February 9, 2015

Cathy Lozier
CITY OF SARATOGA SPRINGS
474 BROADWAY
SARATOGA SPRINGS, NY 12866

Dear Cathy Lozier, **GROUP #** 213747

Thank you for selecting an MVP Health Care benefit plan to offer your employees. MVP is committed to quality, wellness, and customer service. I look forward to working with you.

To ensure that we agree on the details of what MVP is offering **CITY OF SARATOGA SPRINGS** employees, I have provided the contract information with this letter. If any of the information enclosed is inconsistent with your understanding, please let me know immediately.

The rates for the benefit plan for the period January 1, 2015 through December 31, 2015 are listed in Exhibit E. The effective date will be consistent with your new employee policy or your regularly scheduled enrollment period(s).

I have enclosed two copies of the Group Contract cover sheet, one of which has attachments. Please review the cover sheet and attachments carefully. Once you agree with all of the information, please sign both copies of the cover letter and retain the copy with the attachments for your file. A postage-paid envelope is enclosed for your convenience. Please note:

- **We must have the signed contract on file no later than 30 days after your group's effective date.**
- If, at some future time, your group wishes to cancel the MVP Health Care contract, MVP requires a 30-day advance notice prior to your group's renewal date, as mentioned in the enclosed contract.
- Your benefit product has been deemed creditable for the required Centers for Medicare & Medicaid Services (CMS) employee notification.

Please feel free to call me at (518) 386-7926 if you have any questions.

Sincerely,

Gina Piccirillo
Account Manager
MVP Health Insurance Company
Enclosures

cc: Adirondack Trust Insurance Agency (formerly Wise Financial Group) 137

NEW YORK STATE GROUP HEALTH INSURANCE CONTRACT
Between
MVP HEALTH INSURANCE COMPANY ("MVP")
625 State Street, Schenectady, New York 12305
518/370-4793
AND

CITY OF SARATOGA SPRINGS - 213747 (Group)

In consideration of the payment to MVP of the premiums called for herein, MVP agrees to provide the coverage described in this Group Contract ("Contract"), subject to all agreements and mutual covenants contained herein, commencing on January 1, 2015**,** 12:01 a.m. Eastern Standard Time (the "Effective Date") and continuing until December 31, 2015, 11:59 p.m. Eastern Standard Time (this period is referred to as the "Initial Term"). After the Initial Term, this Contract shall automatically renew for subsequent (12) month terms, unless this Contract is non-renewed or terminated in accordance with the provision contained herein.

This Contract consists of this **SIGNATURE PAGE**, and, the following Exhibits.

EXHIBIT "A" GENERAL TERMS AND CONDITIONS
EXHIBIT "B" CERTIFICATE OF COVERAGE
EXHIBIT "C" RIDERS:
PPO RIDER (PNEPO001L)
20% COINSURANCE FOR DURABLE MEDICAL EQUIPMENT / EXTERNAL PROSTHETIC DEVICES AND OSTOMY SUPPLIES (DNEPO001L)
60 VISIT OUTPATIENT PT/OT/ST (MNEPO009L)
VISION EXAM 1 EVERY 2 YEARS- 80% LENS UP TO MAXIMUM OF $160 (YNEPO001L)
200 HOME HEALTH VISITS (MNEPO010L)
WELLSTYLE EXTRAS (MNEPO028L)
PHARMACY BASE $5/$20/$40; MO $12.50/$50/$100 (RXNY1EPO603ZL)
PHARMACY EXCLUDE MAIL ORDER 2010 CHANGES (RXNY1EPO703LA)
PHARMACY EXCLUDE MAC PRICING (RXNY1EPO702LA)
OPEN ENDED PROVIDER PRESCRIPTION DRUG COVERAGE (RXOPEN)
EXHIBIT "D" SCHEDULE OF BENEFITS:
NY1EPC003ZLAN

EXHIBIT "E" PREMIUM RATE SCHEDULE
EXHIBIT "F" GROUP APPLICATION

The parties executing this Contract represent and warrant that they have the authority to bind their respective entities to this Contract.

IN WITNESS WHEREOF, MVP and Group have caused this Group Contract to be executed as of the Effective Date.

MVP HEALTH CARE	CITY OF SARATOGA SPRINGS
By: 	By: _____
Date: February 6, 2015	Date: _____

NEW YORK STATE GROUP HEALTH INSURANCE CONTRACT
Between
MVP HEALTH INSURANCE COMPANY ("MVP")
625 State Street, Schenectady, New York 12305
518/370-4793
AND

CITY OF SARATOGA SPRINGS - 213747 (Group)

In consideration of the payment to MVP of the premiums called for herein, MVP agrees to provide the coverage described in this Group Contract ("Contract"), subject to all agreements and mutual covenants contained herein, commencing on January 1, 2015**,** 12:01 a.m. Eastern Standard Time (the "Effective Date") and continuing until December 31, 2015, 11:59 p.m. Eastern Standard Time (this period is referred to as the "Initial Term"). After the Initial Term, this Contract shall automatically renew for subsequent (12) month terms, unless this Contract is non-renewed or terminated in accordance with the provision contained herein.

