing basis. Call the MVP Customer Care Center at the phone number listed on the back of your MVP Member ID card for more information. Available with all NY Individual Non-Standard plans, NY Small Group plans, and most NY Large Group plans.

MVP Preferred Provider Ambulatory Surgery Facilities

Visit one of these ambulatory surgery facilities to help reduce your out-of-pocket costs.

Albany County

Albany Regional Eye Surgery Center
5 Johnson Road, Latham, NY 12110

Capital Region Ambulatory Surgery Center
1367 Washington Avenue, Suite 401, Albany, NY 12206

Colonie ASC
207 Troy-Schenectady Road, Colonie, NY 12110

New England Laser and Cosmetic Surgery Center
1072 Troy-Schenectady Road, Latham, NY 12110

OrthoNY Ambulatory Surgery Center
3 Atrium Drive, Suite 150, Albany, NY 12205

Chemung County

Elmira ASC
210 William Street, Elmira, NY 14901

Clinton County

Eye Care for the Adirondacks
450 Margaret Street, Plattsburgh, NY 12901

Cortland County

Cortland ASC
64 Pomeroy Street, Suite B, Cortland, NY 13045

Dutchess County

Central New York Eye Center
22 Green Street, Poughkeepsie, NY 12601

Dutchess Ambulatory Surgical Center
23 Davis Avenue, Poughkeepsie, NY 12603

Surgery Center at Orthopedic Associates
1910 South Road, Suite C, Poughkeepsie, NY 12601

Erie County

Ambulatory Surgery Center of Western New York
3112 Sheridan Drive, Buffalo, NY 14226

Buffalo Ambulatory Services
3095 Harlem Road, Cheektowaga, NY 14225

Buffalo Surgery Center
3925 Sheridan Drive, Buffalo, NY 14226

Center for Ambulatory Surgery
550 Orchard Park Road, Suite B101, W. Seneca, NY 14224

Endoscopy Center of Western NY
60 Maple Road, Suite 2, Buffalo, NY 14221

Eye Health Associates
170 Maple Road, Buffalo, NY 14221

Millard Fillmore Surgery Center
215 Klein Road, Buffalo, NY 14221

Franklin County

Adirondack Medical
2233 State Route 86, Saranac Lake, NY 12983

Jefferson County

North Country Orthopaedic Group Ambulatory Surgery Center
1571 Washington Street, Suite 202, Watertown, NY 13601

Livingston County

Noyes Health
111 Clara Barton Street, Dansville, NY 14437

Madison County

Community Memorial Hospital
150 Broad Street, Hamilton, NY 13346

Monroe County

Brighton Surgery Center
980 Westfall Road, Suite 300, Rochester, NY 14618

Linden Oaks Surgery Center
10 Hagen Drive, Suite 110, Rochester, NY 14625

Lindsay House Surgery Center
973 E. Avenue, Suite 101, Rochester, NY 14607

Rochester Ambulatory Surgery Center
360 Linden Oaks, Rochester, NY 14625

Westfall Surgery Center
1065 Senator Keating Boulevard, Rochester, NY 14618

Montgomery County

Mohawk Valley Eye Surgery
108 Holland Circle Drive, Amsterdam, NY 12010

Niagara County

Endo Center of Niagara
6930 Williams Road, Suite 301, Niagara Falls, NY 14304

Oneida County

Apex Surgical Center
5325 State Route 233, Westmoreland, NY 13490

Griffiss Eye Surgery Center
105 Dart Circle, Rome, NY 13441

Mohawk Valley Endoscopy Center
116 Business Park Drive, Utica, NY 13502

OMNI Surgery Center
498 French Road, Utica, NY 13502

Onondaga County

Camillus Surgery Center
5700 W. Genesee Street, Suite 11, Camillus, NY 13031

Digestive Disease Center
5112 W. Taft Road, Suite E, Liverpool, NY 13088

(Ambulatory Surgery Facilities continued)

Endoscopy Center of Central New York
4308 Medical Center Drive, Fayetteville, NY 13066

Endoscopic Procedure Center
260 Township Boulevard, Suite 10, Camillus, NY 13031

Heritage One Day Surgery
5496 E. Taft Road, North Syracuse, NY 13212

Syracuse Endoscopy Associates
739 Irving Avenue, Suite 420, Syracuse, NY 13210

Specialists One Day Surgery
5801 E. Taft Road, North Syracuse, NY 13212

Syracuse Surgery Center
3440 Vickery Road, North Syracuse, NY 13212

Specialty Surgery Center of Central New York
225 Greenfield Parkway, Suite 105, Liverpool, NY 13088

Upstate Gastroenterology
100 E. Genessee Street, Suite 206, Syracuse, NY 13210

Upstate Orthopedics Ambulatory Surgery Center
6620 Fly Road, Suite 300, E. Syracuse, NY 13057

Orange County

Crystal Run Ambulatory Surgery Center of Middletown
95 Crystal Run Road, Middletown, NY 10941

Crystal Run Healthcare
155 Crystal Run Road, Middletown, NY 10941

Eastern Orange Ambulatory Surgery Center
21 Laurel Avenue, Suite 120, Cornwall, NY 12518

Hudson Valley Ambulatory Surgery
75 Crystal Run Road, Suite 225, Middletown, NY 10941

Saratoga County

New York Eye Surgical Center
135 North Road, Suite 2, Wilton, NY 12831

Northway Surgery and Pain Center
1596 Route 9, Clifton Park, NY 12065

Saratoga-Schenectady Endoscopy Center
848 State Route 50, Burnt Hills, NY 12027

Schenectady County

Ellis Hospital
1101 Nott Street, Schenectady, NY 12308

Ulster County

Ellenville Regional Hospital
10 Healthy Way, Ellenville, NY 12428

Grand Street Gastroenterology
33 Grand Street, Kingston, NY 12401

Kingston Ambulatory Surgical Center
40 Hurley Avenue, Suite 13, Kingston, NY 12401

Warren County

Northern GI Endoscopy Center
5 Irongate Center, Glens Falls, NY 12801

Westchester County

Ambulatory Surgery Center of Westchester
34 S. Bedford Road, Mount Kisco, NY 10549

Hudson Valley Center for Digestive Health
1978 Crompond Road, Suite 105, Cortlandt Manor, NY 10567

White Plains Ambulatory Surgery Center
226 Westchester Avenue, White Plains, NY 10604

MVP Preferred Provider Laboratory Facilities

Choose one of these lab facilities to help reduce your out-of-pocket costs. Visit their website to find a location near you.

ACM Medical Lab
acmlab.com

Adirondack Medical
adirondackhealth.org

Albany Medical Center
amc.edu

Ambry Genetics
ambrygen.com

Bio Reference Laboratories
bioreference.com/thelaboratory

Columbia Memorial Hospital
columbiamemorialhealth.org

Community Memorial Hospital
communitymemorial.org

Ellis Medicine
ellismedicine.org

Ellenville Regional Hospital
ellenvilleregional.org

Frederick Ferris Thompson Hospital
thompsonhealth.com

Geneva General Hospital
flhealth.org/labdrawstations

Glens Falls Hospital
glensfallshospital.org

Highland Hospital
urmc.rochester.edu/highland.aspx

LabCorp
labcorp.com

(Laboratory Facilities continued)

Laboratory Alliance of Central New York
laboratoryalliance.com

MedLab
medlabcorp.com

Noyes Health
noyes-health.org

Oneida Healthcare Center
oneidahealthcare.org/lab

Quest Diagnostics
questdiagnostics.com

Rochester Regional Health
rochesterregional.org/services/laboratory-pathology/patient-service-centers

Samaritan Hospital
sphp.com/sam

St. Elizabeth Medical Center
mvhealthsystem.org/lab

St. Mary's Healthcare
smha.org

St. Peter's Hosptial
sphp.com/sph

Strong Memorial Hospital
urmc.rochester.edu

Sunrise Medical Laboratories
sunriselab.com

United Memorial Medical Center
rochesterregional.org/locations/hospitals/united-memorial-medical-center

MVP Preferred Provider Radiology Facilities

Visit one of these radiology facilities to help reduce your out-of-pocket costs.

Albany County

Albany Advanced Imaging
199 Wolf Road, Albany, NY 12205
3 Atrium Drive, Albany, NY 12205

Capital Imaging Associates
1001 Loudon Road, Latham, NY 12110

Community Care Physicians
711 Troy Schenectady Road, Suite 114, Latham, NY 12110

New York Oncology Hematology
43 New Scotland Avenue, Albany, NY 12208
400 Patroon Creek Boulevard, Suite 1, Albany, NY 12206

Broome County

Radiation Oncology Services
169 Riverside Drive, Binghamton, NY 13905

Cayuga County

Magnetic Diagnostic Resources of Central New York
37 W. Garden Street, Suite 107, Auburn, NY 13021

Clinton County

After Hours Imaging, Inc.
675 State Route 3, Plattsburgh, NY 12901

Columbia County

New York Oncology Hematology
69 Prospect Avenue, Hudson, NY 12534

Dutchess County

Hudson Valley Hematology Oncology Associates
159 Barnegat Road, Suite 101, Poughkeepsie, NY 12601

Hudson Valley Oncology Associates
19 Cooke Street, Poughkeepsie, NY 12601

Medical Diagnostic Imaging
1323 Route 9, Suite 107, Wappingers Falls, NY 12590
14 Raymond Avenue, Poughkeepsie, NY 12603

Medical Imaging Center
37 W. Garden Street, Suite 107, Auburn, NY 13021

Erie County

Buffalo MRI
4925 Maine Street, Amherst, NY 14226

Great Lakes Medical Imaging
199 Park Club Lane, Suite 300, Williamsville, NY 14221
3085 Harlem Road, Suite 150, Cheektowaga, NY 14225
500 Suiterling Park, W. Wing, Orchard Park, NY 14127
5959 Big Tree Road, Suite 105, Orchard Park, NY 14127
3850 Saunders Settlement Road, Suite 150, Cambria, NY 14132

Southtowns Radiology Associates
3040 Amsdell Street, Hamburg, NY 14075
3050 Orchard Park Road, W. Seneca, NY 14224
550 Orchard Park Road, W. Seneca, NY 14224

Franklin County

Adirondack Medical
2233 State Route 86, Saranac Lake, NY 12983

Genesee County

United Memorial Medical Center at Genesee Memorial Hospital
127 North Street, Batavia, NY 14020

(Radiology Facilities continued)

Herkimer County

Slocum Dickson Medical Group
55 Central Plaza, Ilion, NY 13357

Jefferson County

Northern Radiology Imaging
1571 Washington Street, Suite 101, Watertown, NY 13601

Madison County

Community Memorial Hospital
150 Broad Street, Hamilton, NY 13346

Oneida Health Systems
321 Genesse Street, Oneida, NY 13421

Monroe County

After Hours Imaging, Inc.
2081 W. Ridge Road, Suite 101, Rochester, NY 14626

Borg & Ide Imaging
10 Hagen Drive, Rochester, NY 14625
125 Lattimore Road, Rochester, NY 14620
1401 Stone Road, Rochester, NY 14615
1561 Long Pond Road, Suite 113, Rochester, NY 14626
200 White Spruce Boulevard, Rochester, NY 14623
2619 Culver Road, Rochester, NY 14609
2655 Ridgeway Avenue, Suite 110, Rochester, NY 14626
995 Senator Keating Blvd., Bldg E Suite 100, Rochester, NY 14618
6668 Fourth Section Road, Brockport, NY 14420
400 Red Creek Drive, Suite 140, Rochester, NY 14623

Montgomery County

New York Oncology Hematology
1700 Riverfront Center, Amsterdam, NY 12010

Niagara County

Great Lakes Medical Imaging
3850 Saunders Settlement Road, Sanborn, NY 14132

Oneida County

Associated Medical Professionals of New York
2 Ellinwood Drive, New Hartford, NY 13413

CMI Professional Service
107 Business Park Drive, Utica, NY 13502
1656 Champlin Avenue, New Hartford, NY 13413
1729 Burrstone Road, New Hartford, NY 13413
2209 Genesee Street, Utica, NY 13501

Mohawk Glen Radiology Associates of Central, NY
91 Perimeter Road, Suite 110, Rome, NY 13441

Slocum Dickson Medical Group
1729 Burrstone Road, New Hartford, NY 13413

St. Elizabeth Medical Center
4401 Middle Settlement Road, New Hartford, NY 13413
2209 Genesee Street, Utica, NY 13501

Onondaga County

Associated Medical Professionals of New York
1226 E. Water Street, Syracuse, NY 13210

CNY Diagnostic Imaging Associates
1000 E. Genesee Street, Syracuse, NY 13210
4820 W. Taft Road, Liverpool, NY 13088
4939 Brittonfield Parkway, E. Syracuse, NY 13057
8100 Oswego Road, Suite 120, Liverpool, NY 13090

Crouse Medical Imaging Services
5000 Brittonfield Parkway, Suite A112, E. Syracuse, NY 13057

Hematology Oncology Associates
4900 Broad Road, Syracuse, NY 13215
5008 Brittonfield Parkway, Suite 700, E. Syracuse, NY 13057

Magnetic Diagnostic Resources of Central New York
301 Prospect Avenue, Syracuse, NY 13203
4109 Medical Center Drive, Fayetteville, NY 13066
4900 Broad Road, Suite 1C, Syracuse, NY 13215
5008 Brittonfield Parkway, East Syracuse, NY 13057
5100 W. Taft Road, Suite 1A, Liverpool, NY 13088
5700 W. Genesse Street, Suite 7, Camillus, NY 13031
725 Irving Avenue, Suite 209, Syracuse, NY 13210
736 Irving Avenue, Suite 2499, Syracuse, NY 13210
8278 Willett Parkway, Syracuse, NY 13207

Ontario County

Finger Lakes Radiology
196 North Street, Geneva, NY 14456

Orange County

Crystal Run Healthcare
155 Crystal Run Road, Middletown, NY 10940
95 Crystal Run Road, Middletown, NY 10941

Orange Radiology & MRI of Newburgh
320 Robinson Avenue, Newburgh, NY 12550
505 Route 208, Monroe, NY 10950

St. Luke's Cornwall
15 Laurel Avenue, Suite 100, Cornwall, NY 12518

Oswego County

Magnetic Diagnostic Resources of Central New York
810 South 1st Street, Fulton, NY 13069

Putnam County

Northeast Radiology
3839 Danbury Road, Brewster, NY 10509

Rensselaer County

New York Oncology Hematology
258 Hoosick Street, Troy, NY 12180

Rockland County

Advanced Radiation Oncology Service
111 N. Highland Avenue, Nyack, NY 10960

(Radiology Facilities continued)

Hudson Valley Radiology Associates
111 N. Highland Avenue, Nyack, NY 10960
18 Squadron Boulevard, New City, NY 10956

Saratoga County

Adirondack Radiology Associates
3 Care Lane, Suite 100, Saratoga Springs, NY 12866

Albany Advanced Imaging
648 Plank Road, Clifton Park, NY 12065

Community Care Physicians
1 W. Avenue, Suite 140, Saratoga Springs, NY 12866

Glens Falls Hospital
13 Palmer Avenue, Corinth, NY 12822

New York Oncology Hematology
3 Crossings Boulevard, Suite 1, Clifton Park, NY 12065

Northeastern Radiology Oncology
211 Church Street, Saratoga Springs, NY 12866

Schenectady County

Community Care Physicians
2546 Balltown Road, Suite 100, Schenectady, NY 12309
3757 Carmen Road, Suite 103, Schenectady, NY 12303

Ellis Hospital
1101 Nott Street, Schenectady, NY 12308

New York Oncology Hematology
600 McClellan Street, Schenectady, NY 12304

Sullivan County

Crystal Run Healthcare
61 Emerald Place, Rock Hill, NY 12775

Ulster County

Hudson Valley Radiology Associates
3 Cherry Hill Road, Suite 1, New Paltz, NY 12561
279 Main Street, Suite 103, New Paltz, NY 12561

River Radiology
45 Pine Grove Avenue, Kingston, NY 12402

Warren County

Adirondack Radiology Associates
102 Park Street, Suite B03, Glens Falls, NY 12801
11 Murray Street, Glens Falls, NY 12801
22 Willowbrook Road, Queensbury, NY 12804

Glens Falls Hospital
100 Park Street, Glens Falls, NY 12801
22 Willowbrook Road, Queensbury, NY 12804

Northeastern Radiology Oncology
100 Park Street, Glens Falls, NY 12801

Washington County

Glens Falls Hospital
1134 State Route 29, Greenwich, NY 12834

Westchester County

Hudson Valley Radiology Associates
115 Main Street 2nd Floor, Tuckahoe, NY 10707
955 Yonkers Avenue, Room 14, Yonkers, NY 10704

New Rochelle Radiology Associates
150 Lockwood Avenue, New Rochelle, NY 10801
175 Memorial Highway, New Rochelle, NY 10801

Northeast Radiology
666 Lexington Avenue, Mount Kisco, NY 10549

WESTMED Medical Group
1 Stone Place, Suite 303, Bronxville, NY 10708
171 Huguenot Street, New Rochelle, NY 10801
210 Westchester Avenue, White Plains, NY 10604
1 Theall Road, Rye, NY 10580
73 Market Street, Yonkers, NY 10710

ATTACHMENT 35

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Commercial Benefits Chart "Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

Offeror Name: MVP Health Plan

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Office Visit	Covered as required by Federal and NYS law and/or regulation	Sec. IX, Para N, Page 44	NA, in COC	Filed/Pending	$25/visit Covered in Full for dependents to age 26	unlimited	Yes, $10 copay decrease to age 26	060 East with RX $756.11	060 East with RX $1796.92
Specialty Office Visit	Covered as required by Federal and NYS law and/or regulation	Sec. IX, Para N, Page 44	NA, in COC	Filed/Pending	$25/visit	unlimited	No	330 Central with RX $855.67	330 Central with RX $2018.30
Chiropractic Care	Covered as required by Federal and NYS law and/or regulation	Sec. IX, Para E, Page 39	NA, in COC	Filed/Pending	$25/visit	unlimited	no	340 Mid Hudson with RX $841.10	340 Mid Hudson with RX $1985.60
Inpatient Hospital Care	Covered as required by Federal and NYS law and/or regulation, not subject to deductibles, copays or coinsurance	Sec. XI, Para A, Page 57	NA, in COC	Filed/Pending	$0 copayment	unlimited	No	058 Rochester with RX $725.72	058 Rochester with RX $1705.44
Surgery (include all settings - Physician-Inpatient , Physician-Outpatient (at a hospital, facility or surgery center), Physician's Office, Outpatient Surgery Facility		Sec. IX, Para T., Page 46	NA, in COC	Filed/Pending	Physician Inpatient - No copayment Physician Outpatient - $25/visit Physician Office - $25/visit Outpatient Surgery Facility - $25/visit, $0/visit at a Preferred Provider	unlimited	Yes, $25 copay decrease at Preferred Provider	360 North with RX $1,058.38	360 North with RX $2487.20
Skilled Nursing Facilities		Sec XI, Para H. Page 59	NA, in COC	Filed/Pending	$0 copayment	45 days per calendar year	no	without RX $618.38	without RX $1453.19
Hospice Benefits	210 Days	Sec X, Para E., Page 55	NA, in COC	Filed/Pending	$0 copayment	210 days per calendar year	No	without RX $689.84	without RX $1628.61
Emergency Room	Covered as required by ACA	Sec VIII, Para A. 1., Page 37	NA, in COC	Filed/Pending	$75/visit	unlimited	No	340 Mid Hudson	340 Mid Hudson
Urgent Care Facility		Sec Viii, Para B., Page 38	NA, in COC	Filed/Pending	$25/visit	unlimited	No	058 Rochester	058 Rochester without RX $1305.51
Ambulance indicate both Non-airborne & Airborne		Sec VII, Page 34 & 35	NA, in COC	Filed/Pending	$50/trip	unlimited	No	360 North without RX $862.48	360 North without RX $2026.82

Offeror Name: MVP Health Plan

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgical Settings									
Radiology	Covered as required by Federal and NYS law and/or regulation	Sec IX, Para L, Page 44	NA, in COC	Filed/Pending	$25/visit, $0/visit at Preferred Provider	unlimited	Yes, $25 copay decrease at Preferred Provider		
Lab Tests	Covered as required by Federal and NYS law and/or regulation	Sec IX, Para L, Page 44	NA, in COC	Filed/Pending	$0 copayment	unlimited	No		
Pathology	Covered as required by Federal and NYS law and/or regulation	Sec IX, Para L, Page 44	NA, in COC	Filed/Pending	$0 copayment	unlimited	No		
EKG/EEG	Covered as required by Federal and NYS law and/or regulation	Sec IX, Para L, Page 44	NA, in COC	Filed/Pending	$25/visit	unlimited	No		
Radiation/ Chemotherapy	Covered as required by Federal and NYS law and/or regulation	Sec IX, Para D, Page 39	NA, in COC	Filed/Pending	$25/visit	unlimited	No		
Preventive Services									
All Members - including but not limited to: annual wellness visit/ physical, standard immunizations (recommended by ACIP), colonoscopy, screening for STDs, HIV. Alcohol/ substance abuse, tobacco use, cholesterol, diabetes and high blood pressure	Covered as required by Federal and NYS law and/or regulation, and ACA	Sec VI, Pages 30-33	NA, in COC	Filed/Pending	No copayment	unlimited	No		
Women's Health - including but not limited to: mammograms, bone density, pap tests, anemia, iron deficiency, etc. for pregnant women	Covered as required by Federal and NYS law and/or regulation	Sec VI, Para D, E, F, G, Pages 32 & 33	NA, in COC	Filed/Pending	No copayment	unlimited	No		
Men's Health - including but not limited to: prostate cancer screening, abdominal aortic aneurysm screening	Covered as required by Federal and NYS law and/or regulation	Sec VI, Para H, Page 33	NA, in COC	Filed/Pending	No copayment	unlimited	No		