This Contract consists of this **SIGNATURE PAGE**, and, the following Exhibits.

EXHIBIT "A" GENERAL TERMS AND CONDITIONS
EXHIBIT "B" CERTIFICATE OF COVERAGE
EXHIBIT "C" RIDERS:
PPO RIDER (PNEPO001L)
20% COINSURANCE FOR DURABLE MEDICAL EQUIPMENT / EXTERNAL PROSTHETIC DEVICES AND OSTOMY SUPPLIES (DNEPO001L)
60 VISIT OUTPATIENT PT/OT/ST (MNEPO009L)
VISION EXAM 1 EVERY 2 YEARS- 80% LENS UP TO MAXIMUM OF $160 (YNEPO001L)
200 HOME HEALTH VISITS (MNEPO010L)
WELLSTYLE EXTRAS (MNEPO028L)
PHARMACY BASE $5/$20/$40; MO $12.50/$50/$100 (RXNY1EPO603ZL)
PHARMACY EXCLUDE MAIL ORDER 2010 CHANGES (RXNY1EPO703LA)
PHARMACY EXCLUDE MAC PRICING (RXNY1EPO702LA)
OPEN ENDED PROVIDER PRESCRIPTION DRUG COVERAGE (RXOPEN)
EXHIBIT "D" SCHEDULE OF BENEFITS:
NY1EPC003ZLAN

EXHIBIT "E" PREMIUM RATE SCHEDULE
EXHIBIT "F" GROUP APPLICATION

The parties executing this Contract represent and warrant that they have the authority to bind their respective entities to this Contract.

IN WITNESS WHEREOF, MVP and Group have caused this Group Contract to be executed as of the Effective Date.

MVP HEALTH CARE	CITY OF SARATOGA SPRINGS
By: 	By: _____
Date: February 6, 2015	Date: _____

Exhibit "E"
Premium Rate Schedule

CITY OF SARATOGA SPRINGS - 213747 0001

Rates effective January 1, 2015 to December 31, 2015	
Single:	$1,000.45
Double:	$2,228.55
Parent + Child(ren)	N/A
Family:	$2,558.88

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

IMPORTANT CERTIFICATE OF COVERAGE INFORMATION
(EXHIBIT B-CERTIFICATE OF COVERAGE)

MVP has provided all contract holders with a copy of the Certificate of Coverage (COC). This is noted as in the contract. If you would like a copy of their Certificate of Coverage please select an option below and return in the enclosed envelope:

- O Please email the COC to:_____ *(your email address)*
- O Please mail the COC (Exhibit "B") to our group address on file

GROUP NAME:
_____
GROUP NUMBER:_____.
NAME:
_____

Please feel free to call me at (518) 386-7926 if you have any questions.

Sincerely,

Gina Piccirillo
Account Manager
MVP Health Insurance Company

EXHIBIT A
GENERAL TERMS AND CONDITIONS

ARTICLE I - DEFINITIONS

A. **Certificate of Coverage or Certificate** refers to the document attached hereto, which describes the services for which MVP provides benefits and other terms and conditions of Coverage.

B. **Contract or Group Contract** refers to the agreement between MVP and Group. The entire agreement includes the Signature Page, and all Exhibits attached hereto.

C. **Covered Person** refers to either a Group Member or his or her dependents who are eligible for Coverage under this Contract.

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

E. **Group, Group Policyholder or Policyholder** refers to the entity named on the cover page of this document and to whom this Contract is issued.

F. **Group Member or Certificate Holder** means an individual who is eligible for group health insurance coverage with MVP, under the terms and conditions established by Group and MVP. Group Member does not include an individual who is eligible for coverage under this Contract solely by virtue of their status as a dependent (e.g. spouse or child) of another insured. All Group Members must meet the requirements set forth in this Contract in order to be eligible for coverage. To be eligible for coverage as a Group Member, under this Contract, by virtue of an individual's status as a "current employee" of Group, such individual must work a minimum of twenty (20) hours per week with Group. If Group seeks to include retirees or association members as Group Members under this Contract, then such election must be made on the Group Application [and applicable exhibit(s) attached hereto].

G. **Initial Term** means the period from the initial Effective Date until the first Renewal Date.

H. **Large Group** means any Group with [fifty-one (51)][one hundred and one (101)] or more [eligible] employees [or members at the time of renewal].

I. **Renewal Date** means the day following the end of the Initial Term and each anniversary thereof, while this Contract remains in effect.

J. **Small Group** means any Group with a minimum of two (2) but no more than [fifty (50)] [one hundred (100)] [eligible] employees [or members at the time of renewal].

K. **Written Notice** is meant to include notice by letter, newsletter, electronic mail or other media by electronic means, including but not limited to electronic mail notifications. By including an email address on this contract and/or your group application, you agree to accept all notices electronically unless otherwise indicated in this contract or as required by law.

In this document, "we," "us," and "our," mean MVP. You, your and yours refer to you the Group. The capitalized terms set forth above, when used in Exhibit "A" General Terms and Conditions, shall have the meanings set forth above. The capitalized terms used in Exhibit "B" Certificate of Coverage, shall have the meanings set forth in the "Definitions" Article of the Certificate of Coverage.

ARTICLE II – WARRANTIES AND REPRESENTATIONS

A. MVP has secured any required licensure, government approval or exemption, necessary to perform the services offered in this Contract.

B. Group hereby warrants and represents that it has accurately completed and responded to all questions presented on the Group Application. Group further warrants and represents that any and all additional information provided to MVP by Group is true and accurate to the best of Group's knowledge. Group agrees to promptly advise MVP of any material changes to the responses provided on the Group Application.

C. Reform Language – Group shall promptly advise MVP of any changes to contribution amounts to employee premiums. Group acknowledges that changes to its employees' premium contribution requirements may affect Group's grandfathered status pursuant to the Patient Protection and Affordable Care Act (PPACA).

D. Federal Health Care Reform [effective beginning September 23, 2012] – Group shall deliver any MVP Summary of Benefits and Coverage forms ("SBC"), Glossary forms, and/or other issuer forms required by the federal health care reform law to all eligible employees (and to their dependents with known other addresses) and covered retirees (if any), including any MVP enrollees in a timely manner. MVP will deliver all required forms to the Group electronically in a timely manner with instructions in order to facilitate this distribution. Groups who do not accept electronic delivery from MVP will be required to notify MVP in advance to accommodate U.S. Mail delivery. The provision of a Group e-mail address as noted above will be deemed acceptance of this distribution method unless the Group notifies MVP otherwise in writing with the execution of this contract. For new business, the delivery of these forms must accompany any other

written enrollment materials, or if no written materials, delivery must occur prior to first day eligible to submit enrollment. For renewals, MVP must provide only enrollee's plan information (not all options) 30 days prior to renewal date; other forms will be provided upon request of employee.

ARTICLE III - HEALTH INSURANCE COVERAGE

A. In consideration of the mutual agreements contained herein, and upon the receipt of required premiums, MVP shall provide the benefits described in this Contract to all Covered Persons, in accordance with the terms of this Contract.

B. MVP shall issue an electronic or hard copy of the Certificate of Coverage, Riders, Schedule of Benefits and Summary of Benefits and Coverage form(s)/Glossaries attached hereto as exhibits, to the Group. These Exhibits describe the coverage available to eligible Group Members and their covered dependents, as well as the terms and conditions of that coverage. The Group shall distribute these Exhibits to Group Members.

C. Subject to applicable law, MVP may unilaterally revise Group's coverage as of any Renewal Date of this Contract upon sixty (60) days prior written notice to Group. In addition, MVP may upon written notice to Group revise your coverage to comply with changes in state or federal laws or regulations. The coverage described in this Contract is the coverage that will be provided during the Initial Term of this Agreement and all subsequent terms, unless this Contract is amended, modified, or revised in accordance with the terms and conditions contained herein. Group may request an amendment, modification or revision to this coverage (e.g. add or delete approved Riders or purchase another available Schedule of Benefits) to take effect on Group's next Renewal Date, provided that Group provides MVP with a minimum of sixty (60) days prior written notice.

D. If you have purchased a Contract that includes a network of health care providers, then Group understands and agrees that such network may change from time to time. MVP reserves the right, consistent with network adequacy requirements and other applicable law, to add or remove health care providers from such network at our discretion.

ARTICLE IV - ELIGIBILITY & ENROLLMENT

A. Eligibility.

1. MVP may only offer coverage: (i) to groups that meet the requirements set forth in Section 4235(c)(1) of the New York State Insurance Law and, to the extent applicable, MVP's Small Group Guidelines; and (ii) of a type for which MVP has received approval from the New York State Department of Financial Services. Group understands and agrees that MVP will evaluate Group's eligibility for coverage based upon information provided on the Group Application and/or other information

provided by Group. MVP reserves the right to request group and/or subscriber eligibility information at any time, and Group agrees to furnish such information to MVP upon request.