Offeror Name: MVP Health Plan

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Children's Health - including but not limited to: certain newborn screenings, metabolic screenings, vision, autism, lead and TB screenings, obesity counseling	Covered as required by Federal and NYS law and/or regulation	Sec VI, Para A., Page 30	NA, in COC	Filed/Pending	No copayment	unlimited	No		
Women's Health Care/OB GYN									
Pre- and Post Natal Visits	Covered as required by Federal and NYS law and/or regulation	Sec IX, Para M., Page 44	NA, in COC	Filed/Pending	No copayment	unlimited	No		
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling	Sec VI, Para F., Page32	NA, in COC	Filed/Pending	$25 spec, per visit	unlimited	No		
Infertility Services	Covered as required by Federal and NYS law and/or regulation and the infertility mandates of 2002 and 2019	Sec IX, Para I, Pages 41 - 43	NA, in COC	Filed/Pending	Cost-Share for approriate service (office visit, diagnostic radiology, surgery, lab and diagnostic procedure)	unlimited	No		
Contraceptive Drugs and Devices	Covered as required by ACA and NYS law and/or regulation whichever provides the higher level of benefit	Sec XIII, Para A, Page 66-67	NA, in COC	Filed/Pending	No copayment	unlimited	No		
Rehabilitative Care, Physical, Speech & Occupational Therapy									
Inpatient Rehabilitative Care		Sec XI, Para G., Page 59	NA, in COC	Filed/Pending	No copayment	60 days per Calendar Year, combined therapies	No		
Outpatient Rehabilitative Care		Sec IX, Para R., Page 45	NA, in COC	Filed/Pending	$25/visit	30 visits/calendar year combined	No		
Mental Health/Substance Abuse									
Outpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation	Sec XII, Para A.2. Page62	NA, in COC	Filed/Pending	$25/visit	unlimitied	No		

Offeror Name: MVP Health Plan

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Inpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation	Sec XII, Para A.1., Page61	NA, in COC	Filed/Pending	No copayment	unlimited	No		
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)	Sec x., Para A, Page 49-51	NA, in COC	Filed/Pending	$25 copayment	unlimited	No		
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS laws and/or regulation	Sec XII, Para B.1., Page 62	NA, in COC	Filed/Pending	No copayment for inpatient detox	unlimited	No		
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation	Sec XII, Para B.2., Page 63	NA, in COC	Filed/Pending	$25/visit	unlimited	No		
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation.	Sec XII, Para B.1., Page 62	NA, in COC	Filed/Pending	No copayment	unlimited	No		
Prescription Drugs: *Medically necessary federal legend and state restricted drugs, compounded medications and injectable insulin. Coverage must include contraceptive drugs and devices, fertility drugs and enteral formulas. (The copayment for injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs except drugs limited to 30 days supply at dispensing.) No annual or lifetime maximum permitted.*									
Prescription Drugs		Sec XIII, Page 65-79	NA, in COC	Filed/Pending	$0 Tier 1, $30 Tier 2 $50 Tier 3	30-day supply	yes		
Other									
Diabetic Supplies	Covered as required by Federal and NYS law and/or regulation	Sec X, Para B. 1., Pages 51-52	NA, in COC	Filed/Pending	$25 copayment	31-day supply	No		
Oral Agents and Insulin	Covered as required by Federal and NYS law and/or regulation	Sec X, Para B. 1., Pages 51-52	NA, in COC	Filed/Pending	$25 copayment	31-day supply	No		
Diabetic Shoes		Sec X, Para B. 1., Pages 51-52	NA, in COC	Filed/Pending			No		
Durable Medical Equipment (DME)	Medically necessary DME which can with- stand repeated use & primarily used to serve a medical purpose must be covered. Examples include but not limited to: wheelchairs, walkers, respiratory equip, oxygen supplies, replacements, repairs & maintenance, not provided for under manufacturer's warranty or purchase agreement must be covered when functionally necessary.	Sec X. Para C, Page 54	NA, in COC	Filed/Pending	50% Coinsurance		No		

Offeror Name: MVP Health Plan

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Prosthetic Devices	Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to: artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses & Ostomy Supplies. Replacements, repairs and maintenance, not provided for under manufacturer's warranty or purchase agreement must be covered when functionally necessary	Sec X, Para G. Page 55	NA, in COC	Filed/Pending	50% Coinsurance	External- one device per limb, per lifetime with coverage for repairs and replacements. Internal - unlimited	No		
Orthotic Devices	Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	Sec x., Para C.2., Page 54	NA, in COC	Filed/Pending	50% Coinsurance	unlimited	No		
NYSHIP Eligibility rider								N/C	N/C

This is Your

HEALTH MAINTENANCE ORGANIZATION CERTIFICATE OF COVERAGE

Issued by

MVP Health Plan, Inc.

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between **MVP Health Plan, Inc.,** (hereinafter referred to as "We", "Us" or "Our") and the Group listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Preferred Benefits.** In-network preferred benefits are the higher level of coverage available. In-network preferred benefits apply when Your care is provided by Preferred Providers in Our Preferred Provider network. You should always consider receiving health services first through Our Preferred Providers in Our Preferred Provider network.

2. **In-Network Benefits.** This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our HMO Network and Participating Pharmacies in our CVS Caremark Network. Except for care for an Emergency or urgent Condition described in the Emergency Services and Urgent Care section of this Certificate, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.

[By:

Christopher Del Vecchio,
President and Chief Executive Officer
MVP Health Plan, Inc.]

If You need foreign language assistance to understand this Certificate, You may call Us at the number on Your Member ID card.

TABLE OF CONTENTS

SECTION I. Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by MVP Health Plan, Inc., including the Schedule of Benefits and any attached riders.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

Co-insurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Co-payment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Co-payments, Deductibles and/or Co-insurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Co-payments or Co-insurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

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

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

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28(or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an agreement with Us as a Contract holder.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to New York Public Health Law Article 40 or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance

or emergency department visit or admission, "Member" also means the Member's designee.

Network: The Providers We have contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide health care services to You. The services of Non-Participating Providers are Covered only for Emergency Services, Urgent Care or when authorized by Us.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website [at mvphealthcare.com] or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: A calendar year ending on December 31 of each year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. Please visit Our website at [mvphealthcare.com] for a complete list of services requiring Preauthorization.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating nurse practitioner or Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Certificate that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Certificate that describes the Co-payments, Deductibles, Co-insurance, Out-of-Pocket Limits, Referral requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Albany, Broome, Cayuga, [Chemung], Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, [Schuyler], Seneca, Steuben, St. Lawrence, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates Counties.

Skilled Nursing Facility: An institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under

Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Student: An unmarried dependent covered under this plan currently enrolled in a part-time or full-time academic program of study in an accredited college or university.

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a participating Physician's office or Urgent Care Center. Urgent care is also covered in a Non-Participating office of Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: MVP Health Plan, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II. How Your Coverage Works

A. Your Coverage Under this Certificate.

Your employer (referred to as the "Group") has purchased a Group HMO Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition and Urgent Care.

C. Participating Providers.

To find out if a Provider is a Participating Provider,

- Check Our Provider directory, available at Your request;
- Call the number on Your Member ID card; or
- Visit Our website [at mvphealthcare.com].

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken;
- [Whether the Provider is a Preferred Provider;] and
- Whether the Participating Provider is accepting new patients.

D. Preferred Providers.

Some Participating Providers are also Preferred Providers. Certain services may be obtained from Preferred Providers. If You receive Covered Services from Preferred Providers, Your Cost-Sharing may be lower than if You received the services from Participating Providers. See the Schedule of Benefits section of this Certificate for coverage of Preferred Provider services.

D. The Role of Primary Care Physicians.

This Certificate requires that You select a Primary Care Physician ("PCP"). Although You are encouraged to receive care from Your PCP, You do not need a Referral from a PCP before receiving [certain] Specialist care from a Participating Provider.

You may select any participating PCP who is available from the list of PCPs in the HMO Network. Each Member may select a different PCP. Children covered under this Certificate may designate a participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist. To select a PCP, visit Our website at [mvphealthcare.com]. If You do not select a PCP, We will assign one to You.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

E. Access to Providers and Changing Providers.

Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a MVP Health Plan, Inc. Preferred Provider Network Member, and explain the reason for Your visit. Have Your Member ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your Member ID card with You.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your Provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

You may change Your PCP by visiting Our website at[mvphealthcare.com] and selecting sign In/Register. Once signed in, click on Select or Change a Doctor from the menu on the left-hand side of the Manage Your account page. Then follow the online steps to change Your PCP. If You have questions or need additional assistance with changing Your PCP, You can contact the Customer Care Center at the phone number on the back of Your Member ID card.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

F. Services Subject to Preauthorization.
Our Preauthorization is required before You receive certain Covered Services. Your PCP is responsible for requesting Preauthorization for in-network services. A list of services requiring Preauthorization can be found on Our website at [mvphealthcare.com].

G. Preauthorization / Notification Procedure.
If You seek coverage for services that require Preauthorization or notification, Your Provider must call Us at the number on Your Member ID card.

Your Provider must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.

- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.

- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.

- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

H. Medical Management.

The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

I. Medical Necessity.

We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health

specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:
- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

J. Protection from Surprise Bills.

1. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:
    - For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
        - A participating Physician is unavailable at the time the health care services are performed;
        - A non-participating Physician performs services without Your knowledge; or
        - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
    - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
    - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
    - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Co-payment, Deductible or Co-insurance if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your Co-payment, Deductible or Co-insurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at [mvphealthcare.com] for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on Your Member ID card and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

K. Delivery of Covered Services Using Telehealth.

If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance

requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

L. Early Intervention Program Services.
We will not exclude Covered Services solely because they are Early Intervention Program services for infants and toddlers under three years of age who have a confirmed disability or an established developmental delay. Additionally, if Early Intervention Program services are otherwise covered under this Certificate, coverage for Early Intervention Program services will not be applied against any maximum annual or lifetime dollar limits if applicable. Visit limits and other terms and conditions will continue to apply to coverage for Early Intervention Program services. However, any visits used for Early Intervention Program services will not reduce the number of visits otherwise available under this Certificate.

M.] [[**Care**; **Case; Disease] Management.**
[Care; Case; Disease] management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our [care; case; disease] management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care [through Our [care; case; disease] management program] that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this [Certificate; Contract; Policy]. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.]

As part of our hospital discharge program you will be offered meals following an inpatient hospital discharge. MVP will contact you and offer you the option to receive 14 nutritious meals during a 7 day period to help you meet your nutritional needs and recover. If you choose to receive the meals, they will be delivered to your home by our partner [Mom's Meals].

N. Important Telephone Numbers and Addresses.

- CLAIMS
  MVP Health Care – claims Department
  P.O. Box 2207
  Schenectady, NY 12305
  (Submit claim forms to this address.)

  submitclaims@mvphealthcare.com
  (Submit electronic claim forms to this e-mail address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  [1-888-687-6277]

- ASSIGNMENT OF BENEFITS FORM
  Refer to the address on Your Member ID card
  (Submit assignment of benefits forms for surprise bills to this address.)

- CUSTOMER CARE CENTER
  [1-888-687-6277]
  (Customer Care Center Representatives are available Monday - Friday, 8:00 a.m. – 8:00 p.m.)

- [PREAUTHORIZATION]
  [1-888-687-6277]

- BEHAVIORAL HEALTH SERVICES
  Call the number on Your Member ID card

- OUR WEBSITE
  [mvphealthcare.com]

SECTION III. Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a referral to an appropriate Non-Participating Provider. Your Participating Provider must request prior approval of the referral to a specific Non-Participating Provider. Approvals of referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event a referral is not approved, any services rendered by a Non-Participating Provider will not be Covered.

B. When a Specialist Can Be Your Primary Care Physician.

If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

C. Standing Referral to a Participating Specialist.

If You need ongoing specialty care, You may receive a standing Referral to a Specialist who is a Participating Provider. This means that You will not need a new Referral from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a standing Referral. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide Your PCP with regular updates on the specialty care provided as well as all necessary medical

information. We will not approve a standing Referral to a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a standing Referral to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

D. Specialty Care Center.

If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may request a Referral to a specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such a Referral. Any Referral will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation with Your PCP or Specialist and You. We will not approve a Referral to a non-participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our network. If We approve a Referral to a non-participating specialty care center, Covered Services rendered by the non-participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a participating specialty care center. You will be responsible only for any applicable in-network Cost-Sharing.

E. When Your Provider Leaves the Network.

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

In order for You to continue to receive Covered Services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will

receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

F. New Members In a Course of Treatment.

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

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

SECTION IV. Cost-Sharing Expenses and Allowed Amount

A. Deductible.

There is no Deductible for Covered Services under this Certificate during each Plan Year.

B. Co-payments.

Except where stated otherwise, You must pay the Co-payments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Co-payment, You are responsible for the lesser amount.

C. Co-insurance.

Except where stated otherwise, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. Out-of-Pocket Limit.

When You have met Your Out-of-Pocket Limit in payment of Co-payments, Deductibles and Co-insurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Pocket Limit in payment of Co-payments, Deductibles and Co-insurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family.

Cost-Sharing for out-of-network services, except for Emergency Services and out-of-network services approved by Us as an in-network exception and out-of-network dialysis, does not apply toward Your Out-of-Pocket Limit.

E. Allowed Amount.

"Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Co-payment, Deductible and Co-insurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

SECTION V. Who is Covered

A. Who is Covered Under this Certificate.

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.

If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and

maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child qualifies and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

D. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed 90 days.
2. If You, the Subscriber, do not elect coverage upon becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage and any Premium payment within 30 days thereafter, coverage for Your Spouse and Child starts on the first day of the following month after We receive Your application. If We do not receive notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.
4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your

desire to switch to parent and child/children or family coverage and pay any additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

E. Special Enrollment Periods.

You, Your Spouse or Child can also enroll for coverage within 30 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within 30 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

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

1. You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or
2. You or Your Spouse or Child becomes eligible for Medicaid or Child Health Plus.

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

F. Domestic Partner Coverage.

This Certificate covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Certificate also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by: .
   a. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
      - The partners are both 18 years of age or older and are mentally competent to consent to contract;
      - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
      - The partners have been living together on a continuous basis prior to the date of the application; and
      - Neither individual has been registered as a member of another domestic partnership within the last six (6) months;
   b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
   c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
      - A joint bank account;
      - A joint credit card or charge card;
      - Joint obligation on a loan;
      - Status as an authorized signatory on the partner's bank account, credit card or charge card;
      - Joint ownership of holdings or investments;
      - Joint ownership of residence;
      - Joint ownership of real estate other than residence;
      - Listing of both partners as tenants on the lease of the shared residence;
      - Shared rental payments of residence (need not be shared 50/50);
      - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
      - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
      - Shared household budget for purposes of receiving government benefits;

- Status of one (1) as representative payee for the other's government benefits;
- Joint ownership of major items of personal property (e.g., appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for child care (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other's life insurance policy;
- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI. Preventive Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care.
We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your ID card or visit Our website [at mvphealthcare.com] for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. **Well-Baby and Well-Child Care.** We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance.

B. **Adult Annual Physical Examinations.** We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website [at mvphealthcare.com], or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

C. Adult Immunizations. We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP.

D. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website [at mvphealthcare.com], or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above.

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

- One (1) baseline screening mammogram for Members age 35 through 39;
- Upon the recommendation of the Member's provider, an annual screening mammogram for Members age 35-39, if Medically Necessary and

- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance.

F. Family Planning and Reproductive Health Services. We Cover family planning services which consist of: FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered under the Prescription Drug Coverage section of this Certificate; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

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

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;

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

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

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

H. Screening for Prostate Cancer. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance.

SECTION VII. Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. Pre-Hospital Emergency Medical Services. We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

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

An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance

In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the [[lesser of the] FAIR Health rate at the 70th percentile [or the Provider's billed charges].

2. Emergency Ambulance Transportation. In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest

Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

SECTION VIII. Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Emergency Services.

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

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**. If You are uncertain whether a Hospital emergency department is the most appropriate place to receive care, You can call Us before You seek treatment.

   We do not Cover follow-up care or routine care provided in a Hospital emergency department.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Certificate and on Your Member ID card within 48 hours of Your admission, or as soon as is reasonably possible.
   We Cover inpatient Hospital services following Emergency Department Care at a non-participating Hospital at the in-network Cost-Sharing. If your medical condition permits Your transfer to a participating Hospital, We will notify You and work with You to arrange the transfer.

3. **Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare. The amounts described above exclude any Co-payment or Co-insurance that applies to Emergency Services provided by a Participating Provider.

   If a dispute involving a payment for physician services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician services.

   You are responsible for any Co-payment, Deductible or Co-insurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Co-

payment, Deductible or Co-insurance. Additionally, if You assign benefits to a Non-Participating Provider in writing, the Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your Copayment, Deductible or Coinsurance, You should contact Us.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. **Urgent Care is Covered in or out of Our Service Area**.

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.

2. **Out-of-Network.** We Cover Urgent Care from a non-participating Urgent Care Center or Physician.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

SECTION IX. Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Advanced Imaging Services.

We Cover PET scans, MRI, nuclear medicine, and CAT scans.

B. Allergy Testing and Treatment.

We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

C. Ambulatory Surgical Center Services.

We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

D. Chemotherapy and Immunotherapy.

We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Certificate.

E. Chiropractic Services.

We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

F. Clinical Trials.

We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and

- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

G. Dialysis.

We Cover dialysis treatments of an Acute or chronic kidney ailment.
We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than 10 dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid

had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

H. Home Health Care.

We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

I. Infertility Treatment.

We Cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

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

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;

- Postcoital test;
- Endometrial biopsy;
- Pelvic ultra sound;
- Hysterosalpingogram;
- Sono-hystogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.

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

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultra sound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Advanced Infertility Services.** We Cover the following advanced infertility services:
   - Three (3) cycles per lifetime of in vitro fertilization; and
   - Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization.

   A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

4. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Latrogenic infertility" means an impairment of Your

fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

5. Exclusions and Limitations. We do not Cover:

- Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs associated with an ovum or sperm donor, including the donor's medical expenses;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

J. Infusion Therapy.

We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy.

K. Interruption of Pregnancy.

We Cover medically necessary abortions including abortions in cases of rape, incest or fetal malformation. We Cover elective abortions for one (1) procedure per Member, per calendar year.

L. Laboratory Procedures, Diagnostic Testing and Radiology Services.
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

M. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for Coverage of inpatient maternity care.

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

N. Office Visits.
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

O. Outpatient Hospital Services.
We Cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

P. Preadmission Testing.
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

Q. Prescription Drugs for Use in the Office and Outpatient Facilities.
We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

R. Rehabilitation Services.
We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to 30 visits per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- The therapy is ordered by a Physician; and
- You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

S. Second Opinions.
1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis when Your attending Physician provides a written Referral to a non-participating Specialist.

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    - The second opinion must be given by a board certified Specialist who personally examines You.
    - If the first and second opinions do not agree, You may obtain a third opinion.
    - The second and third surgical opinion consultants may not perform the surgery on You.

4. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

T. Surgical Services.

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

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

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

U. Oral Surgery.

We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.

- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

V. Reconstructive Breast Surgery.
We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

W. Other Reconstructive and Corrective Surgery.
We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

X. Telemedicine Program.
In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in our telemedicine program for medical conditions.

The telemedicine program is provided pursuant to a contract with [American Well], [and][Upstate Concierge Medicine], [and Physera] and are services that provide Participants with access to a national network of Providers for medical care in connection with a wide range of common, uncomplicated conditions and cases, including some mental health disorders [and physical therapy]. A member can access these services through online video and/or phone, using either desktop or mobile

devices. More information can be found at [www.myvisitnow.com] and [https://myernow.unitedconciergemedicine.com] [and www.physera.com].

Y. Transplants.

We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated [as Centers of Excellence] to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

SECTION X. Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Autism Spectrum Disorder.

We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

1. **Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

2. **Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop or tablet computers. We Cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

   We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We Cover one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to

Your current functional level. We do not Cover delivery or service charges or routine maintenance.

3. **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

4. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

5. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

6. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.

7. **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education

plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Co-payment, Deductible or Co-insurance provisions under this Certificate for similar services. For example, any Co-payment, Deductible or Co-insurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Co-payment, Deductible or Co-insurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

B. Diabetic Equipment, Supplies and Self-Management Education.

We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. **Equipment and Supplies.**

   We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:

   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit

- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose kit
-
- Glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Glucose reagent tape
- Glucose test or reagent strips
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Diabetic equipment and supplies are Covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with Us to provide all diabetic equipment or supplies required by law for Members through participating pharmacies. If You require a certain item not available from Our designated diabetic equipment or supply manufacturer, You or Your Provider must submit a request for a medical exception by calling the number on Your Member ID card. Our medical director will make all medical exception determinations. Diabetic equipment and supplies are limited to a 30-day supply up to a maximum of a 90-day supply when purchased at a pharmacy.

2. Self-Management Education.

Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations.

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

Step Therapy for Diabetes Equipment and Supplies. Step therapy is a program that requires You to try one type of diabetic Prescription Drug, supply or equipment unless another Prescription Drug, supply or equipment is Medically Necessary. The diabetic Prescription Drugs, supplies and equipment that are subject to step therapy include:

- Diabetic glucose meters and test strips;
- Diabetic supplies (including but not limited to syringes, lancets, needles, pens);
- Insulin;
- Injectable anti-diabetic agents; and
- Oral anti-diabetic agents.