2. In order to be eligible for coverage, Group Members must satisfy Group's eligibility requirements, as well as the requirements set forth in this Contract including, without limitation, the eligibility requirements set forth in the Certificate of Coverage. (See definition of "Group Member" in Article I, Section "F" of this Exhibit).

3. Group agrees that it will establish its eligibility requirements in a manner consistent with state and federal laws and regulations. Group agrees that any eligibility requirements adopted by Group for MVP coverage shall be applied in a fair and consistent manner so as not to prejudice or deter Group Members from selecting coverage with MVP.

4. Group agrees to meet and maintain the minimum participation requirements set forth in Section 4235(c)(1) of the New York State Insurance Law applicable to your Group, and/or as detailed in MVP's Small Group Guidelines.

5. MVP may, in its discretion, elect not to provide coverage to Group, if Group has been terminated for non-payment of premiums by MVP or any other payer within the twelve (12) month period immediately preceding the proposed Effective Date of this Contract. Additionally, if MVP has at any time in the past terminated Group for non-payment of premiums, MVP may require Group to remit all past due premiums and late charges to MVP before coverage under this Contract will take effect.

B. Enrollment.

1. Group shall have its Group Members, who want coverage with MVP, complete a hard copy or on-line web enrollment form. Copies of enrollment forms shall be sent to MVP.

2. Group shall report to MVP, via hard copy, electronic format, or on-line web format, all additions to and terminations from Group's list of Covered Persons. MVP shall not go back more than sixty (60) days from its receipt of these reports to make any enrollment additions or terminations. Notwithstanding, for all additions, Group Members must still elect coverage within thirty (30) days from date of hire (for individuals eligible for Group benefits as a result of new employment status) or the end of an employer-imposed waiting period, if applicable, or during Group's "open enrollment period", "special enrollment period", or "dependent special enrollment period", as those terms are described in paragraphs "3", "4", and "5", immediately below.

3. Group agrees to have at least one (1), but no more than two (2) open enrollment periods per Calendar Year, with each being no less than thirty (30) days. During the open enrollment period, eligible Group Members may transfer between multiple health insurance options (if multiple options are offered by Group) and/or enroll in coverage that was previously declined by the Group Member. The collective duration of such open enrollment period(s) shall not exceed two (2) months per Calendar Year. Group and MVP agree to comply with and cooperate during the open enrollment period(s) established by Group. Except for "special enrollment periods", described in Paragraph "4" immediately below, and new hires added within thirty (30) days from date of hire (or the end of an employer-imposed waiting period, if applicable), Group agrees that it will not allow any Group Members to enroll with MVP outside of Group's open enrollment period(s).

4. If a Group Member and his/her Dependent[s] do not initially enroll or enroll during an open enrollment period, then Group Member and his/her Dependent[s] will in most instances be required to wait until the next open enrollment period before they may enroll for coverage with MVP. However, if Group Member and his/her Dependent[s] qualify for a special enrollment period then each are eligible to enroll. To qualify for a special enrollment period, one of the following conditions must be met:

   A. <u>Loss of eligibility for Coverage</u>

      i. Group Member and his/her Dependent[s] seeking to enroll must have been covered under a group health plan or had other health insurance coverage at the time coverage was previously offered; and

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

      iii. Group Member and his/her Dependent[s] applies for coverage within thirty (30) days after such loss of coverage or termination; and

      iv. Group Member and his/her Dependent's coverage was terminated or lost due to one of the following reasons:

         1. Coverage was provided in accordance with the continuation coverage required by state or federal law and was exhausted;
         2. Legal separation, divorce or annulment;

3. Cessation of dependent status;
4. Death of employee;
5. Termination of employment;
6. Reduction in the number of hours of employment;
7. Employer contributions towards such coverage were terminated;
8. Loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
9. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or
10. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals.

B. <u>If you lose eligibility under Medicaid or Children's Health Insurance Program ("CHIP") program</u>

Group Member and his/her Dependent is covered under a state Medicaid or CHIP program and coverage of Group Member and his/her Dependent under such a plan is terminated as a result of loss of eligibility for such coverage AND Group Member and his/her Dependent applies for coverage within sixty (60) days after the date of termination of such coverage; OR

C. <u>If you become Eligible for Medicaid or Children's Health Insurance Program ("CHIP") program</u>

Group Member and his/her Dependent becomes eligible for group health plan premium assistance under a state Medicaid or CHIP plan AND Group Member and his/her eligible Dependents apply for coverage within sixty (60) days after the date Group Member and his/her dependent is determined to be eligible for such assistance.

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

5. In addition to the "special enrollment rights" described in paragraph "4" above, Group and MVP agree to allow Group Members to add otherwise eligible dependents to their coverage either during Group's open enrollment period or during the "dependent special enrollment period." The "dependent special enrollment period" shall be a period of thirty (30) days from the date the dependent became eligible for coverage with MVP

as a result of marriage, birth, adoption or placement for adoption. In order to qualify for enrollment during the "dependent special enrollment period", the Group Member must notify MVP of his or her intent to add such dependent to his or her coverage within the thirty (30) day period described above. If a dependent is properly added during the "dependent special enrollment period", coverage shall commence for such dependent in the manner described in the attached Certificate of Coverage.

6. Group agrees to provide a description of “special enrollment rights” described in paragraphs "4" and "5" above, to each Group Member on or before the time they are offered the opportunity to enroll with MVP.

ARTICLE V – CONTINUATION AND CONVERSION COVERAGE

A. Continuation Coverage.

1. Group shall comply with all applicable requirements under the Consolidated Omnibus Reconciliation Act of 1985, P.L. 99-272 ("COBRA") or Section 3221(m) of the New York Insurance Law ("New York Group Continuation Coverage"), as amended, and any regulations promulgated pursuant thereto, including without limitation, the provision of all required notices to Covered Persons.

2. Group shall not attempt to modify the time periods for notice or election of Group Continuation, premium payments or the eligibility criteria and termination events established by federal and state law. Group shall be responsible for collecting all written requests for Continuation Coverage. Group shall be responsible for collecting and remitting premiums paid by Covered Persons pursuant to COBRA or New York Group Continuation guidelines, whichever is applicable. A Covered Person's Continuation of Coverage under COBRA or New York Group Continuation Coverage shall not be effective unless MVP receives all premiums due since the date of the Covered Person's qualifying event (as that term is defined under applicable laws and regulations).

B. Conversion Coverage. Within fifteen (15) days of Covered Persons' termination of Group Coverage, Group shall notify all such Covered Persons of any conversion options available as set forth in the Certificate of Coverage.

C. Continuation Coverage under New York State Law. If Group Member has a dependent child whose coverage has been terminated or will terminate because of age or if the Dependent is not covered due to age, that Dependent may continue or obtain coverage through the Group Member’s policy in accordance with the following requirements and limitations:

1. The Dependent must be a "Young Adult" who is:

    a. 29 years of age or under;
    b. unmarried
    c. not insured by or eligible for health insurance through his or her own employer;
    d. lives, works or resides in New York State or MVP's service area; and
    e. is not covered under Medicare.

2. The Young Adult does not have to live with or be financially dependent on the Group Member (parent). The Young Adult does not have to be a student.

3. The Group Member (parent) must be eligible for coverage under the Contract as an employee or member of the Group.

4. The Young Adult may enroll:

    a. If Coverage will be terminated due to age: If the Young Adult is currently covered as a Dependent under the Contract, he or she may enroll within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for dependent coverage. Coverage will be retroactive to the date that the Young Adult's coverage would otherwise have terminated;

    b. If he or she experiences a change in circumstances: The Young Adult may enroll within sixty (60) days of newly meeting the eligibility requirements. Coverage will be prospective and will start within thirty (30) days of when MVP receives notice of the Group Member's or Dependent's election and premium payment.

    c. During Open Enrollment: If the Young Adult meets the eligibility requirements, he or she may elect coverage during the annual thirty (30) day open enrollment period. Coverage will be prospective and will start within thirty (30) days of when MVP receives notice of the Group Member's or Dependent's election and premium payment.

5. The cost of coverage is one hundred percent (100%) of the single premium rate of the current group policy under which the Group Member (parent), is enrolled. Either the Group Member (parent) or the Young Adult may elect the Coverage and pay the premium.

6. Young Adult coverage will terminate when one of the following occurs:

    a. the Young Adult terminates his or her coverage pursuant to the terms of the Contract.

b. The Group Member (parent) is no longer eligible for coverage.
c. The Young Adult no longer meets the eligibility requirements
d. The Group Member (parent) or the Young Adult do not pay the premium in full within the grace period.
e. The Contract is terminated and not replaced.

7. The Young Adult Coverage does not extend to children of the Young Adult.

ARTICLE VI - PREMIUMS

A. Premium Rates. The Group agrees to pay premiums to MVP, monthly in advance by payroll deduction or otherwise, on behalf of each Covered Person. The premium rates for the first Contract Period shall be set in accordance with the Premium Rate Schedule attached hereto as Exhibit "E".