These items also require Preauthorization and will be reviewed for Medical Necessity. For diabetic Prescription Drugs, refer to the step therapy provisions in the Prescription Drug section and the Step Therapy Protocol Override Determination provisions in the Utilization Review section of this Certificate.

C. Durable Medical Equipment and Braces.

We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

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

2. Braces.

We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

D. Hearing Aids.

Cochlear Implants.

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

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

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Certificate. We Cover repair and/or

replacement of a bone anchored hearing aid only for malfunctions.

E. Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

F. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

G. Prosthetics.

1. External Prosthetic Devices.

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

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only Covered under the Vision Care section of this Certificate.

We do not Cover shoe inserts.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per lifetime; per Plan Year. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

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

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

SECTION XI. Inpatient Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Hospital Services.

We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis, including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Certificate apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days for the same or related causes.

B. Observation Services.

We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

D. Inpatient Stay for Maternity Care.
We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. Inpatient Stay for Mastectomy Care.
We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a

period of time determined to be medically appropriate by You and Your attending Physician.

F. Autologous Blood Banking Services.
We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Rehabilitation Services.
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:
1. Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and
2. The therapy is ordered by a Physician.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

H. Skilled Nursing Facility.
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 45 days per Plan Year for non-custodial care.

I. End of Life Care.
If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to

initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

J. Centers of Excellence.

Centers of Excellence are Hospitals that We have approved and designated for certain services. We Cover the following Services only when performed at Centers of Excellence:

A. [Bariatric Surgery]
B. [Transplants]

K. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

SECTION XII. Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
    - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
    - A state or local government run psychiatric inpatient Facility;
    - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
    - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

    and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

    We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed

or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

B. Substance Use Services. We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Supports ("OASAS"); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs.

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or

otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission [or a national accreditation organization recognized by Us] as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

   Additional Family Counseling. We also Cover up to 20 outpatient visits per calendar year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from a substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for a substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

C. Disclosures related to Behavioral Health Coverage:

1. We provide broad-based coverage for the diagnosis and treatment of behavioral health conditions, equal to the coverage provided for other health conditions. Behavioral health conditions include mental health and substance use disorders.

2. We provide, subject to medical necessity, unlimited benefits for inpatient and outpatient behavioral health care, as well as for residential treatment for behavioral health conditions, except for family counseling services, which may be capped at 20 visits per year.

3. The utilization review conducted by Us for each request or claim for behavioral health benefits is comparable to, and applied no more stringently than, the utilization review conducted by Us for each request or claim for similar medical/surgical benefits.

4. Any annual or lifetime limits on behavioral health benefits for Our benefit plans are no stricter than such limits on medical/surgical benefits.

5. We do not apply any Cost-Sharing requirements that are applicable only to behavioral health benefits.

6. We do not apply any treatment limitations that are applicable only to behavioral health benefits, except for family counseling services, which may be capped at 20 visits per year.

7. The criteria for medical necessity determinations made by Us regarding behavioral health benefits are made available: (i) on a website accessible by Our Members and providers; and (ii) upon request, to any current or potential participant, beneficiary, or contracting Provider.

8. Where a Member's benefit plan Covers medical/surgical benefits provided by out-of-network Providers, the benefit plan covers behavioral health benefits provided by out-of-network Providers.

9. Where a Member's benefit plan has a Deductible, we charge a single Deductible for all benefits, whether services rendered are for medical/surgical or behavioral health conditions, with the exception that We may charge a separate Deductible for Prescription Drugs.

10. We offer our Members the services of Behavioral Health Advocates, who are trained to assist Our members in accessing their behavioral health benefits, by supplying them detailed, accurate, and current information regarding: treatment options in the Member's area; utilization review determinations and processes; medical necessity criteria; and Appeals.

[SECTION XIII. Prescription Drug Coverage]

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.

We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On Our Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired

absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit, [including in vitro fertilization] in the Outpatient and Professional Services section of this Certificate.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.

You may request a copy of Our Formulary. Our Formulary is also available on Our website [at mvphealthcare.com.] You may inquire if a specific drug is Covered under this Certificate by contacting Us at the number on Your Member ID card.

B. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail, mail order or designated pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Certificate.

C. Benefit and Payment Information.

1. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail, mail order or designated pharmacy.

   You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

   For most Prescription Drugs, You pay only the Cost-Sharing in the Schedule of Benefits. An additional charge, called an "ancillary charge," may apply to some Prescription Drugs when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request and Our formulary includes a chemically equivalent Prescription Drug on a lower tier. You will pay the difference between the full cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference is not Covered and must be paid by You in addition to the lower tier Cost-Sharing. If Your Provider thinks that a chemically equivalent Prescription Drug on a lower tier is not clinically appropriate, You, Your designee or Your Provider may request that We approve coverage at the higher tier Cost-Sharing. If approved, You will pay the higher tier Cost-Sharing only. If We do not approve coverage at the higher tier Cost-Sharing, You are entitled to an Appeal as outlined in the Utilization Review and External Appeal sections of this Certificate. If We do not approve coverage for the Prescription

Drug on the higher tier, the ancillary charge will not apply toward Your Out-of-Pocket Limit.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You

2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail, mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your Member ID card or visit Our website [at mvphealthcare.com] to request approval.

3. **Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

4. **Designated Pharmacies.** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

   Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

- Age related macular edema;
- Anemia, neutropenia, thrombocytopenia;
- Contraceptives;
- Cardiovascular;
- Crohn's disease;
- Cystic fibrosis;
- Cytomegalovirus;
- Endocrine disorders/neurologic disorders such as infantile spasms;
- Enzyme deficiencies/liposomal storage disorders;
- Gaucher's disease;
- Growth hormone;
- Hemophilia;
- Hepatitis B, hepatitis C;
- Hereditary angioedema;
- HIV/AIDS;
- Immune deficiency;
- Immune modulator;
- Infertility;
- Iron overload;
- Iron toxicity;
- Multiple sclerosis;
- Oncology;
- Osteoarthritis;
- Osteoporosis;
- Parkinson's disease;
- Pulmonary arterial hypertension;
- Respiratory condition;
- Rheumatologic and related conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis)
- Transplant;
- RSV prevention.

5. Mail Order. Certain Prescription Drugs may be ordered through Our mail order pharmacy after an initial 30-day supply, with the exception of contraceptive

drugs, devices, or products which are available for a 12-month supply. You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days' supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website [at mvphealthcare.com] or by calling the number on Your Member ID card.

6. Tier Status. The tier status of a Prescription Drug may change periodically, but no more than four (4) times per calendar year, or when a Brand-Name Drug becomes available as a Generic Drug as described below, based on Our tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier or is being removed from Our Formulary, We will notify You at least 30 days before the change is effective. When such changes occur, Your Cost-Sharing may change. You may also request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Certificate. You may access the most up to date tier status on Our website [at mvphealthcare.com] or by calling the number on Your Member ID card.

7. When a Brand-Name Drug Becomes Available as a Generic Drug. When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the

Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being placed on a higher tier due to a Generic Drug becoming available, You will receive 30 days' advance written notice of the change before it is effective.

8. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of this Certificate. Visit Our website [at mvphealthcare.com] or call the number on Your Member ID card to find out more about this process.

   Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone and in writing no later than 72 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

   Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone and in writing no later than 24 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

9. **Supply Limits.** **[**Except for contraceptive drugs, devices, or products,] We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail

pharmacy or Designated Pharmacy. You are responsible for one (1) Cost-Sharing amount amounts for up to a 30-day supply.

[You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing when provided by a Participating Pharmacy.]

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two and a half (2.5) Cost-Sharing amounts for a 90-day supply.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website [at mvphealthcare.com] or by calling the number on Your Member ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Certificate.

10. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Co-payment, Your Co-payment will be prorated. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the seven (7) day supply, Your Co-payment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Co-payment(s) total more than Your Co-payment for a 30-day supply.

11. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You as the Cost-Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this Certificate.

D. Medical Management.

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, ask Your Provider to complete a Preauthorization form. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement. Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

   For a list of Prescription Drugs that need Preauthorization, please visit Our website [at mvphealthcare.com] or call the number on Your Member ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Certificate. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy**. Step therapy is a process in which You may need to use one (1) types of Prescription Drug before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Certificate.

3. **Therapeutic Substitution**. Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website [at mvphealthcare.com] or call the number on Your Member ID card.

E. Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies [and prescribing Providers] may be limited. If this happens, We may require You to select a single Participating Pharmacy [and a single Provider] that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. [Benefits will be paid only if Your Prescription Orders or Refills are written by the selected Provider or a Provider authorized by Your selected Provider.] If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy [and/or prescribing Provider] for You.

3. Compounded Prescription Drugs will be Covered only when the primary ingredient is a Covered legend Prescription Drug, and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over $100 require Your Provider to obtain Preauthorization.

4. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate.

6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient and Professional Services section of this Certificate.

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.

8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.

11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

E. General Conditions.

1. You must show Your Member ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

2. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the Premiums for Your coverage.

   We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Co-payment or Co-insurance applicable under Our Prescription Drug coverage.

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Certificate).

1. **Brand-Name Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.

2. **Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a

pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Certificate. This list is subject to Our periodic review and modification (no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a Generic Drug). To determine which tier a particular Prescription Drug has been assigned, visit Our website [at mvphealthcare.com] or call the number on Your Member ID card.

4. **Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, pharmacy or Your Physician may not be classified as a Generic Drug by Us.

5. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

6. **Participating Pharmacy:** A pharmacy that has:
   - Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
   - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
   - Been designated by Us as a Participating Pharmacy.

   A Participating Pharmacy can be either a retail or mail-order pharmacy.

   Prescription Drug: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

7. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating

Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

8. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

9. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by New York Education Law Section 6826-a.]

SECTION [XIV]. Wellness Benefits

A. General Description of Program.

MVP's WellBeing Rewards Program focuses on the total health of our members. The program considers several key areas in support of a member's physical and mental health and well-being: Social, Physical, Mind & Spirit, Surroundings, and Financial considerations all contribute to a holistic approach to disease prevention and health promotion . This program is designed to help you take an active role in managing your life by providing incentives for meeting health recommendations, participating in programs or completing healthy activities in support of the key areas of well-being. The program is easily accessible through the member website [at www.mvphealthcare.com] or by calling MVP's Customer Care Center Department at [1-888-687-6277.]

i. Earnable Rewards.

You can receive up to [200] points per Certificate per Calendar Year for completing and documenting activities through the Wellness & Rewards section of the MVP Health Care member website. A description and listing of activities for which you can earn WellBeing Reward points is included on the website and as part of your membership materials. You can also request a copy by calling MVP's Customer Care Center Department at [1-888-687-6277.] Each point earned is equal to one dollar. Please log into the MVP website at [www.mvphealthcare.com] and select [[**Begin Your Path to Well-Being]** for helpful instructions on how to earn and redeem your WellBeing Reward points. We encourage you to use cash rewards for a product or service that promotes good health.

You can earn an additional [200] points per Certificate per Calendar Year for participating in Connected! Activity Tracking program. Connect your wearable fitness device or fitness tracking app on your smartphone via the MVP website at [www.mvphealthcare.com] and begin earning. [Earn one credit each day that you achieve 8,000 steps, or 30 minutes of activity or one check-in at a fitness facility. Each day is an opportunity to earn 1 credit and a maximum of 200 credits can be earned annually]. Please log into the MVP website at [www.mvphealthcare.com] and select [[**Begin Your Path to Well-Being**]for helpful instructions on how to earn and redeem your

Wellbeing Rewards points.

ii. Reimbursement Rewards.

The reimbursement rewards portion of WellBeing Rewards will provide up to [a two hundred dollar ($200) reimbursement] per Contract per Calendar Year for items, programs, and activities in the dimensions of Social, Physical, Mind & Spirit, Surroundings, and Financial well-being. Interventions in all areas of life have been tied to improved physical health and well-being. We encourage you to use cash rewards for a product or service that promotes good health. We provide reimbursement in connection with the use of or participation in programs and activities such as:

Social:

- [Registration fees for walks / runs
- fees for community based, continuing educational classes (e.g. art classes, dance classes, driver safety, book clubs)
- Healthy cooking and nutrition classes
- Museum subscriptions, entrance fees]

Physical:

- [Healthy Weight support programs (e.g. Weight Watchers, Nutrisystem, Jenny Craig, apps)
- Youth sports programs (e.g. organized sports fees, sports camps, swim lessons, YMCA)
- Fitness, Gym memberships, classes (e.g. clubs, gyms, subscriptions – Beachbody on Demand, Esquared, Peloton)
- Tobacco Cessation courses and education
- Activity tracking devices (e.g. Fitbit, Garmin)
- Clean eating apps or cookbooks (e.g. Mealplan+, MyFitness Pal, Nutrifix)]

Mind & Spirit:

- [Yoga, Meditation classes
- Mindfulness based stress reduction programs and classes
- Meditation & mindfulness apps (e.g. Calm, Headspace)

- Massage Therapy
- Reiki]

Surroundings:

- [Home/Life organization apps (e.g. Sortly, decluttr, KonMari)
- Fees for home safety and organization programs & consultants
- Safe dwelling security systems & subscriptions]

Financial:

- [Financial planning and personal finance programs & advisor fees
- Budgeting & financial planning apps (e.g. Mint, YNAB, Clarity Money)
- Health literacy education programs & apps (e.g. HealthIQ, MyFitnessPal)

How to receive reimbursement:

- Submit a completed [WellBeing Rewards Reimbursement Form] to MVP Health Care. This form can be found in the Form page on the MVP website at [www.mvphealthcare.com,] under Claims & Reimbursement. You may also contact MVP's Customer Care Center Department at [1-888-687-6277] to have a form sent to you.
- You must pay for the service before submitting a request for reimbursement. Reimbursement applies to the calendar year in which the service is paid. For each reimbursement you are requesting, you must attach:
  - Proof of payment
  - Documentation from the service provider, such as:
    - Provider Name,
    - Type of service/item provided,
    - Date the service/item was paid,
    - Name of the person(s) receiving the service.

B. Additional Program Provisions.

The Earnable Rewards points you and/or your covered dependents earn are tracked online automatically. You can go online to the MVP website or contact MVP's

Customer Care Center Department at [1-888-687-6277] at any time to find out how many reward points you and your covered dependents have earned. Covered dependents eligible to earn Wellness Reward points include the Subscriber's covered spouse or domestic partner and any dependent age 18 or older.

While all members on the Certificate can contribute to earn points, only the subscriber is eligible to redeem WellBeing Rewards. The Subscriber will not be able to see the actual activities completed by the covered dependents, but rather will be able to see the total points earned by all members of the Certificate. WellBeing Rewards are issued per Certificate NOT per member/person.

Wellness Rewards points are earned and redeemed on a Calendar Year basis. The points do not roll over from year to year and will expire at the end of each Calendar Year. [To earn points for submitting a Health Risk Screening Form and/or attending an onsite biometric screening the form/data must be received by December 1st. All other activities to earn points must be completed by December 31st. All points must be redeemed by December 31st or they will be forfeited.]

If you do not redeem your points prior to disenrollment you will lose any accumulated points unless you move from an MVP plan with WellBeing Rewards to another MVP plan with WellBeing Rewards in the same Calendar Year. In this situation your account will remain intact and will still have your bank of points until the end of the calendar year.

You are responsible for any tax consequences related to the redemption of WellBeing Reward points.

All members have access to health, fitness, wellness program and product discounts via the ChooseHealthy® program available on the MVP website at [www.mvphealthcare.com].

C. Reasonable Accommodations.

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program call MVP's Customer Care Center Department at [1-888-687-6277] and we will work with you to develop a way for you to qualify for the reward.

SECTION [XV]. Routine Vision Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits and any Preauthorization or Referral requirements that apply to these benefits.

A. Routine Vision Care.

We Cover emergency, preventive and routine vision care for Members through the end of the month in which the Member turns 19 years of age. We also Cover routine vision examinations for Members over age 18.

B. Vision Examinations.

We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any 24-month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Prescribed Lenses and Frames.

We do not Cover prescribed lenses and frames.

SECTION[XVI]. Pediatric Dental Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following services, described below, subject to all conditions, exclusions and limitations set forth in this section of Your Certificate. We Cover Dental Care services for Members up to age 19.

A. Preventive Dental Care. We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth once per tooth per child up to age (16); and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);

B. Conditions On Coverage. In addition to all other conditions, exclusions and limitations set forth in this Certificate, MVP will only provide benefits for the Preventive Dental Services, described above, for Covered Members to age nineteen (19), when such services have been recommended by a licensed dentist. You must obtain services from a licensed dentist of Your choice. (See the Claims Determination Section of this Certificate for more information.)

C. Other Dental Services. See the Exclusions and Limitations Section of this Certificate for more information.

SECTION [XVII]. Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

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

C. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

D. Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

E. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care section of this Certificate.

F. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

G. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

H. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

I. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

J. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

K. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, We will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

L. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

M. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

N. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

O. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

P. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Q. Services with No Charge.
We do not Cover services for which no charge is normally made.

R. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Routine Vision Care section of this Certificate.

S. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

T. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION [XVIII]. Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your Member ID card or visiting Our website [at mvphealthcare.com]. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate or on Your Member ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Certificate or visiting Our website [at mvphealthcare.com].

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. Urgent Pre-Service Reviews. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION [XIX]. Grievance Procedures

A. Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.

You can contact Us by phone at the number on Your Member ID card, in person, or in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of Your Grievance.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your Member ID card, in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

E. Assistance.

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Health at 1-800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION [XX]. Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your Member ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. For substance use disorder treatment, We will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your Member ID card or visit Our website [at www.mvphealthcarecom].

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will

make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

4. [**Inpatient Rehabilitation Services Reviews.** After receiving a Preauthorization request for coverage of inpatient rehabilitation services following an inpatient Hospital admission provided by a Hospital or skilled nursing facility, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.]

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within

one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for

inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

4. **Inpatient Mental Health Treatment for Members under 18 at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed Hospital notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary, and We will use clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

5. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

6. **Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient

treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Step Therapy Override Determinations.

You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
   - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
   - The required Prescription Drug(s) is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;
   - You have tried the required Prescription Drug(s) while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
   - You are stable on a Prescription Drug(s) selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
   - The required Prescription Drug(s) is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination and provide notification to You (or Your designee) and Your Health Care Professional within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the

earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If We do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. Reconsideration.

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

H. Utilization Review Internal Appeals.

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any

additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
   - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
   - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
   - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and

- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

I. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

   Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

J. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. Appeal Assistance.

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION [XXI]. External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure Covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.

If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. Your Right to Appeal a Formulary Exception Denial.

If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Certificate for more information on the formulary exception process.

G. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing

requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

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

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your

external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within 72 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

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

We will charge You a fee of $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

H. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State

Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION [XXII]. Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. **"Plan"** is other group health coverage with which We will coordinate benefits. The term "plan" includes:
   - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.

3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    - The plan of the parent who has custody will be primary;
    - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
    - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an

active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
Except as described below, We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption

that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this Certificate is primary.

SECTION [XXIII]. Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium had been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the month in which the Child turns 26 years of age.

6. For all other Dependents, the day in which the Dependent ceases to be eligible.

7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. The date that the Group Contract is terminated. If We decide to stop offering a particular class of group Contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days' prior written notice.

10. If We decide to stop offering all hospital, surgical and medical expense coverage in the large group market in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.

11. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

12. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

13. The date there is no longer any Subscriber who lives, resides, or works in Our Service Area.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage. See the Conversion Right to a New Contract after Termination section of this Certificate for Your right to conversion to an individual Contract.

SECTION [XXIV]. Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Contract terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, "total disability" means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When You May Continue Benefits.

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

B. Termination of Extension of Benefits.

Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the 12-month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

C. Limits on Extended Benefits.

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

SECTION [XXV]. Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

A. Qualifying Events.

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 36 months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See the Conversion Right to a New Contract after Termination section of this Certificate.

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

C. Availability of Age 29 Dependent Coverage Extension – Young Adult Option.

The Subscriber's Child may be eligible to purchase continuation coverage under the Group's Contract through the age of 29 if he or she:

1. Is under the age of 30;
2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works or resides in New York State or Our Service Area; and
5. Is not covered by Medicare.

The Child may purchase continuation coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s).

The Subscriber's Child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the Group or the Group's designee receives notice and We receive Premium payment; or
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when the Group or the Group's designee receives notice of election and We receive Premium payment.

The Subscriber or Subscriber's Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. The Child's children are not eligible for coverage under this option.

SECTION [XXVI]. Conversion Right to a New Certificate after Termination

A. Circumstances Giving Rise to Right to Conversion.

You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.

1. **Termination of the Group Contract.** If the Group Contract between Us and the Group is terminated as set forth in the Termination of Coverage section of this Certificate, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as a direct payment member.

2. **If You Are No Longer Covered in a Group.** If Your coverage terminates under the Termination of Coverage section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.

3. **On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

4. **Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.

5. **Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

6. **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the Termination of Coverage section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.

7. **Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under the Termination of Coverage section of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.

B. When to Apply for the New Contract.

If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of coverage under this Contract. You must also pay the first Premium of the new Contract at the time You apply for coverage.

C. The New Contract.

We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four (4) Contracts offered by Us. The coverage may not be the same as Your current coverage. If You are age 65 or over and enrolled in Medicare, We will also offer You Contracts issued to Medicare-enrolled individuals.

SECTION [XXVII]. General Provisions

1. Agreements Between Us and Participating Providers.

Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.