B. Rolling Premium Rates. Group understands and agrees that the aforementioned premium is based on rates in effect for the Calendar Quarter in which this Contract becomes effective ("Effective Date"). It is further understood and agreed that the aforementioned premium rates are based on rates and/or a rating methodology that has been approved by, and is on file with, the New York State Department of Financial Services. Group and MVP understand and agree that any quoted estimate of such premium provided by MVP, prior to the Department issuing its final approved rate, will be subject to change. MVP shall notify Group [or Group's designee] at least thirty (30) days prior to the start of each Contract Year, of the final approved rate for the next Contract Year. Notwithstanding the above, MVP reserves the right to revise premiums upon thirty (30) days written notice to Group upon the enactment or promulgation of any applicable state or federal law or regulation, or any amendment thereto, that MVP determines, in the exercise of its discretion, will have a material impact upon the cost of providing the Coverage herein described.

C. Payment of Premiums. Group must pay the total of all billed premiums on or before the due date and must not make any adjustment to the billed premium. MVP will make any necessary adjustments to billed premium based upon changes in Group enrollment as described in this Section "D" immediately below. Any failure by Group to pay the entire billed premium shall be deemed a non-payment of premium. MVP will allow a grace period of thirty (30) days for the payment of each premium except for the initial premium. Group will be billed for Covered Persons electing Coverage under this Contract as follows.

1. For Covered Persons whose coverage becomes effective prior to the 16th day of the month, an entire month's premium shall be charged.

2. For Covered Persons whose coverage becomes effective after the 15th day of the month, no premium will be charged.

3. For persons whose coverage terminates prior to the 16th day of the month, no premium shall be charged.

4. For persons whose coverage terminates after the 15th day of the month, an entire month's premium will be charged.

D. Premium Adjustments Based on Retroactive Changes to Group Enrollment. Group shall not receive any premium credit for more than sixty (60) days with respect to any terminated Covered Person. MVP will make adjustments to Group billing statement to reflect additions and/or deletions to Group enrollment within sixty (60) days from the date that MVP was provided with notice of the requested change.

E. Termination for Non-Payment of Premiums. MVP may automatically terminate this Contract for failure to pay premiums as of the end of any grace period. MVP will provide written notice to the Group if the Contract is terminated in this manner. If so terminated, the Group will remain liable for any outstanding premiums and late payments.

F. Late Charges. MVP reserves the right to charge Group a late charge of eighteen percent (18%) per annum for any premiums paid after the due date and applicable grace period. MVP will provide written notice to the Group for any late payment charges due to MVP.

ARTICLE VII - TERMINATION

A. Conditions under which the Group Contract May Terminate. This Contract shall continue through the Initial Term and will automatically be renewed for successive one (1) year terms thereafter, unless this Contract is terminated as described below:

1. by Group, for any reason on Group's Renewal Date, by providing MVP with thirty (30) days prior written notice; or

2. by MVP, for any of the following reasons:

a. Group has failed to pay premiums due under the Contract. The termination shall automatically take effect at the end of the grace period or later date established by MVP.

b. Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract. MVP may, upon written notice to Group, terminate this Contract as of the date of the fraudulent act or

intentional misrepresentation or later date specified in the notice of termination.

c. Group has failed to comply with a material term relating to employer contribution or group participation rules, as set out in this Contract and as permitted by the New York State Insurance Law and MVP Small Group Guidelines, as applicable. MVP may, upon written notice to Group, terminate this Contract as of the date the Group fails to comply with such rules.

d. MVP terminates the class of contracts to which this Contract belongs. In such case, MVP shall provide at least ninety (90) days prior written notice to Group and each Group Member covered under this class of contract.

e. MVP withdraws from the applicable market through which you obtained coverage under this Contract, and, we cease offering any similar products in that market. In such case, MVP shall provide Group and each Group Member covered under this Contract at least one hundred and eighty (180) days prior written notice of the withdrawal.

f. Group ceases to meet the requirements for a group under Section 4235 of the New York State Insurance Law or, if applicable, a participating employer, labor union, association or other entity ceases membership or participation in your Group. MVP may, upon written notice to Group, terminate this Contract as of the date the Group no longer satisfied the requirements of the New York State Insurance Law or a participating employer, labor union, association or other entity ceased participation in Group.

g. Group no longer has any Group Members located within MVP's operating area. MVP may, upon prior written notice to Group, terminate this Contract if there are no longer any Group Members who live, work or reside within MVP's operating area. MVP's "operating area" means the area in which MVP has been authorized by the New York State Department of Financial Services to do business. This provision shall only apply to Contracts offering network plans. For purposes of this section, a "network plan" is any Contract that provides financial incentives in the way of lower deductible, co-payment or coinsurance requirements for obtaining services from health care providers who have contracted, either directly or indirectly, with MVP.

h. For Groups with an MVP POS Group Contract, the date your MVP HMO contract terminates.

B. Discretionary Reinstatement. In the event that this Contract is terminated for delinquent premium payment, MVP may, in the exercise of its sole discretion, agree, in writing, to reinstate this Contract upon timely receipt from Group of the delinquent premiums for the period prior to the termination date, together with any additional premiums for the period from termination through reinstatement.

C. Adjustment of Termination Date. If any termination date established pursuant to this Contract is inconsistent with any applicable and binding statutory or regulatory requirements, then the earliest date allowable under the pertinent statute or regulation shall be the date of termination.

D. Group Agrees to Provide Notice of Termination to its Group Members. Group understands and agrees that, except with respect to terminations in accordance with Article VII, Section A, Subsection 2, Subparts (d) & (e) above, Group shall be responsible for notifying its Group Members of the termination of this Group Contract in a manner consistent with all applicable laws.

E. Effect of Termination. In the event of termination of this Contract, the Group shall be liable to MVP for the payment of outstanding premiums through the date of termination. MVP shall not be liable for health care rendered to a Covered Person after the date of termination, unless the Covered Person is entitled to an extension of benefits as set forth in the Certificate of Coverage.

ARTICLE VIII - NOTICE

Unless otherwise mutually agreed between the parties, all notices given under this Contract shall be in writing and sent as follows.

A. Notices to Group. All notices sent by MVP to Group shall be sent to the address stated on the Group Application, unless, after application, the Group notifies MVP in writing of a change in address.

B. Notice to MVP. All notices to MVP should be in writing and sent to:

MVP Health Insurance Company
625 State Street
Schenectady, NY 12305

C. Bankruptcy Notices. Notices of Bankruptcy will not be deemed to have been received by MVP unless sent to:

MVP Health Insurance Company
Attn: Legal Department
625 State Street
Schenectady, NY 12305

ARTICLE IX - GENERAL PROVISIONS

A. Assignment. Any assignment by Group of this Contract without MVP's prior written consent shall be voidable by MVP. MVP may assign this Contract to any parent, subsidiary or affiliate of MVP, upon prior notice to Group.

B. Entire Agreement. This Contract constitutes the entire agreement between the parties. No agent or representative of MVP other than a duly authorized officer may change or waive any of its provisions.

C. Legal Action. No action at law or in equity shall be brought against MVP by Group after the expiration of two (2) years from the date of the alleged loss or breach, whichever is applicable.

D. Governing Law. This Group Contract shall be governed by the laws of the State of New York and applicable federal law.

E. Venue for Legal Action. You agree that any legal action commenced by you against MVP shall be commenced in a court located in the State of New York. You also consent and agree that the courts of the State of New York shall have personal jurisdiction over you in the event that an action is brought against you by MVP or any subsidiary of MVP.

F. Waiver. Failure by MVP to enforce any provision of this Contract shall not be deemed a waiver of the rights of either party under this Contract. The waiver of any breach or violation of any term or provision hereof shall not constitute a waiver of any subsequent breach or violation of the same or any other term or provision.

G. Force Majeure. Any delay in or failure of performance by either party under this Contract (other than a failure to comply with payment obligations) shall not be a breach of this Contract if and to the extent caused by events beyond the reasonable control of the party affected, including without limitation, acts of God, embargoes, governmental restrictions, strikes (other than those only affecting Policyholder), riots, wars or other military action, civil disorders, rebellion, fires, floods, vandalism, or sabotage. Market conditions and/or fluctuations (including a downturn of Policyholder's business) shall not be deemed force majeure circumstances. Any party so prevented shall resume performance as soon as reasonably possible after the impediment to its performance is removed.

H. Severability. In the event that one or more of the provisions of this Contract is found to be invalid, illegal, or unenforceable, the validity, legality and enforceability of the remaining provisions shall not, in any way, be affected or impaired.

I. Relationship of Parties. No provision of this Group Contract is intended to create, nor shall be deemed or construed to create, any relationship or joint venture among Group, Providers or MVP other than as independent entities contracting with each other solely for the purpose of effectuating the provisions of this Group Contract. Neither Group, Covered Persons, MVP nor any Provider, nor any of their respective employees, shall be deemed or construed to be the agent, employee or representative of the others, and shall not bind the others by its actions or failure to act. MVP and Group agree that Group's employee benefit plan is a "plan" within the meaning of Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended (hereinafter "ERISA"), unless specifically exempted thereunder. MVP and Group, further agree that Group is the plan sponsor and administrator of the employee benefit plan as defined in Section 3(16) of ERISA.