You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill. See the How Your Coverage Works section of this Certificate for more information about surprise bills. Any assignment of benefits or legal claims based on a denial of benefits by You other than for monies due for a surprise bill will be void and unenforceable. Assignment means the transfer to another person, corporation or organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

[You may request Us to make payment for services directly to Your Provider instead of You, including a payment for a surprise bill or to a Hospital for Emergency Services and inpatient services following Emergency Department Care. See the How Your Coverage Works section of this Certificatefor more information about surprise bills.]

3. Changes in this Certificate.

We may unilaterally change this Certificate upon renewal, if We give the Group 45 days' prior written notice.

4. Choice of Law.

This Certificate shall be governed by the laws of the State of New York.

5. Clerical Error.

Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.

Any term of this Certificate which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Enrollment ERISA.
The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Certificate, and any other information required to confirm their eligibility for coverage.

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

9. Entire Agreement.
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

10. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.]

11. Furnishing Information and Audit.
The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the

telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

12. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

13. Incontestability.
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

14. Input in Developing Our Policies.
Subscribers may participate in the development of Our policies by calling Our Customer Care Center at [1-888-MVP-MBRS] or writing us at MVP Health Care, Inc., 625 State Street, Schenectady, NY 12305.

15. Material Accessibility.
We will give the Group, and the Group will give You ID cards , Certificates;, riders and other necessary materials.

16. More Information about Your Health Plan.
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.

- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Certificate.

17. Notice.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or to the address of the Group. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: the address on Your Member ID card.

18. Premium Refund.
We will give any refund of Premiums, if due, to the Group.

19. Recovery of Overpayments.
On occasion, a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

20. Renewal Date.
The renewal date for this Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Certificate or by the Group upon 30 days' prior written notice to Us.

21. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to

determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

22. Right to Offset.

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, 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 owe You.

23. Severability.

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

24. Subrogation and Reimbursement.

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law Section 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any Contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

25. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

26. Time to Sue.
No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

27. Translation Services.
Translation services are available free of charge under this Certificate for non-English speaking Members. Please contact Us at the number on Your Member ID card to access these services.

28. Venue for Legal Action.
If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

29. Waiver.
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

30. Who May Change this Certificate.
This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

31. Who Receives Payment under this Certificate.
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either the Subscriber or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Certificate for more information about surprise bills.

32. Workers' Compensation Not Affected.
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

33. Your Medical Records and Reports.
In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

34. Your Rights and Responsibilities.

As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits. You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

As a Member, You should also take an active role in Your care. We encourage You to:

- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Certificate. This may include information about other health insurance benefits You have along with Your coverage with Us; and
- Inform Us if You have any changes to Your name, address or Dependents covered under Your Certificate.

SECTION [XXVIII]. Other Covered Services

Out of Area Coverage

Members up to the end of the month they turn age 26 covered under this plan may receive Benefits for Covered Services received outside of Our Service Area up to [$2,500] per Member per Plan Year.

This coverage does not apply to the following Covered Services:

A. Preventive Care Services, including Well Baby Care and Child Care, periodic health evaluations and Gynecological health care services.

B. Transplant Services/Donor Costs.

C. Elective inpatient hospital services.

D. Any days for visits beyond the maximum number authorized in this Certificate, whether provided within or outside of our service area.

E. Any service MVP determines are or were not Medically Necessary.

To access Out of Area Covered Services, you must get preauthorization.

Preauthorization is not required for Emergency Services. Emergency Services are covered as described in this Certificate and are not changed by these provisions.

All services received out of area are subject to the In-Network cost share as described in the Cost Share Section of this Certificate.

A claim must be submitted directly to MVP at the address in the "How Your Coverage Works" section of this Certificate within 180 days of the date of service..

Upon receipt of a claim for these services, We will notify Your PCP to update their medical record.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.mvphealthcare.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-888-687-6277 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network -$6,350 individual /$12,700 family	The out-of-pocket limit is the most you could pay in a year for covered services.If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.mvphealthcare.com or call 1-888-687-6277 for a list of network providers.	You pay the least if you use a provider in the Preferred Provider tier. You pay more if you use a provider in the In-Network tier. You will pay the most if you use an Out-of-Network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/office visit	$25 copay/office visit	Not covered	$0 copayment to age 26
	Specialist visit	$25 copay/office visit	$25 copay/office visit	Not covered	None
	Preventive care/screening/ immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - No charge; Lab Facility - No charge; Radiology Office - $25/visit; Radiology Facility - $0/visit	Lab Office - No charge; Lab Facility - No charge; Radiology Office - $25/visit ;Radiology Facility - $25/visit	Not covered	Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None
	Imaging (CT/PET scans, MRIs)	Office - $25 copay/procedure ; Facility - $0 copay/procedure	Office - $25 copay/procedure; Facility - $25 copay/procedure	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mvphealthcare.com	Tier 1 (Generic drugs)	Not covered	Not covered	Not covered	None
	Tier 2 (Preferred brand drugs)	Not covered	Not covered	Not covered	None
	Tier 3 (Non-preferred brand drugs)	Not covered	Not covered	Not covered	None
	Tier 4 Specialty drugs	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copay/day	$25 copay/day	Not covered	None
	Physician/surgeon fees	No charge	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	$75 copay/visit	None
	Emergency medical transportation	$50 copay/trip	$50 copay/trip	$50 copay/trip	None
	Urgent care	$25 copay/visit	$25 copay/visit	$25 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	Per continuous confinement
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	$25 copay/visit	Not covered	None
	Inpatient services	No charge	No charge	Not covered	Including residential treatment

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay, coinsurance, and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	Not covered	
	Childbirth/delivery facility services	No charge	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	$25 copay/visit	$25 copay/visit	Not covered	None
	Rehabilitation services/ Habilitation services	OP ReHab: $25 copay/visit IP ReHab: No charge	OP ReHab: $25 copay/visit IP ReHab: No charge	OP ReHab: Not covered IP ReHab: Not covered	OP ReHab: 30 visits per Calendar Year combined therapies IP ReHab: 60 days per Calendar Year combined therapies
	Skilled nursing care	No charge	No charge	Not covered	45 days per Calendar Year
	Durable medical equipment	50% coinsurance	50% coinsurance	Not covered	None
	Hospice services	No charge	No charge	Not covered	210 days per Calendar year, 5 visits for family bereavement counseling

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$25 copay/exam	$25 copay/exam	Not covered	One exam every 2 Calendar Years
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	$25 copay/visit	$25 copay/visit	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's Glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Generic drugs
- Hearing Aids
- Long-Term Care
- Non-Emergency care when traveling outside the U.S
- Non-preferred brand drugs
- Preferred brand drugs
- Private-Duty Nursing
- Routine Foot Care
- Specialty drugs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

MVP Health Care
P.O. Box 2207
Schenectady, NY 12301
Toll Free: 1-888-687-6277
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

MVP Health Care
Attn: Member Appeals
P.O.Box 2207
Schenectady, NY 12301
Toll Free:1-888-687-6277
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the NYS Department of Insurance at 1-800-342-3736 or dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Health Advocates at 1-888-614-5400 or communityhealthadvocates.org.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? No.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist Copay	$25
Hospital (facility) Copay	$0
Other Copay	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	$120

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist Copay	$25
Hospital (facility) Copay	$0
Other Copay	$25

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$500
The total Joe would pay is	$1,200

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist Copay	$25
Hospital (facility) Copay	$0
Other Copay	$75

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$330

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Notice

for MVP Commercial Plans

MVP Health Care® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MVP Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

What MVP Health Care Provides

Free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If You Need These Services

If you need these services, contact Jane Strange at **1-844-946-8009** (TTY: **1-800-662-1220**).

How to File a Grievance or Complaint

If you believe that MVP has not given you these services or has treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with MVP by:

Mail: ATTN: JANE STRANGE
CIVIL RIGHTS COORDINATOR
MVP HEALTH CARE
625 STATE ST
SCHENECTADY NY 12305

Phone: **1-844-946-8009**
(TTY/TDD: **1-800-662-1220**)

In person: 625 State Street, Schenectady, NY

Email: **civilrightscoordinator@mvphealthcare.com**

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights by:

Online: **ocrportal.hhs.gov**

Mail: US DEPT OF HEALTH & HUMAN SRVS
200 INDEPENDENCE AVE SW
HHH BLDG ROOM 509F
WASHINGTON DC 20201

Phone: **1-800-368-1019**
(TTY/TDD: **1-800-537-7697**)

Complaint forms are available by visiting **hhs.gov** and selecting *Laws & Regulations*, then *Complaints & Appeals*, then *Civil Rights: How to file a complaint*.

Multi-Language Interpreter Services

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia linguística. Llame al **1-844-946-8010** (TTY: **1-800-662-1220**).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-844-946-8010**（TTY：**1-800-662-1220**）。

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-844-946-8010** (телетайп: **1-800-662-122**0).

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-844-946-8010** (TTY: **1-800-662-1220**).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-844-946-8010** (TTY: **1-800-662-1220**) 번으로 전화해 주십시오.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-844-946-8010** (TTY: **1-800-662-1220**).

אידיש (Yiddish)
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (TTY: 1-800-662-1220) 1-844-946-8010.

বাংলা (Bengali) লক্ষ্য করনঃ যদি আপনি বাংলা, কথা বলেত পারেন, তাহেল নিঃখরচায় ভাষা সহায়তা পিরেষবা উপলব্ধ আছে। ফোন করন ১-844-946-8010 (TTY: ১-800-662-1220)।

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-844-946-8010** (TTY: **1-800-662-1220**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-946-8010 (رقم هاتف الصم والبكم: 1-800-266-0221).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-844-946-8010** (ATS : **1-800-662-1220**).

اُردُو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں . **1-844-946-8010** (TTY: **1-800-662-1220**)

Tagalog (Tagalog-Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-946-8010** (TTY: **1-800-662-1220**).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-844-946-8010** (TTY: **1-800-662-1220**).

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-844-946-8010** (TTY: **1-800-662-1220**).

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.mvphealthcare.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-888-687-6277 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network -$6,350 individual /$12,700 family	The out-of-pocket limit is the most you could pay in a year for covered services.If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.mvphealthcare.com or call 1-888-687-6277 for a list of network providers.	You pay the least if you use a provider in the Preferred Provider tier. You pay more if you use a provider in the In-Network tier. You will pay the most if you use an Out-of-Network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/office visit	$25 copay/office visit	Not covered	$0 copayment to age 26
	Specialist visit	$25 copay/office visit	$25 copay/office visit	Not covered	None
	Preventive care/screening/ immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - No charge; Lab Facility - No charge; Radiology Office - $25/visit; Radiology Facility - $0/visit	Lab Office - No charge; Lab Facility - No charge; Radiology Office - $25/visit ;Radiology Facility - $25/visit	Not covered	Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None
	Imaging (CT/PET scans, MRIs)	Office - $25 copay/procedure ; Facility - $0 copay/procedure	Office - $25 copay/procedure; Facility - $25 copay/procedure	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mvphealthcare.com	Tier 1 (Generic drugs)	$0/prescription	$0/prescription	Not covered	None
	Tier 2 (Preferred brand drugs)	Retail $30/prescription; Mail order $75/prescription	Retail $30/prescription; Mail order $75/prescription	Not covered	None
	Tier 3 (Non-preferred brand drugs)	Retail $50/prescription;Mail order $125/prescription	Retail $50/prescription;Mail order $125/prescription	Not covered	None
	Tier 4 Specialty drugs	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes	Not covered	Prior Authorization may be required. 30 day supply available through Specialty Pharmacy. Members required to use Caremark Specialty.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copay/day	$25 copay/day	Not covered	None
	Physician/surgeon fees	No charge	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	$75 copay/visit	None
	Emergency medical transportation	$50 copay/trip	$50 copay/trip	$50 copay/trip	None
	Urgent care	$25 copay/visit	$25 copay/visit	$25 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	Per continuous confinement
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	$25 copay/visit	Not covered	None
	Inpatient services	No charge	No charge	Not covered	Including residential treatment

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay, coinsurance, and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	Not covered	
	Childbirth/delivery facility services	No charge	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	$25 copay/visit	$25 copay/visit	Not covered	None
	Rehabilitation services/ Habilitation services	OP ReHab: $25 copay/visit IP ReHab: No charge	OP ReHab: $25 copay/visit IP ReHab: No charge	OP ReHab: Not covered IP ReHab: Not covered	OP ReHab: 30 visits per Calendar Year combined therapies IP ReHab: 60 days per Calendar Year combined therapies
	Skilled nursing care	No charge	No charge	Not covered	45 days per Calendar Year
	Durable medical equipment	50% coinsurance	50% coinsurance	Not covered	None
	Hospice services	No charge	No charge	Not covered	210 days per Calendar year, 5 visits for family bereavement counseling

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$25 copay/exam	$25 copay/exam	Not covered	One exam every 2 Calendar Years
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	$25 copay/visit	$25 copay/visit	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's Glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency care when traveling outside the U.S
- Private-Duty Nursing
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

MVP Health Care
P.O. Box 2207
Schenectady, NY 12301
Toll Free: 1-888-687-6277
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

MVP Health Care
Attn: Member Appeals
P.O.Box 2207
Schenectady, NY 12301
Toll Free:1-888-687-6277
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the NYS Department of Insurance at 1-800-342-3736 or dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Health Advocates at 1-888-614-5400 or communityhealthadvocates.org.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? No.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $0
- **Specialist** Copay $25
- **Hospital (facility)** Copay $0
- **Other** Copay $0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	$120

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $0
- **Specialist** Copay $25
- **Hospital (facility)** Copay $0
- **Other** Copay $25

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$500
The total Joe would pay is	$1,200

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $0
- **Specialist** Copay $25
- **Hospital (facility)** Copay $0
- **Other** Copay $75

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$330

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Notice

for MVP Commercial Plans

MVP Health Care® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MVP Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

What MVP Health Care Provides

Free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If You Need These Services

If you need these services, contact Jane Strange at **1-844-946-8009** (TTY: **1-800-662-1220**).

How to File a Grievance or Complaint

If you believe that MVP has not given you these services or has treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with MVP by:

Mail: ATTN: JANE STRANGE
CIVIL RIGHTS COORDINATOR
MVP HEALTH CARE
625 STATE ST
SCHENECTADY NY 12305

Phone: **1-844-946-8009**
(TTY/TDD: **1-800-662-1220**)

In person: 625 State Street, Schenectady, NY

Email: **civilrightscoordinator@mvphealthcare.com**

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights by:

Online: **ocrportal.hhs.gov**

Mail: US DEPT OF HEALTH & HUMAN SRVS
200 INDEPENDENCE AVE SW
HHH BLDG ROOM 509F
WASHINGTON DC 20201

Phone: **1-800-368-1019**
(TTY/TDD: **1-800-537-7697**)

Complaint forms are available by visiting **hhs.gov** and selecting *Laws & Regulations*, then *Complaints & Appeals*, then *Civil Rights: How to file a complaint*.

Multi-Language Interpreter Services

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia linguística. Llame al **1-844-946-8010** (TTY: **1-800-662-1220**).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-844-946-8010**（TTY：**1-800-662-1220**）。

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-844-946-8010** (телетайп: **1-800-662-122**0).

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-844-946-8010** (TTY: **1-800-662-1220**).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-844-946-8010** (TTY: **1-800-662-1220**) 번으로 전화해 주십시오.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-844-946-8010** (TTY: **1-800-662-1220**).

אידיש (Yiddish)
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (TTY: 1-800-662-1220) 1-844-946-8010.

বাংলা (Bengali) লক্ষ্য করনঃ যদি আপনি বাংলা, কথা বলেত পারেন, তাহেল নিঃখরচায় ভাষা সহায়তা পিরেষবা উপলব্ধ আছে। ফোন করন ১-844-946-8010 (TTY: ১-800-662-1220)।

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-844-946-8010** (TTY: **1-800-662-1220**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-946-8010 (رقم هاتف الصم والبكم: 1-800-266-0221).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-844-946-8010** (ATS : **1-800-662-1220**).

اُردُو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں . **1-844-946-8010** (TTY: **1-800-662-1220**)

Tagalog (Tagalog-Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-946-8010** (TTY: **1-800-662-1220**).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-844-946-8010** (TTY: **1-800-662-1220**).

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-844-946-8010** (TTY: **1-800-662-1220**).

HMO Schedule of Benefits

Schedule of Member Payments
Embedded Out of Pocket Maximum
MVP Health Plan, Inc.
NYSHIP07HMO2525ZLAPN

Cost-Sharing	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider services are not Covered except as required for emergency care
Medical Deductible			
•□Individual	None	None	
•□Family	None	None	
Out-Of-Pocket Limit			Preferred and Participating Provider Out-of-Pockets Limits are Combined
•□Individual	$6,350	$6,350	
•□Family	$12,700	$12,700	

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	NA	$25 Copayment $0 Copayment to age 26	See benefit for description All Copayment and Coinsurance requirements are per visit
Specialist Office Visits (or Home Visits)	NA	$25 Copayment	See benefit for description All Copayment and Coinsurance requirements are per visit

Preventive Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Well Child Visits and Immunizations*	NA	Covered in Full	See benefit for description
Adult Annual Physical Examinations*	NA	Covered in Full	
Adult Immunizations*	NA	Covered in Full	
Routine Gynecological Services/Well Woman Exams*	NA	Covered in Full	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	NA	Covered in Full	

Sterilization Procedures for Women*	NA	Covered in Full	
Vasectomy	NA	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)	
Bone Density Testing*	NA	Covered in Full	
Screening for Prostate Cancer	Covered in Full	Covered in Full	
All other preventive services required by USPSTF and HRSA.	NA	Covered in Full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	NA	Use Cost-Sharing for appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
Emergency Care	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services) **Cost Share applies to both participating and non- participating providers**	NA	$50 Copayment	See benefit for description
Non-Emergency Ambulance Services	NA	$50 Copayment	See benefit for description
Emergency Department Cost Share applies to both participating and non- participating providers Copayment waived if admitted to Hospital	NA	$75 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	NA	$25 Copayment	See benefit for description
Professional Services and Outpatient Care	**Preferred Provider Member Responsibility for**	**Participating Provider Member Responsibility for**	**Limits**

	Cost-Sharing	Cost-Sharing	
Advanced Imaging Services			
•□Performed in a Specialist Office	NA	$25 Copayment	See benefit for description
•□Performed in a Freestanding Radiology Facility	$0 Copayment	$25 Copayment	
•□Performed as Outpatient Hospital Services	$0 Copayment	$25 Copayment	
Allergy Testing and Treatment			
•□Performed in a PCP Office	NA	Covered in Full	See benefit for description
•□Performed in a Specialist Office	NA	Covered in Full	
Ambulatory Surgical Center Facility Fee	$0 Copayment	$25 Copayment	See benefit for description
Anesthesia Services (all settings)	NA	Covered in Full	See benefit for description
Autologous Blood Banking	NA	Covered in Full	See benefits for description
Cardiac and Pulmonary Rehabilitation			
•□Performed in a Specialist Office	NA	$0 Copayment	36 visits per Calendar Year
•□Performed as Outpatient Hospital Services	NA	$0 Copayment	
•□Performed as Inpatient Hospital Services	NA	Included as part of Inpatient Hospital Service Cost Sharing	
Chemotherapy and Immunotherapy			
•□Performed in a PCP Office	NA	$25 Copayment	See benefit for description
•□Performed in a Specialist Office	NA	$25 Copayment	
•□Performed as Outpatient Hospital Services	NA	$25 Copayment	
Chiropractic Services	NA	$25 Copayment	See benefit for description
Clinical Trials	NA	Use Cost-Sharing for Appropriate Service	See benefit for description
Diagnostic Testing			See benefit for description

•□Performed in a PCP Office	NA	$25 Copayment	
•□Performed in a Specialist Office	NA	$25 Copayment	
•□Performed as Outpatient Hospital Services	NA	$25 Copayment	
Dialysis			
•□Performed in a PCP Office	NA	$25 Copayment	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10 visits per Calendar Year and requires authorization for the out of network
•□Performed in a Specialist Office	NA	$25 Copayment	
•□Performed in a Freestanding Center	NA	$25 Copayment	
•□Performed as Outpatient Hospital Services	NA	$25 Copayment	
Home Health Care	NA	$25 Copayment	See benefit for description
Infertility Services	NA	Use Cost-Sharing for appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy			
•□Performed in a PCP Office	NA	$25 Copayment	
•□Performed in Specialist Office	NA	$25 Copayment	See benefit for description
•□Performed as Outpatient Hospital Services	NA	$25 Copayment	
•□Home Infusion Therapy	NA	Covered in Full	
Inpatient Medical Visits	NA	Covered in Full	See benefit for description
Interruption of Pregnancy			
•□ Medically Necessary Abortions	Covered in Full	Covered in Full	Unlimited One (1) procedure per Calendar Year
•□ Elective Abortions	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge	

Laboratory Procedures			See benefit for description
•□Performed in a PCP Office	NA	Covered in Full	
•□Performed in a Specialist Office	NA	Covered in Full	
•□Performed in a Freestanding Laboratory Facility	$0 Copayment	Covered in Full	
•□Performed as Outpatient Hospital Services	$0 Copayment	Covered in Full	
Maternity and Newborn Care			See benefit for description
•□Prenatal Care		Covered in Full	
-□ Provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	NA		One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
-□ Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	NA	Use Cost-Sharing for appropriate service Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing	
•□Inpatient Hospital Services and Birthing Center	NA	Covered in Full	Covered for duration of breast feeding. Must use designated provider.
•□Physician and Midwife Services for Delivery	NA	Covered in Full	
•□Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	NA	Covered in Full	
•□Postnatal Care	NA	Included as part of the surgeon's cost share for delivery	
Outpatient Hospital Surgery Facility Charge	$0 Copayment	$25 Copayment	See benefit for description
Preadmission Testing	NA	Covered in Full	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
•□Performed in a PCP Office	NA	Included as part of the PCP office visit Cost-Sharing	

•□Performed in Specialist Office	NA	Included as part of the Specialist office visit Cost-Sharing	
•□Performed in an Outpatient Facility	NA	Covered in Full	
Diagnostic Radiology Services			
•□Performed in a PCP Office	NA	$25 Copayment	
•□Performed in a Specialist Office	NA	$25 Copayment	See benefit for description
•□Performed in a Freestanding Radiology Facility	$0 Copayment	$25 Copayment	
•□Performed as Outpatient Hospital Services	$0 Copayment	$25 Copayment	
Therapeutic Radiology Services			
•□Performed in a Specialist Office	NA	$25 Copayment	See benefit for description
•□Performed in a Freestanding Radiology Facility	$0 Copayment	$25 Copayment	
•□Performed as Outpatient Hospital Services	$0 Copayment	$25 Copayment	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)		$25 Copayment	30 visits per Calendar Year, combined therapies
•□Performed in a PCP Office	NA	$25 Copayment	
•□Performed in a Specialist Office	NA	$25 Copayment	
•□Performed in an Outpatient Facility	NA		
Second Opinions on the Diagnosis of Cancer, Surgery and Other	NA	$25 Copayment	See benefit for description Non-Participating Provider services are not covered, and You pay the full cost Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-

			Participating Specialist
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery and Transplants)			See benefit for description **All Transplants must be performed at designated Facilities and require Prior Authorization**
• Inpatient Hospital Surgery	NA	Covered in Full	All inpatient admissions require notification to MVP. Select procedures are reviewed prior to admission Certain procedures whether done in office, outpatient hospital, ambulatory surgery center or office require prior authorization; your participating provider has a list of these procedures
• Outpatient Hospital Surgery	NA	Covered in Full	
• Surgery Performed at an Ambulatory Surgical Center	NA	Covered in Full	
• Office Surgery	NA	$25 Copayment	
Telemedicine Program	NA	Covered in Full	See benefit for description
Additional Services, Equipment and Devices	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	NA	$25 Copayment	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	NA	$25 Copayment	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
• Diabetic Equipment, Supplies and Insulin (30-day supply)	NA	$25 Copayment	
• Diabetic Education	NA	$25 Copayment	
Durable Medical Equipment and Braces	NA	50% Coinsurance	See benefit for description
Cochlear Implants	NA	See Surgical Services; internal Prosthetic Devices Cost-Sharing	One (1) Per Ear Per Time Covered
Hospice Care • Inpatient	NA	Covered in Full	210 days per Calendar Year; Five (5) visits for family

• Outpatient	NA	Covered in Full	bereavement counseling
Medical Supplies	NA	50% Coinsurance	See benefit for description
Out of Service Area	NA	Use Cost-Sharing for Appropriate Service	Up to $2500 in out of service area covered benefits per member, per Calendar Year. See benefit for description Use of this benefit does not eliminate the need for prior authorization or medical necessity on services that would otherwise require Prior Approval
Prosthetic Devices •□External	NA	50% Coinsurance	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements; See benefit for description
•□Internal	NA	Covered in Full	Unlimited; See benefit for description
Inpatient Services and Facilities	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	NA	Covered in Full	See benefit for description
Observation Stay	NA	Covered in Full	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	NA	Covered in Full	45 days per Calendar Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	NA	Covered in Full	60 days per Calendar Year, combined therapies
Mental Health and Substance Use Disorder Services	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous	NA	Covered in Full	See benefit for description

confinement when in a Hospital including Residential Treatment			
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	NA	$25 Copayment	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital including Residential Treatment	NA	Covered in Full	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	NA	$25 Copayment	Unlimited; Up to 20 visits per Calendar Year may be used for family counseling
Wellness Benefits	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Wellness Program	NA	Up to $200 earnable for completing activities through MVP's Website and up to $200 reimbursement for participation in WellBeing program and activities and up to $200 for tracking steps via MVP's Connected! program	See benefit for description **Up to $600 per Calendar Year**
Pediatric Dental Care and Vision Care	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care			
• Preventive Dental Care	NA	$25 Copayment	See benefit for description
Vision Care			
• Exams	Na	$25 Copayment	One (1) Exam Per Two (2) Calendar Years
• Lenses & Frames	NA	Not a Covered Benefit	
• Contact Lenses	NA	Not a Covered Benefit	

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the full cost of the services.

HMO Schedule of Benefits

Schedule of Member Payments
Embedded Out of Pocket Maximum
MVP Health Plan, Inc.
NYSHIP07HMO2525XLAPN

Cost-Sharing	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider services are not Covered except as required for emergency care
Medical Deductible			
•□Individual	None	None	
•□Family	None	None	
Out-Of-Pocket Limit			Preferred and Participating Provider Out-of-Pockets Limits are Combined
•□Individual	$6,350	$6,350	
•□Family	$12,700	$12,700	

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	NA	$25 Copayment $0 Copayment to age 26	See benefit for description All Copayment and Coinsurance requirements are per visit
Specialist Office Visits (or Home Visits)	NA	$25 Copayment	See benefit for description All Copayment and Coinsurance requirements are per visit

Preventive Care	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Limits
Well Child Visits and Immunizations*	NA	Covered in Full	See benefit for description
Adult Annual Physical Examinations*	NA	Covered in Full	
Adult Immunizations*	NA	Covered in Full	
Routine Gynecological Services/Well Woman Exams*	NA	Covered in Full	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	NA	Covered in Full	

Sterilization Procedures for Women*	NA	Covered in Full	
Vasectomy	NA	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)	
Bone Density Testing*	NA	Covered in Full	
Screening for Prostate Cancer	Covered in Full	Covered in Full	
All other preventive services required by USPSTF and HRSA.	NA	Covered in Full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	NA	Use Cost-Sharing for appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
Emergency Care	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services) **Cost Share applies to both participating and non- participating providers**	NA	$50 Copayment	See benefit for description
Non-Emergency Ambulance Services	NA	$50 Copayment	See benefit for description
Emergency Department Cost Share applies to both participating and non- participating providers Copayment waived if admitted to Hospital	NA	$75 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	NA	$25 Copayment	See benefit for description
Professional Services and Outpatient Care	**Preferred Provider Member Responsibility for**	**Participating Provider Member Responsibility for**	**Limits**

	Cost-Sharing	Cost-Sharing	
Advanced Imaging Services			
•□Performed in a Specialist Office	NA	$25 Copayment	See benefit for description
•□Performed in a Freestanding Radiology Facility	$0 Copayment	$25 Copayment	
•□Performed as Outpatient Hospital Services	$0 Copayment	$25 Copayment	
Allergy Testing and Treatment			
•□Performed in a PCP Office	NA	Covered in Full	See benefit for description
•□Performed in a Specialist Office	NA	Covered in Full	
Ambulatory Surgical Center Facility Fee	$0 Copayment	$25 Copayment	See benefit for description
Anesthesia Services (all settings)	NA	Covered in Full	See benefit for description
Autologous Blood Banking	NA	Covered in Full	See benefits for description
Cardiac and Pulmonary Rehabilitation			
•□Performed in a Specialist Office	NA	$0 Copayment	36 visits per Calendar Year
•□Performed as Outpatient Hospital Services	NA	$0 Copayment	
•□Performed as Inpatient Hospital Services	NA	Included as part of Inpatient Hospital Service Cost Sharing	
Chemotherapy and Immunotherapy			
•□Performed in a PCP Office	NA	$25 Copayment	See benefit for description
•□Performed in a Specialist Office	NA	$25 Copayment	
•□Performed as Outpatient Hospital Services	NA	$25 Copayment	
Chiropractic Services	NA	$25 Copayment	See benefit for description
Clinical Trials	NA	Use Cost-Sharing for Appropriate Service	See benefit for description
Diagnostic Testing			See benefit for description

•□Performed in a PCP Office	NA	$25 Copayment	
•□Performed in a Specialist Office	NA	$25 Copayment	
•□Performed as Outpatient Hospital Services	NA	$25 Copayment	
Dialysis			
•□Performed in a PCP Office	NA	$25 Copayment	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10 visits per Calendar Year and requires authorization for the out of network
•□Performed in a Specialist Office	NA	$25 Copayment	
•□Performed in a Freestanding Center	NA	$25 Copayment	
•□Performed as Outpatient Hospital Services	NA	$25 Copayment	
Home Health Care	NA	$25 Copayment	See benefit for description
Infertility Services	NA	Use Cost-Sharing for appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy			
•□Performed in a PCP Office	NA	$25 Copayment	
•□Performed in Specialist Office	NA	$25 Copayment	See benefit for description
•□Performed as Outpatient Hospital Services	NA	$25 Copayment	
•□Home Infusion Therapy	NA	Covered in Full	
Inpatient Medical Visits	NA	Covered in Full	See benefit for description
Interruption of Pregnancy			
•□ Medically Necessary Abortions	Covered in Full	Covered in Full	Unlimited One (1) procedure per Calendar Year
•□ Elective Abortions	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge	

Laboratory Procedures			See benefit for description
•□Performed in a PCP Office	NA	Covered in Full	
•□Performed in a Specialist Office	NA	Covered in Full	
•□Performed in a Freestanding Laboratory Facility	$0 Copayment	Covered in Full	
•□Performed as Outpatient Hospital Services	$0 Copayment	Covered in Full	
Maternity and Newborn Care			See benefit for description
•□Prenatal Care		Covered in Full	
-□ Provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	NA		One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
-□ Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	NA	Use Cost-Sharing for appropriate service Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing	
•□Inpatient Hospital Services and Birthing Center	NA	Covered in Full	Covered for duration of breast feeding. Must use designated provider.
•□Physician and Midwife Services for Delivery	NA	Covered in Full	
•□Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	NA	Covered in Full	
•□Postnatal Care	NA	Included as part of the surgeon's cost share for delivery	
Outpatient Hospital Surgery Facility Charge	$0 Copayment	$25 Copayment	See benefit for description
Preadmission Testing	NA	Covered in Full	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
•□Performed in a PCP Office	NA	Included as part of the PCP office visit Cost-Sharing	

•□Performed in Specialist Office	NA	Included as part of the Specialist office visit Cost-Sharing	
•□Performed in an Outpatient Facility	NA	Covered in Full	
Diagnostic Radiology Services			
•□Performed in a PCP Office	NA	$25 Copayment	
•□Performed in a Specialist Office	NA	$25 Copayment	See benefit for description
•□Performed in a Freestanding Radiology Facility	$0 Copayment	$25 Copayment	
•□Performed as Outpatient Hospital Services	$0 Copayment	$25 Copayment	
Therapeutic Radiology Services			
•□Performed in a Specialist Office	NA	$25 Copayment	See benefit for description
•□Performed in a Freestanding Radiology Facility	$0 Copayment	$25 Copayment	
•□Performed as Outpatient Hospital Services	$0 Copayment	$25 Copayment	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)		$25 Copayment	30 visits per Calendar Year, combined therapies
•□Performed in a PCP Office	NA	$25 Copayment	
•□Performed in a Specialist Office	NA	$25 Copayment	
•□Performed in an Outpatient Facility	NA		
Second Opinions on the Diagnosis of Cancer, Surgery and Other	NA	$25 Copayment	See benefit for description Non-Participating Provider services are not covered, and You pay the full cost Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-

			Participating Specialist
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery and Transplants)			See benefit for description **All Transplants must be performed at designated Facilities and require Prior Authorization**
• Inpatient Hospital Surgery	NA	Covered in Full	All inpatient admissions require notification to MVP. Select procedures are reviewed prior to admission Certain procedures whether done in office, outpatient hospital, ambulatory surgery center or office require prior authorization; your participating provider has a list of these procedures
• Outpatient Hospital Surgery	NA	Covered in Full	
• Surgery Performed at an Ambulatory Surgical Center	NA	Covered in Full	
• Office Surgery	NA	$25 Copayment	
Telemedicine Program	NA	Covered in Full	See benefit for description
Additional Services, Equipment and Devices	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	NA	$25 Copayment	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	NA	$25 Copayment	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
• Diabetic Equipment, Supplies and Insulin (30-day supply)	NA	$25 Copayment	
• Diabetic Education	NA	$25 Copayment	
Durable Medical Equipment and Braces	NA	50% Coinsurance	See benefit for description
Cochlear Implants	NA	See Surgical Services; internal Prosthetic Devices Cost-Sharing	One (1) Per Ear Per Time Covered
Hospice Care • Inpatient	NA	Covered in Full	210 days per Calendar Year; Five (5) visits for family

• Outpatient	NA	Covered in Full	bereavement counseling
Medical Supplies	NA	50% Coinsurance	See benefit for description
Out of Service Area	NA	Use Cost-Sharing for Appropriate Service	Up to $2500 in out of service area covered benefits per member, per Calendar Year. See benefit for description Use of this benefit does not eliminate the need for prior authorization or medical necessity on services that would otherwise require Prior Approval
Prosthetic Devices •□External	NA	50% Coinsurance	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements; See benefit for description
•□Internal	NA	Covered in Full	Unlimited; See benefit for description
Inpatient Services and Facilities	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	NA	Covered in Full	See benefit for description
Observation Stay	NA	Covered in Full	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	NA	Covered in Full	45 days per Calendar Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	NA	Covered in Full	60 days per Calendar Year, combined therapies
Mental Health and Substance Use Disorder Services	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous	NA	Covered in Full	See benefit for description

confinement when in a Hospital including Residential Treatment			
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	NA	$25 Copayment	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital including Residential Treatment	NA	Covered in Full	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	NA	$25 Copayment	Unlimited; Up to 20 visits per Calendar Year may be used for family counseling
Prescription Drugs *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy – *30-day supply* •□Tier 1 •□Tier 2 •□Tier 3 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal	 NA NA NA	 $0 Copayment $30 Copayment $50 Copayment	See benefit for description

and/or stabilization and for opioid overdose reversal			
Up to a 90-day supply for Maintenance Drugs • Tier 1 • Tier 2 • Tier 3	 NA NA NA	 $0 Copayment $30 Copayment $50 Copayment	See benefit for description
Mail Order Pharmacy – *Up to a 90-day supply* • Tier 1 • Tier 2 • Tier 3 • Enteral Formulas	 NA NA NA NA	 $0 Copayment $75 Copayment $125 Copayment Subject to the applicable pharmacy Copayments and days' supply per dispensing	See benefit for description
Wellness Benefits	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Wellness Program	NA	Up to $200 earnable for completing activities through MVP's Website and up to $200 reimbursement for participation in WellBeing program and activities and up to $200 for tracking steps via MVP's Connected! program	See benefit for description **Up to $600 per Calendar Year**
Pediatric Dental Care and Vision Care	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care	 NA	 $25 Copayment	 See benefit for description
Vision Care • Exams • Lenses & Frames • Contact Lenses	 NA NA NA	 $25 Copayment Not a Covered Benefit Not a Covered Benefit	 One (1) Exam Per Two (2) Calendar Years

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the full cost of the services.

Lower your health care costs with preferred provider facilities.

MVP Health Care® preferred provider facilities give you lower-cost options for laboratory, radiology, and ambulatory/outpatient surgery services—without compromising quality.

Pay as little as $0!

If your plan is not subject to an annual deductible, medically necessary services are covered in full from day one at MVP preferred provider facilities.

If your plan is subject to an annual deductible, you can save on out-of-pocket costs at MVP preferred provider facilities until your deductible is met, then medically necessary services are covered in full.

How much money can you save by visiting a preferred provider facility?

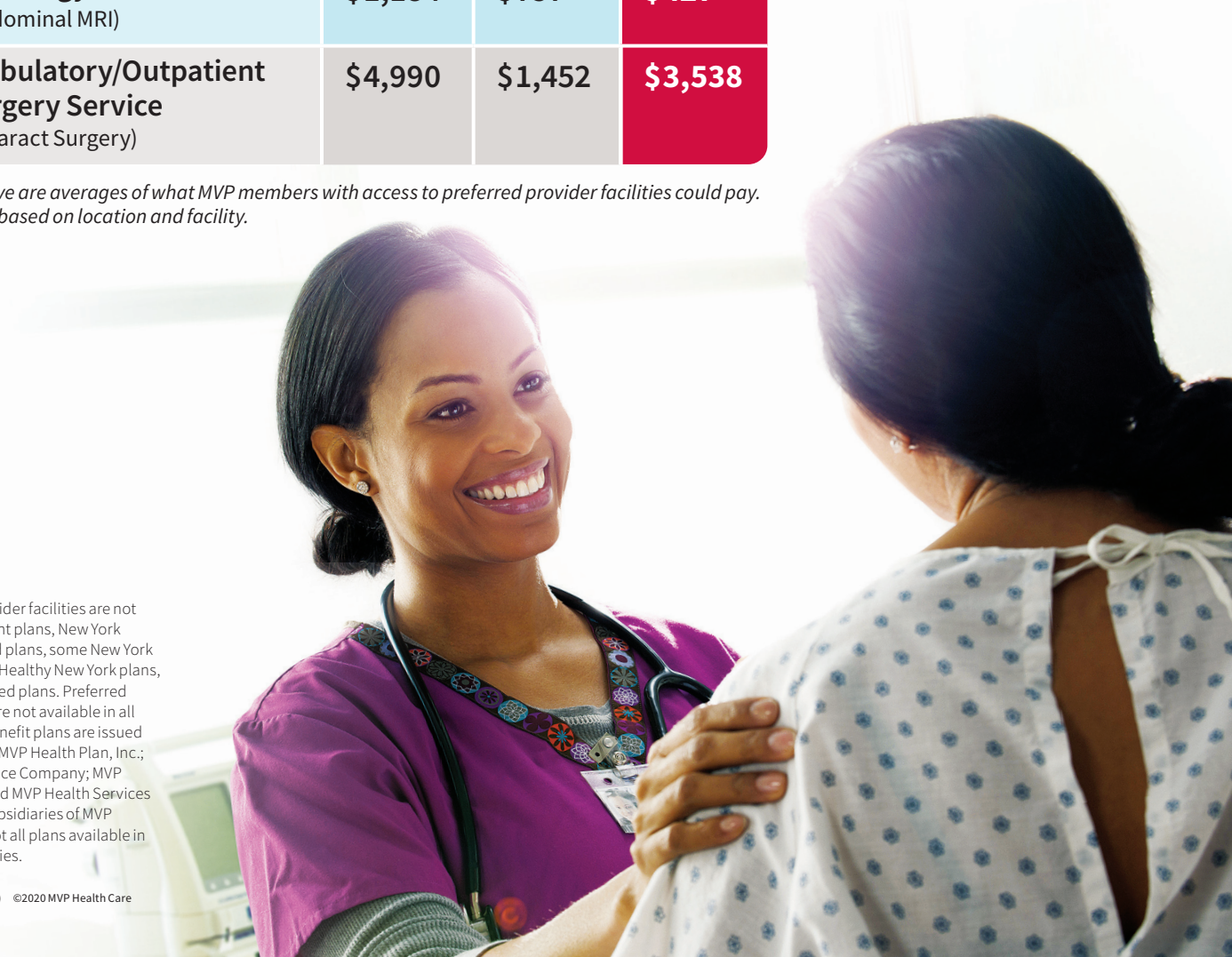
	Facility A *Non-Preferred*	Facility B *Preferred*	Your Savings
Laboratory Service (Comprehensive Metabolic Screening and Lipid Panel)	$172	$40	$132
Radiology Service (Abdominal MRI)	$1,184	$757	$427
Ambulatory/Outpatient Surgery Service (Cataract Surgery)	$4,990	$1,452	$3,538

The figures above are averages of what MVP members with access to preferred provider facilities could pay. Costs may vary based on location and facility.

Find an MVP preferred provider facility near you.

Visit **mvphealthcare.com/findadoctor** and simply *Sign In* to your online account, then select *Preferred Provider Facilities* to see a list of participating facilities.

Or, call the MVP Customer Care Center phone number listed on the back of your MVP Member ID card.



MVP preferred provider facilities are not available on Vermont plans, New York Individual Standard plans, some New York Large Group plans, Healthy New York plans, and some self-funded plans. Preferred provider facilities are not available in all counties. Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

TO: **M□□ New York State Employees/Retirees**
FROM: **MVP Health Care**
DATE: **Effective January 1, 2021**
RE: **Option Transfer Period**

You now have an opportunity to enroll in MVP Health Care – a Health Maintenance Organization (HMO) serving the following New York State Counties:

NYSHIP CODE #060 **COUNTIES INCLUDED**
Albany, Columbia, Fulton, Greene, Hamilton, Jefferson, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington

NYSHIP CODE #058 **COUNTIES INCLUDED**
Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates

NYSHIP CODE #330 **COUNTIES INCLUDED**
Broome, Cayuga, Chemung, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Schuyler, Tioga and Tompkins

NYSHIP CODE #340 **COUNTIES INCLUDED**
Dutchess, Orange, Putnam**,** Rockland**,** Sullivan, Ulster and Westchester

NYSHIP CODE #360 **COUNTIES INCLUDED**
Clinton, Essex, Franklin and St. Lawrence

MVP Plan Highlights

- $25 PCP/$25 Specialist office visit copayment
- **NEW!** $0 PCP office visit copayment to age 26
- **NEW!** $0 Telemedicine services
- Prescription drug benefit: (for enrollees not eligible for prescription drug benefits through a union benefit fund)
  - **NEW!** Retail: **$0 Tier 1 generic**, $30 Tier 2 formulary brand, $50 Tier 3 non-formulary brand (30 day supply)
  - Mail-Order: **$0 Tier 1 generic**, $75 Tier 2 formulary brand, $125 Tier 3 non-formulary brand (up to 90 day supply)
- Prescription benefits include 100% coverage for oral contraceptives
- **NEW!** Preferred provider facilities benefit - $0 copayment for laboratory, radiology, and ambulatory / outpatient surgery services at preferred facilities
- Routine preventive care services covered in full
- Out-of-Area student coverage

Your Eligibility Guidelines may be different from those guidelines listed in the contract. Please refer to your NYSHIP General Information Book for these guidelines or visit the New York State Department of Civil Service's website at www.cs.ny.gov.

TO ENROLL:

Active Employees Complete a PS 404 and an HMO enrollment form in your Agency Health Benefits Administrator's Office. The Department of Civil Service Division of Employee Benefits will distribute payroll deductions.

Retired Employees Complete the Option Change Coupon found in the Benefit Choices Brochure and return it to the Department of Civil Service.

Questions? Call **1-888-687-6277** or visit **www.mvphealthcare.com**

Privacy Notice

MVP Health Plan Inc., MVP Health Services Corp., MVP Health Insurance Company, and Hudson Health Plan, Inc.

Effective Date

This Notice of Privacy Practices is effective as of April 1, 2014 and revised May 25, 2017.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

MVP Health Plan, Inc., MVP Health Services Corp., MVP Health Insurance Company, and Hudson Health Plan, Inc. (collectively "MVP") respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, provide you with this notice of our privacy practices and legal duties and to abide by the terms of this notice.

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and state laws and regulations regarding the confidentiality of health information, MVP provides this notice to explain how we may use and disclose your health information to carry out payment and health care operations and for other purposes permitted or required by law. Health information is defined as enrollment, eligibility, benefit, claim, and any other information that relates to your past, present, or future physical or mental health.

The terms and conditions of this privacy notice supplement any other communications, policies, or notices that MVP may have provided regarding your health information. In the event of conflict between this notice and any other MVP communications, policies, or notices, the terms and conditions of this notice shall prevail.

MVP's Duties Regarding Your Health Information

MVP is required by law to:

- Maintain the privacy of information about your health in all forms including oral, written, and electronic.
- Train all MVP employees in the protection of oral, written, and electronic protected health information (PHI).
- Limit access to MVP's physical facility and information systems to the required minimum necessary to provide services.
- Maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard PHI.
- Notify you following a breach of unsecured health information.
- Provide you with this notice of our legal duties and health information privacy rules.
- Abide by the terms of this notice.

We reserve the right to change the terms of this notice at any time, consistent with applicable law, and to make those changes effective for health information we already have about you. Once revised, we will advise you that the notice has been updated, provide you with information on how to obtain the updated notice, and will post it on **mvphealthcare.com**.

How We Use or Disclose Your Health Information

As a member, you agree to let MVP share information about you for treatment, payment, and health care operations. The following are ways we may use or disclose your health information.

For treatment. We may share your health information with a physician or other health care

provider in order for them to provide you with treatment.

For payment. We may use and/or disclose your health information to collect premium payments, determine benefit coverage, or to provide payment to health care providers who render treatment on your behalf.

For health care operations. We may use or disclose your health information for health care operations that are necessary to enable us to arrange for the provision of health benefits, the payment of health claims, and to ensure that our members receive quality service. For example, we may use and disclose your health information to conduct quality assessment and improvement activities (including, e.g., surveys), case management and care coordination, licensing, credentialing, underwriting, premium rating, fraud and abuse detection, medical review, and legal services. We will not use or disclose your health information that is genetic information for underwriting purposes. We also use and disclose your health information to assist other health care providers in performing certain health care operations for those health care providers, such as quality assessment and improvement, reviewing the competence and qualifications of health care providers, and conducting fraud detection or investigation, provided that the information used or disclosed pertains to the relationship you had or have with the health care provider.

Health-related benefits and services. We may use or disclose your health information to tell you about alternative medical treatments and programs, or about health-related products and services that may be of interest to you.

Disclosures to a business associate. We may disclose your health information to other companies that perform certain functions on our behalf. These companies are called Business Associates. These Business Associates must agree in writing to protect your privacy and follow the same rules we do.

Disclosures to a plan sponsor. We may disclose limited information to the plan sponsor of your group health plan (usually your employer) so that the plan sponsor may obtain premium bids, modify, amend, or terminate your group health plan and perform enrollment functions on your behalf.

Disclosures to a third party representative. We may disclose to a Third Party Representative (family member, relative, friend, etc.) health information that is directly relevant to that person's involvement with your care or payment for care if we can reasonably infer that the person is involved in your care or payment for care and that you would not object.

Email communications to you. You agree that we may communicate via email with you regarding insurance premiums or for other purposes relating to your benefits, claims, or our products/services and that such communications (utilizing encryption software for our email transmissions) may contain confidential information, protected health information, or personally identifiable information.

Disclosures authorized by you. Except for the scenarios described in this notice, HIPAA prohibits the disclosure of your health information without first obtaining your authorization. MVP will not use or disclose your health information to engage in marketing, other than face to face communications, the offering of a promotional gift, or as set forth in this notice, unless you have authorized such use or disclosure. MVP will not use or disclose your health information for any reason other than those described above, unless you have provided authorization. We can accept an Authorization to Disclose Information form if you would like us to share your health information with someone for a reason we have not stated above. Using this form, you can designate whom you would like us to share information with, what information you would like us to share, and how long you want us to be able to share your information with that individual. A copy of this form is available by calling the MVP Customer Care Center or at **mvphealthcare.com**. You must complete this form and send it to the address or fax it to the fax number on the form. You can cancel this Authorization at any time in writing and per the requirements on the form.

Special Use and Disclosure Situations

Under certain circumstances, as required by law, MVP would be required to share your information without your permission. Some circumstances include the following.

Uses and Disclosures required by law. We may use and disclose health information about you when we are required to do so by federal, state, or local law.

Public health. We may disclose your health information for public health activities. These activities include preventing or controlling disease, injury, or disability; reporting births or deaths; or reporting reactions to medications or problems with medical products, or to notify people of recalls of products they have been using.

Health oversight. We may disclose your health information to a health oversight agency that monitors the health care system and government programs for designated oversight activities.

Legal proceedings. We may disclose your health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and, in certain situations, in response to a subpoena, discovery request, or other lawful process.

Law enforcement. We may disclose your health information, so long as applicable legal requirements are met, for law enforcement purposes.

Abuse or neglect. We may disclose your health information to a public health authority, or other government authority authorized by law to receive reports of child abuse, neglect, or domestic violence consistent with the requirements of applicable federal and state laws.

Coroners, funeral directors, and organ donation. We may disclose your health information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose your health information to funeral directors as necessary to carry out their duties. If you are an organ donor, we may release your health information for procurement, banking, or transplantation.

Research purposes. In certain circumstances, we may use and disclose your health information for research purposes.

Criminal activity. We may disclose your health information when necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Military activity. We may disclose your health information to authorized federal officials if you are a member of the military (or a veteran of the military).

National security. We may disclose your health information to authorized federal officials for national security, intelligence activities, and to enable them to provide protective services for the President and others.

Workers' compensation. We may disclose your health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

What Are Your Rights?

The following are your rights with respect to your health information. Requests for restrictions, confidential communications, accounting of disclosures, amendments to your health information, to inspect or copy your health information, or questions about this notice can be made by using the Contact Information below.

Right to request restrictions. You have the right to request a restriction or limitation on your health information we disclose for payment or health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment for your care, like a family member, relative, or friend. While we will try to honor your request, we are not legally required to agree to restrictions or limitations. If we agree, we will comply with your request or limitations except in emergency situations.

Right to request confidential communications. You have the right to request that we communicate with you about your health information in a certain way or at a certain location if the disclosure of information could endanger you. We will require the reason for the request and will accommodate all reasonable requests.

Right to an accounting of disclosures. You have the right to request an accounting of disclosures of your health information made by us other than those necessary to carry out treatment, payment, and health care operations, disclosures made to you or authorized by you, or in certain other situations.

Right to inspect and obtain copies of your health information. You have the right to inspect and obtain a copy of certain health information that we maintain. In limited circumstances, we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing of the reason for the denial and if applicable the right to have the denial reviewed.

Right to amend. If you feel that the health information we maintain about you is incomplete or inaccurate, you may ask us to amend the information. In certain circumstances we may deny your request. If we deny the request, we will explain your right to file a written statement of disagreement. If we approve your request, we will include the change in your health information and tell others that need to know about your changes.

Right to a copy of the notice of privacy practices. You have the right to obtain a copy of this notice at any time.

Exercising Your Rights

Unless you provide us with a written authorization, we will not use or disclosure your health information in any manner not covered by this notice. If you authorize us in writing to use or disclose your health information in a manner other than described in this notice, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your authorization; however, we will not reverse any uses or disclosures already made in reliance on your authorization before it was revoked.

You have a right to receive a paper copy of this notice at any time. You can also view this notice at **mvphealthcare.com**.

If you believe that your privacy rights have been violated, you may file a complaint by contacting an MVP Customer Care Representative at the address or phone number indicated in the Contact Information below.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request.

We Will Not Take Any Action Against You for Filing a Complaint

We will not retaliate in any way if you choose to file a complaint in good faith with us or with the U.S. Department of Health and Human Services. We support your rights to the privacy of your medical information.

Contact Information

MVP Medicaid Customer Care Center

1-800-852-7826 (TTY **1-800-662-1220**)

MVP Medicare Customer Care Center

1-800-665-7924 (TTY **1-800-662-1220**)

Customer Care Center for All Other MVP Members

1-888-687-6277 (TTY **1-800-662-1220**)

Mail all written communications to:

MVP CUSTOMER CARE CENTER
PO BOX 2207
SCHENECTADY NY 12301-2207

New York State Insurance Law Changes

Behavioral Health

Cost share and out-of-pocket expenses for inpatient and outpatient substance use disorder benefits, autism spectrum disorder benefits, and mental health must be consistent with those for all medical and surgical benefits. Other changes include:

- The co-pay/co-insurance for outpatient mental health services on all fully insured plans cannot exceed that of a primary care office visit.
- The Applied Behavior Analysis benefit cap (previously 680 hours per year) has been eliminated and there is no longer a benefit maximum.
- Prior authorization for medication-assisted substance use disorder treatment has been removed.
- The prohibition of concurrent utilization review for substance use disorder is extended from 14 to 28 days for inpatient treatment and from 14 to 28 visits for outpatient treatment.
- On Large Group plans, the co-pay/co-insurance for outpatient substance use disorder treatment cannot exceed that of a primary care office visit and only one co-pay can be charged for all services provided in a single day.

Applies to New York Large Group, Small Group, and Individual
Effective January 1, 2020 (MVP already provides coverage for some of the services included in this mandate.)

Contraception Coverage

All contraception approved by the Food and Drug Administration (FDA), is covered, including certain over-the counter female contraceptive products. Policies must also cover a 12-month supply of contraceptive at one time, removing the current, initial three-month supply requirement. Coverage is provided for emergency contraception without cost share. Voluntary sterlization procedures for women, patient education, counseling, and follow up contraception services are also covered.

Applies to New York Large Group, Small Group, and Individual
Effective January 1, 2020 (MVP already provides coverage for some of the services included in this mandate.)

Fertility Preservation

Coverage is required for standard fertility preservation services when a medical treatment directly or indirectly causes iatrogenic infertility, defined as an impairment by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. MVP will require prior authorization.

Applies to New York Large Group, Small Group, and Individual
Effective January 1, 2020, upon renewal

In-Vitro Fertilization (IVF)

Coverage is required for three (3) cycles of IVF used for the treatment of infertility. Coverage may be subject to annual deductible, co-insurance, and co-payment, but they must be in line with other costs within the policy. The new law also amends the definition of infertility, removing an age parameter of 21 to 44, and prohibits discrimination. MVP will cover three (3) cycles of IVF per lifetime and will require prior authorization.

Applies to New York Large Group
Effective January 1, 2020, upon renewal

Mammography Coverage

Fully insured Large Group plans must cover medically necessary annual mammograms for members ages 35 to 39.

Applies to New York Large Group
Effective MVP already provides coverage for these services

Maternal Depression Screening

Early screening and referral to treatment specialists for maternal depression is encouraged. Health plans that cover the child but not the mother must provide coverage for maternal depression screening under the child's policy if screening is performed by the Pediatrician.

Applies to New York Large Group, Small Group, and Individual
Effective MVP already provides coverage for these services

PrEP and HIV Screening

All fully insured commercial plans must provide coverage of Pre-Exposure Prophylaxis (PrEP) and screening for Human Immunodefficiency Virus (HIV) with no cost share.

Applies to New York Large Group, Small Group, and Individual
Effective January 1, 2020

Questions?

Contact your MVP Sales Representative or visit **mvphealthcare.com** and select *Contact Us*.

Earn up to $600 with WellBeing Rewards.

MVP Health Care® is committed to helping our members become healthier in all aspects of life by providing even more ways to earn rewards and get reimbursed.

Get rewarded for making healthy choices!

Earn up to $200 by completing any of the activities listed below. Each point earned is equal to $1.

Point-Earning Activities and Maximum Points	
Personal Health Assessment *(Required)*	**50**
myVisitNow® Registration *(One-time points earning activity)*	**25**
Biometric Screening or Health Risk Screening	**100**
Email/Text Sign-Up	**10**
ASH Connected!™ Activity Tracking	**200**
225,000 Steps/Movement Merits per Month	**50**
175,000 Steps/Movement Merits per Month	**35**
100,000 Steps/Movement Merits per Month	**25**
Online Classes (10 points per class; maximum of five)	**50**
Quarterly Well-Being Challenges (25 points per quarter)	**100**
Online Attestations (50 points for a Preventive Screening attestation; all others are 10 points each)	**100**

Earn an additional $200 with Connected! activity tracking.

Take your activity to the next level! Each quarter, track at least 750,000 steps/Movement Merits to earn an additional $50. Reach the goal every quarter to earn the full $200.

Receive up to $200 in reimbursements.

MVP will reimburse members for expenses associated with activities, tools, and apps that enhance their well-being.

See reverse side for more information about online tools.

Receive up to $600 per contract, per calendar year. The subscriber of the health plan must redeem all points by December 31 or they will be forfeited for that calendar year. $600 WellBeing Rewards is not available on Vermont Individual Standard plans, Vermont Small Group Standard plans, or New York Essential plans.

myVisitNow is a covered benefit on all fully insured plans and select self-funded plans.

Online tools that help you stay on track and earn rewards.

Know Your Numbers

Complete the online *Personal Health Assessment (PHA)*, a survey that helps you identify potential health risks to create a healthier lifestyle.

Get Connected!®

Sync your account to a variety of popular, wearable fitness devices and apps to track your activity online, anytime.* The more active you are, the more rewards you can earn! One step is equal to one Movement Merit. Earn 5,000 Movement Merits for every 30 minutes of activity (like biking, swimming, walking) and 10,000 Movement Merits for every workout tracked at a fitness center.

ASHConnect™

Track your physical activity and earn points by logging workout sessions at more than 41,000 fitness centers and select YMCA locations nationwide. To participate, you will need to download the **ASHConnect App** from the App Store® or Google Play.™

MSG&DATA rates may apply.

Challenge Yourself

Compete in quarterly well-being challenges.

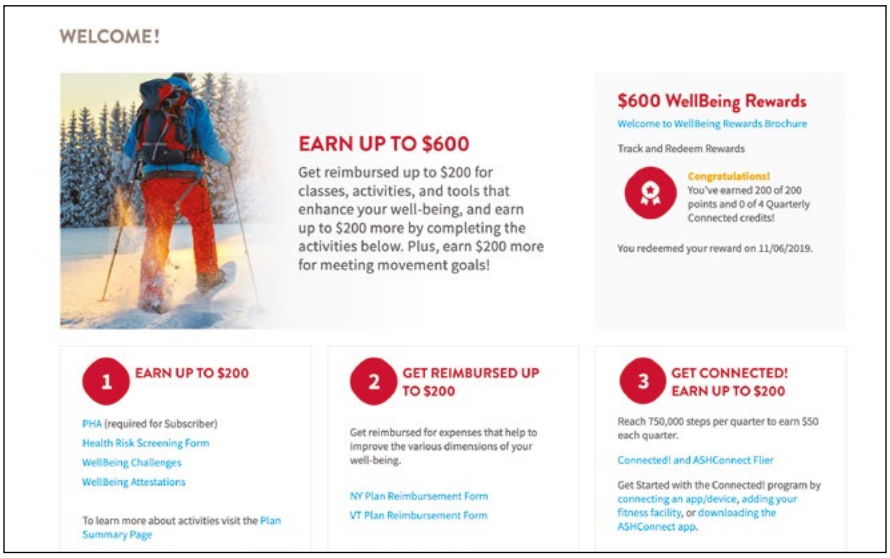
Document Your Progress

Show that you are taking steps toward improving your overall well-being by completing the online *WellBeing Rewards Attestations*.

Be Prepared with myVisitNow®

Register for **myVisitNow** online doctor visits and be prepared for when you may need care. Please note that these points may take up to four weeks to process—make sure you register by **December 1**. *Sign Up* at **myvisitnow.com**.

Earning and redeeming is as easy as 1-2-3!



1. **Sign In to your MVP online account**. Visit **mvphealthcare.com** and *Sign In* or *Register*, then select *Begin Your Path to Well-Being*.

2. **Complete activities and earn points**. Access your well-being homepage to see what tasks you have completed and if any still need your attention.

3. **Redeem your earned points**. Points can be redeemed in increments of $50. Don't forget that you must complete the PHA before the Redeem button will appear on your well-being homepage.

Important Deadlines: On January 15 of the new calendar year, your program will reset on your well-being homepage, and it will include credit for all activities completed beginning on January 1. All points must be redeemed no later than December 31 or they will be forfeited permanently.

*The Healthyroads® program and MVP do not cover the cost of wearable fitness devices/apps. The Healthyroads program is provided by American Specialty Health Management, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Healthyroads Connected! and ASHConnect are registered trademarks of ASH and used with permission herein. Other names and logos may be trademarks of their respective owners.

myVisitNow from MVP Health Care is powered by American Well. Regulatory restrictions may apply.

Healthyroads, a well-being program operated by American Specialty Health Management, Inc., (ASH Management), may use and/or provide your plan sponsor, or other entities that have contracted with your plan sponsor to administer your plan, with information (such as program activity points) involving your participation in our programs so that your plan sponsor or its contracted entity can administer the applicable incentive program. ASH Management may also use personal information obtained from your participation in our programs to provide you with other Healthyroads services on behalf of your plan sponsor. By participating in this program, you acknowledge that ASH Management may use and/or provide this information as stated above. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your plan sponsor and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Incentives may be taxable income that you are responsible to report.

Lower your health care costs with preferred provider facilities.

MVP Health Care® preferred provider facilities give you lower-cost options for laboratory, radiology, and ambulatory/outpatient surgery services—without compromising quality.

Pay as little as $0!

If your plan is not subject to an annual deductible, medically necessary services are covered in full from day one at MVP preferred provider facilities.

If your plan is subject to an annual deductible, you can save on out-of-pocket costs at MVP preferred provider facilities until your deductible is met, then medically necessary services are covered in full.

How much money can you save by visiting a preferred provider facility?

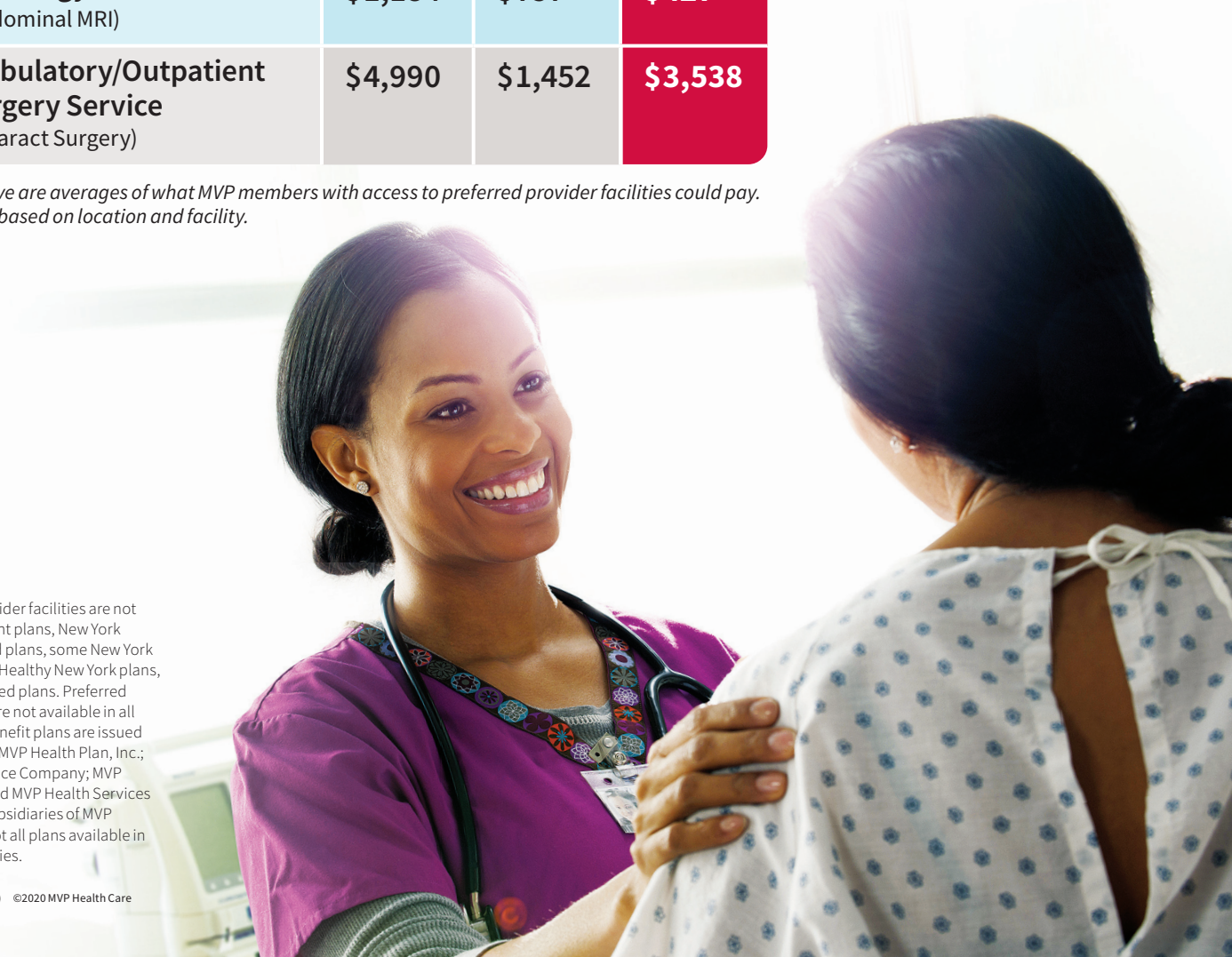
	Facility A *Non-Preferred*	Facility B *Preferred*	Your Savings
Laboratory Service (Comprehensive Metabolic Screening and Lipid Panel)	$172	$40	$132
Radiology Service (Abdominal MRI)	$1,184	$757	$427
Ambulatory/Outpatient Surgery Service (Cataract Surgery)	$4,990	$1,452	$3,538

The figures above are averages of what MVP members with access to preferred provider facilities could pay. Costs may vary based on location and facility.

Find an MVP preferred provider facility near you.

Visit **mvphealthcare.com/findadoctor** and simply *Sign In* to your online account, then select *Preferred Provider Facilities* to see a list of participating facilities.

Or, call the MVP Customer Care Center phone number listed on the back of your MVP Member ID card.



MVP preferred provider facilities are not available on Vermont plans, New York Individual Standard plans, some New York Large Group plans, Healthy New York plans, and some self-funded plans. Preferred provider facilities are not available in all counties. Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

MVP® HEALTH CARE | myVisitNow®

The doctor can see you now.

Join thousands of MVP Health Care® members who use **myVisitNow**®. Access 24/7 adult and pediatric urgent care and convenient, self-scheduled appointments with psychiatrists, behavioral health specialists, nutrition and diet specialists, and lactation consultants.

myVisitNow offers members:

Convenience. Have your visit at home, on-the-go, or anywhere from your smartphone, tablet, or computer with a webcam.

Confidentiality. Visits are HIPAA*-compliant, allowing you to meet safely and securely.

Availability. See an urgent care doctor within minutes, or self-schedule same- or next-day appointments.

Affordability. Co-pays will be the same as a sick visit to your Primary Care Physician (PCP). If you have a plan where the benefit is subject to the deductible, and have not met your annual deductible, you can save on out-of-pocket costs. To view costs specific to your health plan, *Log In* at **myvisitnow.com**.

Use myVisitNow for non-emergency† situations when you:

- Can't fit an appointment into your busy schedule
- Are traveling
- Need access to care for your children
- Feel too sick to drive
- Can't access your Primary Care Physician (PCP)

See reverse for steps on how to get started.

*HIPAA (Health Insurance Portability and Accountability Act of 1996) is United States legislation that provides data privacy and security provisions for safeguarding medical information.

† myVisitNow is not for life-threatening or emergency situations.

Getting started is easy.

Complete the registration form at **myvisitnow.com** and select *Sign Up*.

You'll be asked to provide basic information, such as your *Current Location*, *date of birth*, and *MVP Subscriber ID*. Once your health insurance information is verified, your account will be created.

Dependent and Spouse Registration

Dependents over the age of 18, including your spouse, must create their own account for claims to process accurately.

To register a dependent under the age of 18 on your account, *Log In* at **myvisitnow.com**, and choose *My Account*. Select *My Children*, then *Add*.

To register, your dependent(s) and spouse must use their MVP Member ID number.

Now, schedule your visit!

1 Choose the type of visit you want and select a provider.

Using your smartphone, tablet, or computer with a webcam, you'll be face-to-face with a health care professional within minutes or be able to schedule your visit, depending on the service selected.

2 Provide payment information.

Prior to your visit, you'll be presented with the appropriate cost. Simply provide your credit/debit card information and authorize payment.

3 Look for your visit summary and Explanation of Benefits (EOB).

After your appointment you'll receive a visit summary, which includes your diagnosis, treatment recommendations, and a prescription, if necessary. Share the visit summary with your PCP so he/she is informed of your health history. A claim will automatically be generated and sent to MVP for processing. Once the claim is processed, you'll receive an EOB.

myVisitNow services:

- 24/7 Adult Urgent Care
- 24/7 Pediatric Urgent Care
- Behavioral Health Therapy
- Psychiatry
- Nutrition & Diet
- Lactation Consultations

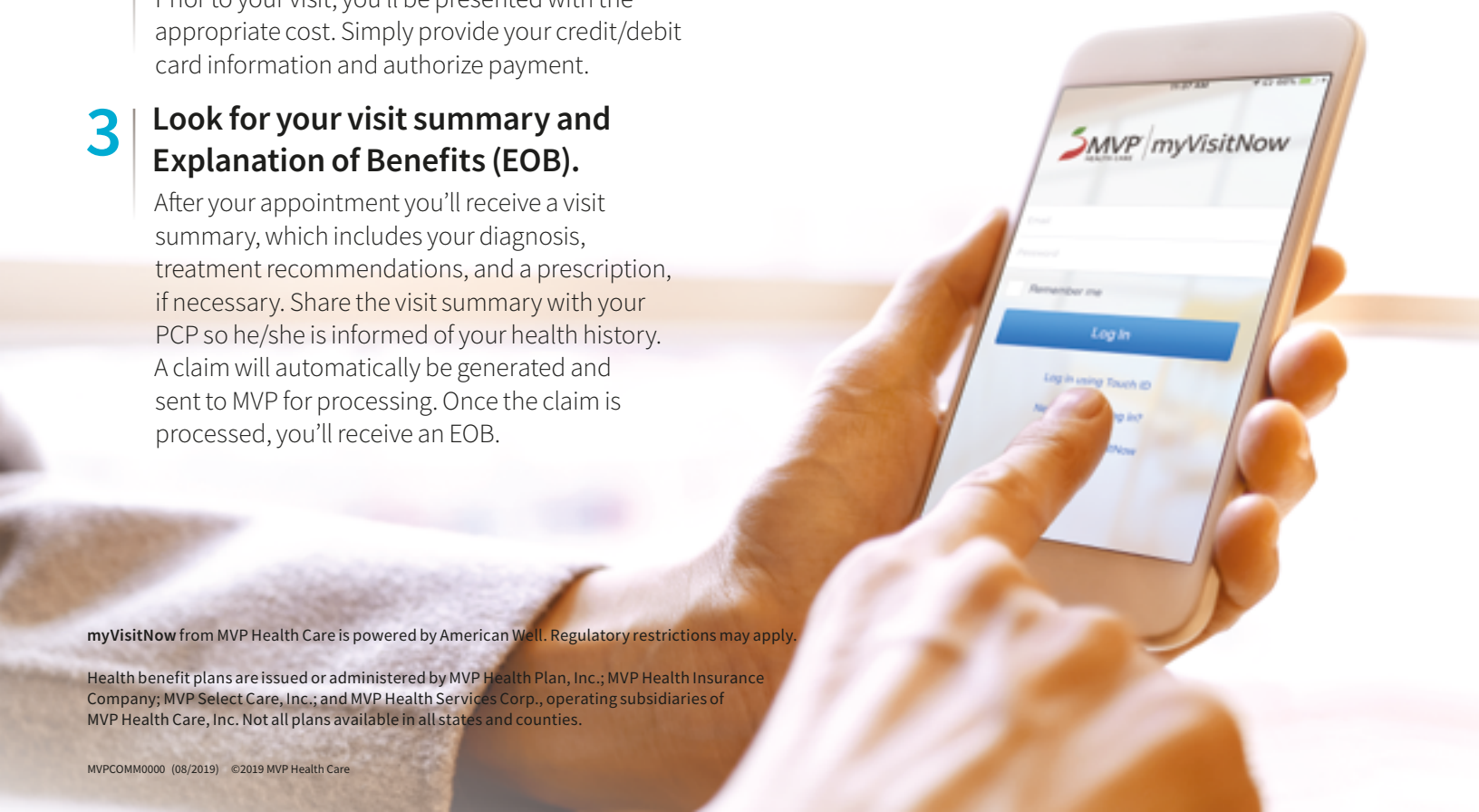
Download the free **myVisitNow** mobile app from the App Store® or Google Play™

Trouble logging in or have program questions?

Call **myVisitNow** Support at **1-855-666-9557**.

Billing or claims questions?

Call the MVP Customer Care Center phone number on the back of your MVP Member ID card.



myVisitNow from MVP Health Care is powered by American Well. Regulatory restrictions may apply.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

MVP Members Save at CVS Pharmacy!

Save 20% In Store and Online

Prescription benefits from MVP Health Care®, include a 20% discount on CVS Pharmacy brand health-related items.*

- **Save 20% on thousands of products**, including over-the-counter medications (such as allergy, cold and flu, or pain relievers), contact lens solution, first aid, and oral hygiene products.†
- Use your discount at any CVS Pharmacy location or online at **cvs.com**.
- This program is included with most MVP prescription plans at no additional cost to you.

Start saving today!

If you already have an MVP ExtraCare Health Card, just present it when you make purchases at CVS. New members can visit **bit.ly/extracarehealth** to get started. Need help? Call **1-800-SHOP-CVS**.

Online and On-the-Go with MVP and CVS Caremark

Your MVP membership comes with a variety of online tools to help you with your prescription drug benefits. *Sign In* to your member account at **mvphealthcare.com** and select *Pharmacy (CVS Caremark)*.

Learn More about Your Prescription Drug Plan

Stay up-to-date on medication costs, manage your personal health and wellness information, and search for generic medication alternatives to save money.

Find Ways to Save

From using generic medicines to setting up mail order service for maintenance medications, you can choose the right ways to save money based on your plan and prescriptions.

Order Prescriptions

Purchase qualified maintenance drugs—at a savings to both you and MVP—and have them delivered right to your door. Use the *Find a Pharmacy* tool at **mvphealthcare.com** to locate participating pharmacies near your home or within a specific zip code.

Get information About Medications

Learn more about specific drug interactions and possible side effects.

Download the CVS Caremark Mobile App

- Refill and renew mail service prescriptions.
- Identify unknown pills with the Pill Identifier.
- Check for drug interactions among medications.
- Check order status and prescription history.
- Check drug coverage and cost.
- Find local pharmacies.

For more about the CVS Caremark mobile app, visit **caremark.com/mobile**.

*The 20% discount is restricted to items purchased for the cardholder, spouse, or dependents.

†Excludes prescriptions, alcohol, tobacco, lottery tickets, postage stamps, gift cards, money orders, pre-paid cards, and photofinishing, and are not valid on other items reimbursed by a governmental program. Some exclusions apply. Not available with all plans.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

SERVICES	MVP HMO 25/25 (2020)	MVP HMO 25/25 (2021)
OFFICE VISIT PHYSICIAN SERVICES		
Diagnostic Office Visit	PCP: $25 co-payment per visit Specialist: $25 co-payment per visit	PCP: $25 co-payment per visit, $0 co-payment to age 26 Specialist: $25 co-payment per visit $0 co-payment per visit at a preferred provider facility
Well-Child Care	Covered in full for children to age 19	Covered in full for children to age 19
Allergy Tests and Injections	$25/$25 co-pay for tests; 100% covered for treatments if not affiliated with office visit	$25/$25 co-pay for tests; 100% covered for treatments if not affiliated with office visit
Eye Exams	Routine eye exams covered once every two years with a $25 co-payment Eye exams associated with disease or injury, $25 co-payment	Routine eye exams covered once every two years with a $25 co-payment Eye exams associated with disease or injury, $25 co-payment
Eyewear	Eyewear not covered	Eyewear not covered
Hearing Evaluations	PCP: $25 co-payment per visit Specialist: $25 co-payment per visit *Screenings Only*	PCP: $25 co-payment per visit Specialist: $25 co-payment per visit *Screenings Only*
Hearing Aids	Hearing aids not covered	Hearing aids not covered
Diagnostic Laboratory	Covered in full	Covered in full $0 co-payment per visit at a preferred provider facility
Diagnostic X-ray	$25 co-payment per visit	$25 co-payment per visit $0 co-payment per visit at a preferred provider facility
Surgical Care/ Ambulatory	$25 co-payment per visit	$25 co-payment per visit $0 co-payment per visit at a preferred provider facility
Physical/Speech/ Occupational Therapy	$25 co-payment per visit with a 30-day annual maximum benefit combined for PT/OT/ST	$25 co-payment per visit with a 30-day annual maximum benefit combined for PT/OT/ST
Chiropractic Services	$25 co-payment when medically necessary	$25 co-payment when medically necessary

SERVICES	MVP HMO 25/25 (2020)	MVP HMO 25/25 (2021)
OFFICE VISIT PHYSICIAN SERVICES		
Chemotherapy and Immunotherapy	Covered in full in inpatient setting. Oral chemotherapy covered under prescription benefit. IV/injectable chemotherapy covered with specialist co-payment ($25). Physician administered injectable drugs (including chemotherapy) will be covered with a $25 co-payment on the drug, in addition to any applicable co-payment for administering the drug.	Covered in full in inpatient setting. Oral chemotherapy covered under prescription benefit. IV/injectable chemotherapy covered with specialist co-payment ($25). Physician administered injectable drugs (including chemotherapy) will be covered with a $25 co-payment on the drug, in addition to any applicable co-payment for administering the drug.
Radiation Therapy	$25 co-payment per visit	$25 co-payment per visit $0 co-payment per visit at a preferred provider facility
MATERNITY		
Hospital Charges for Mother (including Delivery Room and Newborn Nursery Care)	Semi-private accommodations and all medically necessary services are covered in full.	Semi-private accommodations and all medically necessary services are covered in full.
Prenatal and Postnatal Care	Covered with a $25 co-payment per pregnancy. Co-payment applies to the initial visit only. No co-payment for pregnancy-related radiological procedures, such as ultrasound and amniocentesis done during a prenatal and postnatal office visit.	Covered with a $25 co-payment per pregnancy. Co-payment applies to the initial visit only. No co-payment for pregnancy-related radiological procedures, such as ultrasound and amniocentesis done during a prenatal and postnatal office visit.
INPATIENT SERVICES		
Hospital Services Private room covered when medically necessary and authorized by an MVP Medical Director.	Unlimited days of semi-private room accommodations and all medically necessary services for acute care are covered in full.	Unlimited days of semi-private room accommodations and all medically necessary services for acute care are covered in full.
Skilled Nursing Facility Private room covered when medically necessary and authorized by An MVP Medical Director.	Covered in full up to 45 days maximum per member, per calendar year.	Covered in full up to 45 days maximum per member, per calendar year.

SERVICES	MVP HMO 25/25 (2020)	MVP HMO 25/25 (2021)
OFFICE VISIT PHYSICIAN SERVICES		
Hospice	Covered in full up to 210 days maximum lifetime benefit per member, per calendar year.	Covered in full up to 210 days maximum lifetime benefit per member, per calendar year.
Surgery and Anesthesia	Covered in full	Covered in full
EMERGENCY SERVICES		
Ambulance	Covered with a $50 co-payment	Covered with a $50 co-payment
Life Threatening and Urgent Medical Emergencies	In Emergency Room, $75 co-payment per visit or waived when admitted within 24 hours Urgent Care Centers, $25 co-payment	In Emergency Room, $75 co-payment per visit or waived when admitted within 24 hours Urgent Care Centers, $25 co-payment
PRESCRIPTION SERVICES		
Prescription Drugs Under the Generic MAC program, if there is an A-rated generic drug, you have the option of choosing the brand name drug but will be responsible for the difference in cost between the generic and the brand name drug plus your co-payment. **Not Covered:** Non-standard/unevaluated medications and cosmetic drugs.	**Retail:** Up to a 30-day supply of approved drugs is covered with a $10 co-pay for Tier 1 generic drugs, $30 co-pay for Tier 2 brand name drugs, or $50 co-pay for Tier 3 non-formulary drugs. **Mail Order Program:** Up to a 90-day supply of approved drugs is covered with a $25 co-payment for Tier 1 generic drugs, $75 co-payment for Tier 2 brand name drugs, or $125 co-payment for Tier 3 non-formulary drugs.	**Retail:** Up to a 30-day supply of approved drugs is covered with a $0 co-pay for Tier 1 generic drugs, $30 co-pay for Tier 2 brand name drugs, or $50 co-pay for Tier 3 non-formulary drugs. **Mail Order Program:** Up to a 90-day supply of approved drugs is covered with a $0 co-payment for Tier 1 generic drugs, $75 co-payment for Tier 2 brand name drugs, or $125 co-payment for Tier 3 non-formulary drugs.
Diabetic Supplies and Insulin/Oral Agents	**Retail:** up to 30-day supply is covered with a $25 co-payment per boxed item. **Mail Order:** up to 90-day supply is covered with a $50 co-payment per boxed item.	**Retail:** up to 30-day supply is covered with a $25 co-payment per boxed item. **Mail Order:** up to 90-day supply is covered with a $50 co-payment per boxed item.
Injectable Medications	Physician administered injectable drugs (including chemotherapy) will be covered with a $25 co-payment.	Physician administered injectable drugs (including chemotherapy) will be covered with a $25 co-payment.

SERVICES	MVP HMO 25/25 (2020)	MVP HMO 25/25 (2021)
PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES		
Mental Health Inpatient	Acute psychiatric covered in full	Acute psychiatric covered in full
Mental Health Outpatient	$25 co-payment per visit	$25 co-payment per visit
Substance Abuse Inpatient	Acute detoxification and rehabilitation covered in full. Coverage is not subject to concurrent utilization review for the first 14 visits.	Acute detoxification and rehabilitation covered in full. Coverage is not subject to concurrent utilization review for the first 28 visits.
Substance Abuse Outpatient	$25 co-payment per visit for alcohol/chemical dependency. Coverage is not subject to concurrent utilization review for the first 14 visits.	$25 co-payment per visit for alcohol/chemical dependency. Coverage is not subject to concurrent utilization review for the first 28 visits.
OTHER SERVICES		
Home Care	Covered with a $25 co-payment per visit, when medically necessary and arranged by Primary Care Physician.	Covered with a $25 co-payment per visit, when medically necessary and arranged by Primary Care Physician.
Internal Prosthetics	Covered in full	Covered in full
Durable Medical Equipment	Coverage is limited to 50% of Covered Expenses and must be prescribed (and, in some cases, Pre-Certified and/or Prior-Justified) by a Plan Physician and obtained through a Participating Provider.	Coverage is limited to 50% of Covered Expenses and must be prescribed (and, in some cases, Pre-Certified and/or Prior-Justified) by a Plan Physician and obtained through a Participating DME Provider.
External Prosthetics and Orthopedic Braces and Supports	Coverage is limited to 50% of Covered Expenses and must be prescribed (and, in some cases, Pre-Certified and/or Prior-Justified) by a Plan Physician and obtained through a Participating Provider.	Coverage is limited to 50% of Covered Expenses and must be prescribed (and, in some cases, Pre-Certified and/or Prior-Justified) by a Plan Physician and obtained through a Participating Provider.
Acupuncture	Not Covered	Not Covered
Infertility Treatment	Not Covered	Covered for three cycles per lifetime of in-vitro fertilization; Standard fertility preservation is covered for iatrogenic infertility.
Telemedicine	$25 co-payment	Covered in full

TO: **M□□ New York State Employees/Retirees**
FROM: **MVP Health Care**
DATE: **Effective January 1, 2021**
RE: **Option Transfer Period**

You now have an opportunity to enroll in MVP Health Care – a Health Maintenance Organization (HMO) serving the following New York State Counties:

NYSHIP CODE #060 COUNTIES INCLUDED
Albany, Columbia, Fulton, Greene, Hamilton, Jefferson, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington

NYSHIP CODE #058 COUNTIES INCLUDED
Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, and Yates

NYSHIP CODE #330 COUNTIES INCLUDED
Broome, Cayuga, Chemung*, Chenango, Cortland, Delaware, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Schuyler*, Tioga, and Tompkins

NYSHIP CODE #340 COUNTIES INCLUDED
Dutchess, Orange, Putnam**,** Rockland**,** Sullivan, Ulster, and Westchester

NYSHIP CODE #360 COUNTIES INCLUDED
Clinton, Essex, Franklin, and St. Lawrence

*Pending DFS approval

MVP Plan Highlights

- $25 PCP/$25 Specialist office visit copayment
- **NEW!** $0 PCP office visit copayment to age 26
- **NEW!** $0 Telemedicine services
- Prescription drug benefit: (for enrollees not eligible for prescription drug benefits through a union benefit fund)
    - **NEW!** Retail: **$0 Tier 1 generic**, $30 Tier 2 formulary brand, $50 Tier 3 non-formulary brand (30 day supply)
    - Mail-Order: **$0 Tier 1 generic**, $75 Tier 2 formulary brand, $125 Tier 3 non-formulary brand (up to 90 day supply)
- Prescription benefits include 100% coverage for oral contraceptives
- **NEW!** Preferred provider facilities benefit - $0 copayment for laboratory, radiology, and ambulatory / outpatient surgery services at preferred facilities
- Routine preventive care services covered in full
- Out-of-Area student coverage

Your Eligibility Guidelines may be different from those guidelines listed in the contract. Please refer to your NYSHIP General Information Book for these guidelines or visit the New York State Department of Civil Service's website at www.cs.ny.gov.

TO ENROLL:

Active Employees Complete a PS 404 and an HMO enrollment form in your Agency Health Benefits Administrator's Office. The Department of Civil Service Division of Employee Benefits will distribute payroll deductions.

Retired Employees Complete the Option Change Coupon found in the Benefit Choices Brochure and return it to the Department of Civil Service.

Questions? Call **1-888-687-6277** or visit **www.mvphealthcare.com**

From: Miller, Alexandra
To: cs.sm.DCSprocurement
Cc: Rivelo, Anna; Molloy, Peter; Perry, Jillian
Subject: RE: MVP Health Care_Clarifying Questions submission
Date: Wednesday, September 02, 2020 9:55:12 AM
Attachments: VendRep System - View Certification (002).pdf

Good morning,

As promised, please find the finalized ASH Vendor Responsibility documentation attached to this email as a follow up from Clarifying Question #6.

Thank you,
Alex

Alexandra Miller
Professional, Client Support
300 Westage Business Center Drive
Suite 407
Fishkill, NY 12524
Phone: 845.897.6038
www.mvphealthcare.com
almiller@mvphealthcare.com

From: Miller, Alexandra
Sent: Tuesday, August 25, 2020 1:26 PM
To: cs.sm.DCSprocurement <DCSprocurement@cs.ny.gov>
Cc: Rivelo, Anna <ARivelo@mvphealthcare.com>; Molloy, Peter <PMolloy@mvphealthcare.com>; Perry, Jillian <JPerry@mvphealthcare.com>
Subject: MVP Health Care_Clarifying Questions submission

Good afternoon,

Please find MVP's response to the clarifying questions attached to this email and let us know if there are any questions.

Thank you so much,
Alex

Alexandra Miller
Professional, Client Support
300 Westage Business Center Drive
Suite 407
Fishkill, NY 12524
Phone: 845.897.6038
www.mvphealthcare.com
almiller@mvphealthcare.com

Printed By: Theresa McGoldrick
Date Printed: Aug 31, 2020

Vendor Responsibility For-Profit v2 Form

Status:	Certified
Note:	The content of any attached documents will not print with this page. To view or print an attached document, you must open it separately by clicking the corresponding hyperlink in the 'Uploaded Files' section of a question.

Basic Vendor Data

Entity Information

Legal Business Entity Name:	AMERICAN SPECIALTY HEALTH MANAGEMENT INC
TIN (EIN or SSN):	330783504
Vendor ID:	1100250080
Principal Place of Business:	10221 Wateridge Circle San Diego, CA 92121 United States
Telephone:	(800)848-3555
Website:	www.ashcompanies.com

Business Entity Information

Business Type:	For-Profit
Business Activity:	Non-Construction

Authorized Contacts

Name:	Ben Chan	**Address:**	10221 Wateridge Circle San Diego, CA 92121 United States
Title:	Manager, Delegation Support		
Telephone:	(800)848-3555 x3424		
Email:	BenC@ashn.com		

I. Legal Business Entity Information

1.0 Legal Business Entity type - Check appropriate box and provide additional information:

- (●) Corporation (including PC)
- ( ) Limited Liability Company (LLC or PLLC)
- ( ) Limited Liability Partnership
- ( ) Limited Partnership
- ( ) General Partnership
- ( ) Sole Proprietor
- ( ) Other

Date of Incorporation

08/25/1997

1.1 Was the Legal Business Entity formed or incorporated in New York State?

- ( ) Yes
- (●) No

Indicate jurisdiction where the Legal Business Entity was formed or incorporated:

- (●) USA
- ( ) Other

State

California

Attach a Certificate of Good Standing from the applicable jurisdiction or provide an explanation if a Certificate of Good Standing is not available:

Select method for providing this information:

- ( ) Enter Below
- (●) Attach Document(s)
- ( ) Attach Document(s) with Explanation

Uploaded Files

07-01-21 Certificate of Status.pdf 120K

1.2 Is the Legal Business Entity publicly traded?

- ( ) Yes
- (●) No

1.3 Does the Legal Business Entity have a DUNS Number?

- (●) Yes
- ( ) No

Enter DUNS number

42451505

1.4 If the Legal Business Entity's Principal Place of Business is *not* in New York State, does the Legal Business Entity maintain an office in New York State?

Note: Select "N/A" if Principal Place of Business is in New York State.

- ( ) Yes
- (●) No
- ( ) N/A

1.5 Is the Legal Business Entity a New York State certified Minority-Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), New York State Small Business (SB), or federally certified Disadvantaged Business Enterprise (DBE)?

- ○ Yes
- ◉ No

1.6 Identify Officials and Principal Owners, if applicable.

Note: If more than four (4) Officials or Principal Owners need to be listed, select "Attach Document" as the response.

If applicable, reference to relevant SEC filing(s) containing the required information is optional.

Select method for providing this information:

- ◉ Enter Below
- ○ Attach Document(s)

Name

George T. DeVries III

Title

Chief Executive Officer/Chairman of the Board

% of Ownership (Enter 0%, if not applicable)

86

Add another?

- ○ Yes
- ◉ No

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

II. Reporting Entity Information

2.0 The Reporting Entity for this questionnaire is:

(Note: Select only one)

- (●) Legal Business Entity
- ( ) Organizational Unit within and operating under the authority of the Legal Business Entity

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

III. Leadership Integrity

Within the past five (5) years, has any current or former Reporting Entity Official or any individual currently or formerly having the authority to sign, execute or approve bids, proposals, contracts or supporting documentation on behalf of the Reporting entity with any government entity been:

3.0 Sanctioned relative to any business or professional permit and/or license?

- ○ Yes
- ◉ No
- ○ Other

3.1 Suspended, debarred or disqualified from any government contracting process?

- ○ Yes
- ◉ No
- ○ Other

3.2 The subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation for any business-related conduct?

- ○ Yes
- ◉ No
- ○ Other

3.3 Charged with a misdemeanor or felony, indicted, granted immunity, convicted of a crime or subject to a judgment for:

a. Any business-related activity; or
b. Any crime, whether or not business-related, the underlying conduct of which is related to truthfulness?

- ○ Yes
- ◉ No
- ○ Other

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

IV. Integrity - Contract Bidding

Within the past five (5) years, has the Reporting Entity:

4.0 Been suspended or debarred from any government contracting process or been disqualified on any government procurement, permit, license, concession, franchise or lease, including, but not limited to, debarment for a violation of New York State Workers' Compensation or Prevailing Wage laws or New York State Procurement Lobbying Law?

- ○ Yes
- ◉ No

4.1 Been subject to a denial or revocation of a government prequalification?

- ○ Yes
- ◉ No

4.2 Been denied a contract award or had a bid rejected based on a non-responsibility finding by a government entity?

- ○ Yes
- ◉ No

4.3 Had a low bid rejected on a government contract for failure to make good faith efforts on any Minority-Owned Business Enterprise, Women-Owned Business Enterprise or Disadvantaged Business Enterprise goal or statutory affirmative action requirements on a previously held contract?

- ○ Yes
- ◉ No

4.4 Agreed to a voluntary exclusion from bidding/contracting with a government entity?

- ○ Yes
- ◉ No

4.5 Initiated a request to withdraw a bid submitted to a government entity in lieu of responding to an information request or subsequent to a formal request to appear before the government entity?

- ○ Yes
- ◉ No

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

V. Integrity - Contract Award

Within the past five (5) years, has the Reporting Entity:

5.0 Been suspended, cancelled or terminated for cause on any government contract including, but not limited to, a non-responsibility finding?

- ( ) Yes
- (•) No

5.1 Been subject to an administrative proceeding or civil action seeking specific performance or restitution in connection with any government contract?

- ( ) Yes
- (•) No

5.2 Entered into a formal monitoring agreement as a condition of a contract award from a government entity?

- ( ) Yes
- (•) No

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

VI. Certification/Licenses

Within the past five (5) years, has the Reporting Entity:

6.0 Had a revocation, suspension or disbarment of any business or professional permit and/or license?

- ( ) Yes
- (•) No

6.1 Had a denial, decertification, revocation or forfeiture of New York State certification of Minority-Owned Business Enterprise, Women-Owned Business Enterprise or federal certification of Disadvantaged Business Enterprise status for other than a change ownership?

- ( ) Yes
- (•) No

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

VII. Legal Proceedings

Within the past five (5) years, has the Reporting Entity:

7.0 Been the subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation?

- ( ) Yes
- (•) No

7.1 Been the subject of an indictment, grant of immunity, judgment or conviction (including entering into a plea bargain) for conduct constituting a crime?

- ( ) Yes
- (•) No

7.2 Received any OSHA citation and Notification of Penalty containing a violation classified as serious or willful?

- ( ) Yes
- (•) No

7.3 Had a government entity find a willful prevailing wage or supplemental payment violation or any other willful violation of New York State Labor Law?

- ( ) Yes
- (•) No

7.4 Entered into a consent order with the New York State Department of Environmental Conservation, or received an enforcement determination by any government entity involving a violation of federal, state or local environmental laws?

- ( ) Yes
- (•) No

7.5 Other than the previously disclosed:

a. Been subject to fines or penalties imposed by government entities which in the aggregate total $25,000 or more; or
b. Been convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any government entity?

- ( ) Yes
- (•) No

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

VIII. Financial and Organizational Capacity

8.0 Within the past five (5) years, has the Reporting Entity received any formal unsatisfactory performance assessment(s) from any government entity on any contract?

- ○ Yes
- ◉ No

8.1 Within the past five (5) years, has the Reporting Entity had any liquidated damages assessed over $25,000?

- ○ Yes
- ◉ No

8.2 Within the past five (5) years, have any liens or judgments (not including UCC filings) over $25,000 been filed against the Reporting Entity which remain undischarged?

- ○ Yes
- ◉ No

8.3 In the last seven (7) years, has the Reporting Entity initiated or been the subject of any bankruptcy proceedings, whether or not closed, or is any bankruptcy proceeding pending?

- ○ Yes
- ◉ No

8.4 During the past three (3) years, has the Reporting Entity failed to file or pay any tax returns required by federal, state or local tax laws?

- ○ Yes
- ◉ No

8.5 During the past three (3) years, has the Reporting Entity failed to file or pay any New York State unemployment insurance returns?

- ○ Yes
- ◉ No

8.6 During the past three (3) years, has the Reporting Entity had any government audit(s) completed?

- ○ Yes
- ◉ No

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

IX. Associated Entities

This section pertains to any entity(ies) that either controls or is controlled by the Reporting Entity.

(See definition of "Associated Entity" for additional information to complete this section.)

9.0 Does the Reporting Entity have any Associated Entities?

Note: The response must be "Yes," if the Reporting Entity is either:

- An Organizational Unit; or
- The entire Legal Business Entity which controls, or is controlled by, any other entity(ies).

(•) Yes
( ) No

Within the past five (5) years, has any Associated Entity Official or Principal Owner been charged with a misdemeanor or felony, indicted, granted immunity, convicted of a crime or subject to a judgment for:

- Any business-related activity; or
- Any crime, whether or not business-related, the underlying conduct of which was related to truthfulness?

( ) Yes
(•) No

Does any Associated Entity have any currently undischarged federal, New York State, New York City or New York local government liens or judgments (not including UCC filings) over $50,000?

( ) Yes
(•) No

Within the past five (5) years, has any Associated Entity been disqualified, suspended or debarred from any federal, New York State, New York City or other New York local government contracting process?

( ) Yes
(•) No

Within the past five (5) years, has any Associated Entity been denied a contract award or had a bid rejected based upon a non-responsibility finding by any federal, New York State, New York City, or New York local government entity?

( ) Yes
(•) No

Within the past five (5) years, has any Associated Entity been suspended, cancelled or terminated for cause (including for non-responsibility) on any federal, New York State, New York City or New York local government contract?

( ) Yes
(•) No

Within the past five (5) years, has any Associated Entity been the subject of an investigation, whether open or closed, by any federal, New York State, New York City, or New York local government entity for a civil or criminal violation with a penalty in excess of $500,000?

( ) Yes
(•) No

Within the past five (5) years, has any Associated Entity been the subject of an indictment, grant of immunity, judgment, or conviction (including entering into a plea bargain) for conduct constituting a crime?

( ) Yes
(•) No

Within the past five (5) years, has any Associated Entity been convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any federal, New York State, New York City, or New York local government entity?

( ) Yes
(•) No

Within the past five (5) years, has any Associated Entity initiated or been the subject of any bankruptcy proceedings, whether or not closed, or is any bankruptcy proceeding pending?

( ) Yes
(•) No

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

X. Freedom of Information Law (FOIL)

10.0 Indicate whether any information supplied herein is believed to be exempt from disclosure under the Freedom of Information Law (FOIL).

Note: A determination of whether such information is exempt from FOIL will be made at the time of any request for disclosure under FOIL.

- ○ Yes
- ◉ No

Last Modified: Aug 31, 2020
Modified By: Theresa McGoldrick

Certification

The undersigned: (1) recognizes that this questionnaire is submitted for the express purpose of assisting New York State government entities (including the Office of the State Comptroller (OSC)) in making responsibility determinations regarding award or approval of a contract or subcontract and that such government entities will rely on information disclosed in the questionnaire in making responsibility determinations; (2) acknowledges that the New York State government entities and OSC may, in their discretion, by means which they may choose, verify the truth and accuracy of all statements made herein; and (3) acknowledges that intentional submission of false or misleading information may result in criminal penalties under State and/or Federal Law, as well as a finding of non-responsibility, contract suspension or contract termination.

The undersigned certifies that he/she:

- is knowledgeable about the submitting Business Entity's business and operations;
- has read and understands all of the questions contained in the questionnaire;
- has reviewed and/or supplied full and complete responses to each question;
- to the best of his/her knowledge, information and belief, confirms that the Business Entity's responses are true, accurate and complete, including all attachments, if applicable;
- understands that New York State government entities will rely on the information disclosed in the questionnaire when entering into a contract with the Business Entity; and
- is under an obligation to update the information provided herein to include any material changes to the Business Entity's responses at the time of bid/proposal submission through the contract award notification, and may be required to update the information at the request of the New York State government entities or OSC prior to the award and/or approval of a contract, or during the term of the contract.

Legal Business Name:	AMERICAN SPECIALTY HEALTH MANAGEMENT INC
Certifier's Name:	Theresa McGoldrick
Certifier's Title:	Compliance Analyst II
Certification Date:	Aug 31, 2020

NEW YORK STATE OF OPPORTUNITY. | Department of Civil Service

ANDREW M. CUOMO
Governor
LOLA W. BRABHAM
Commissioner

September 15, 2020

Ms. Kelly Smith
Senior Vice President, Chief of Sales
MVP Health Plan, Inc.
625 State St.
Schenectady, NY 12305

VIA U.S. POSTAL MAIL & ELECTRONIC MAIL:
KSmith@mvphealthcare.com

RE: Clarification Request #2 - Solicitation entitled "Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

Dear Ms. Smith:

On July 27, 2020, MVP Health Plan Inc. (MVP) submitted a proposal in response to the Department of Civil Service's above Solicitation. In addition to the clarifying questions sent to you on August 18, 2020, the Department is requesting the following clarifying information:

Administrative Proposal:

1. MVP indicates that the current contract for radiology services is only valid through December 31, 2020. Please explain how MVP plans to provide radiology services to NYSHIP members as required, for the 2021 plan year and beyond.

Technical Proposal:

1. Regarding future submissions, MVP should only include benefits that have changed year-to-year in their Side by Side document. Please ensure only benefit changes are included in this document so members may clearly identify changes that are occurring for the upcoming plan year.

A response to this request is due no later than September 21, 2020. Your response should be sent to the Department at DCSprocurement@cs.ny.gov. We look forward to your timely response and advancing to the next stage of the implementation process.

Sincerely,

[redacted]

James DeWan
Director

Employee Benefits Division

NYSHIP Clarifying Questions Response 9/15/2020

Administrative Proposal:

1. **MVP indicates that the current contract for radiology services is only valid through December 31, 2020. Please explain how MVP plans to provide radiology services to NYSHIP members as required, for the 2021 plan year and beyond.**

   MVP plans to renew the agreement with eviCore for 2021. The 2021 negotiations are still in process and MVP is aware that we need to submit the amendments to NYS before October 1st; it is expected that the renegotiated contract for 1/1/21 will be available on or before September 28th.

   As soon as the renegotiated contract is in place MVP will inform the Department.

Technical Proposal:

1. **Regarding future submissions, MVP should only include benefits that have changed year-to-year in their Side by Side document. Please ensure only benefit changes are included in this document so members may clearly identify changes that are occurring for the upcoming plan year.**

   Confirmed—going forward MVP will only be sending out the Side-by-Side document that reflects benefit changes from the previous year.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

ANDREW M. CUOMO
Governor
LOLA W. BRABHAM
Commissioner

September 21, 2020

VIA ELECTRONIC MAIL & US POSTAL MAIL

Kelly Smith
Senior Vice President, Chief of Sales
MVP Health Plan, Inc.
625 State St.
Schenectady, NY 12305
KSmith@mvphealthcare.com

RE: Communications Clarification Request
Solicitation entitled "Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

Dear Ms. Smith:

On July 27, 2020, MVP Health Plan Inc. submitted a proposal in response to the Department of Civil Service's above Solicitation. Upon review, the Department identified the following sections of your proposal that require clarification:

2021 NYSHIP Choices Publication:

1. ***Choices,* Commercial:** Footnote #1 - Instead of presenting the definition of "children" as "newborn to age 26" in a footnote, could we include it as part of the benefit description? (E.g., Adult (27+): $25 per visit, Child (0-26) $0 per visit)

2. ***Choices,* Commercial:** Additional Rx Drug Info - "If a brand-name drug is requested over the prescribed generic, you pay the difference between the cost of the two drugs plus the Tier 1 copayment." As the Tier 1 copay = $0, should we eliminate reference to it here?

3. ***Choices,* Commercial:** Plan Highlights for 2021 - With your approval, could we reword as follows for clarification? "No copayment for laboratory, radiology and ambulatory/outpatient surgery services when using Preferred Provider Network."?

4. ***Choices,* MAP:** Plan Highlights for 2021 - With your approval, could we reword as follows for clarification? "No copayment for preventive care visits, telemedicine or generic drugs. $100 in Wellness Rewards. Up to 14 no-cost Mom's Meals delivered to your home after an inpatient stay. Our Silver Sneaker Fitness Program includes free membership at participating fitness centers."

5. ***Choices,* Commercial and MAP:** Telemedicine - Please confirm that there is no copayment associated with telemedicine visits. Should the 2021 benefit description include “for general office or behavioral health visits” as it did in the 2020 *Choices* books?

6. ***Choices,* Commercial and MAP:** Additional Rx Drug Info: “If a brand-name drug is requested over the prescribed generic, you pay the difference between the cost of the two drugs plus the Tier 1 copayment.” As the Tier 1 copay = $0, should we eliminate reference to it here?

7. ***Choices,* Commercial and MAP:** Pharmacies & Prescriptions - Please clarify: Is the formulary closed or incented?

A response to this request is due no later than September 25, 2020.

Sincerely,

[redacted]

Daniel Yanulavich
Director, Employee Insurance Programs
Employee Benefits Division

From: Perry, Jillian <JPerry@mvphealthcare.com>
Sent: Wednesday, September 23, 2020 10:38 AM
To: Rusiecki, Tessa (CS) <Tessa.Rusiecki@cs.ny.gov>
Cc: Yanulavich, Daniel T (CS) <Daniel.Yanulavich@cs.ny.gov>; Casella-Evans, Tricia (CS) <Tricia.Casella-Evans@cs.ny.gov>; Graetzer, Katherine (CS) <Katherine.Graetzer@cs.ny.gov>; Scoons, Lisa K (CS) <Lisa.Scoons@cs.ny.gov>; Johnson, Seth R (CS) <Seth.Johnson@cs.ny.gov>
Subject: FW: MVP - 2021 Choices Clarifying Questions letter

Hello Daniel and Tessa,

Good morning, I have posted the answer to the questions below. Please let me know if you have any further questions.

Would it be possible to make sure I am included in all correspondence? Kelly Smith is our Senior VP here at MVP and I am the Account Manager for the State. I handle the RFP and all day to day tasks regarding the State Account. Please let me know if you can accommodate this request or if you would like me to address it to someone else.

All language is approved for questions 1,2,3,4,6

Question 5. Regarding Telemedicine.

- The language "for general office" is not approved.
- The telemedicine benefit is: Access 24/7 adult and pediatric urgent care and convenient, self-scheduled appointments with psychiatrists, behavioral health specialists, nutrition and diet specialists, and lactation consultants.

Question 7. The formulary is a closed formulary.

Please let me know if I can be of further assistance.

Have a great day!
Jillian

Jillian Perry
Professional, Account Management & Engagement
MVP Health Care
300 Westage Drive, Suite 407 Fishkill NY, 12524
845-897-6062 Phone
845-418-9701 cell
jperry@mvphealthcare.com
www.mvphealthcare.com