GROUP ACKNOWLEDGES AND AGREES THAT MVP IS NOT A HEALTH CARE PROVIDER, AND IS NOT ENGAGED IN THE PRACTICE OF MEDICINE OR THE PROVISION OF PROFESSIONAL MEDICAL SERVICES. NOTWITHSTANDING ANYTHING TO THE CONTRARY, NEITHER MVP NOR ITS OFFICERS, DIRECTORS, SHAREHOLDERS, EMPLOYEES, AGENTS OR OTHER REPRESENTATIVES SHALL BE LIABLE OR RESPONSIBLE TO GROUP, ANY COVERED PERSON OR ANY OTHER PERSON FOR ANY ACT OR OMISSION OF A PARTICIPATING PROVIDER OR ANY OTHER PROVIDER OF HEALTH CARE, OR ITS EMPLOYEES, AGENTS, OR REPRESENTATIVES, IN CONNECTION WITH THE PROVISION OF HEALTH CARE SERVICES TO COVERED PERSONS OR OTHERWISE.

J. Indemnification. Group shall indemnify and hold harmless MVP for, from and against any and all claims, demands, liabilities and expenses (including, without limitation, reasonable attorneys' fees and costs), which are related to, arise out of or are in connection with any negligent or intentional acts or omissions of Group, or any of its employees or agents, in performance of the obligations of Group or Covered Persons under this Group Contract.

K. Execution of the Agreement. This Contract shall be executed by MVP and Group once the Signature Page of this Contract is signed by both MVP and Group.

L. Counterparts. This Group Contract may be executed in one or more counterparts, each of which shall be deemed to be original, but all of which together shall constitute one and the same Group Contract.

MVP PREFERRED EPO
SCHEDULE OF BENEFITS
MVP Health Insurance Company
NY1EPC003ZL

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible		
• Individual	None	
• Family	None	
Out-of-Pocket Limit		
• Individual	[$4,600]	
• Family	[$9,200]	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$15 Copayment	See benefit for description
Specialist Office Visits (or Home Visits)	$15 Copayment	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammography Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectomy	$15 Copayment	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive	Covered in full	

services required by USPSTF and HRSA. • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost-Sharing for appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	Covered in full	See benefit for description
Non-Emergency Ambulance Services	Covered in full	See benefit for description
Emergency Department Cost Share applies to both participating and non-participating providers Copayment waived if Hospital admission	$50 Copayment	See benefit for description
Urgent Care Center	$15 Copayment	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	 $15 Copayment $15 Copayment	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 $15 Copayment $15 Copayment	See benefit for description
Ambulatory Surgical Center	$75 Copayment	See benefit for description

Facility Fee		
Anesthesia Services (all settings)	Covered in full	See benefit for description
Autologous Blood Banking	Covered in Full	See benefits for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $15 Copayment $15 Copayment Included as part of inpatient Hospital service Cost Sharing	36 visits per Plan Year
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $15 Copayment $15 Copayment	See benefit for description
Chiropractic Services	$15 Copayment	See benefit for description
Clinical Trials	Use Cost-Sharing for Appropriate Service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $15 Copayment $15 Copayment	See benefit for description
Dialysis • Performed in a PCP	 $15 Copayment	See benefit for description Dialysis performed by Non-Participating Providers is

Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 $15 Copayment $15 Copayment	limited to 10 visits per plan year
Home Health Care	$15 Copayment	60 visits per Plan Year
Infertility Services	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 • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $15 Copayment $15 Copayment $15 Copayment $15 Copayment	See benefit for description Home Infusion counts toward Home Health Care visit limits
Inpatient Medical Visits	Covered in Full	See benefit for description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 Covered in Full Covered in Full Covered in Full	See benefit for description
Maternity and Newborn Care • Prenatal Care	 Covered in Full Covered in Full	See benefit for description 1 home care visit is covered at no Cost-

• Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care	 Covered in Full Covered in Full Covered in Full	Sharing if mother is discharged from Hospital early Covered for duration of breast feeding. Must use designated provider.
Outpatient Hospital Surgery Facility Charge	$75 Copayment	See benefit for description
Preadmission Testing	$15 Copayment	See benefit for description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $15 Copayment $15 Copayment	See benefit for description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $15 Copayment	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$15 Copayment	30 visits per Plan Year combined therapies
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$15 Copayment	See benefit for description
Surgical Services (including Oral Surgery;		See benefit for description

Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 Covered in Full Covered in Full Covered in Full $15 Copayment	**All Transplants must be performed at designated Facilities**
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$15 Copayment	680 hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$15 Copayment	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education	 $15 Copayment $15 Copayment	See benefit for description
Durable Medical Equipment and Braces	50% Coinsurance	See benefit for description
Hospice Care • Inpatient • Outpatient	 Covered in Full Covered in Full	210 days per Plan Year 5 visits for family bereavement counseling
Medical Supplies	50% Coinsurance	See benefit for description
Prosthetic Devices		See benefit for description

• External • Internal	50% Coinsurance Covered in Full	
INPATIENT SERVICES and FACILITIES	**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)	Covered in Full	See benefit for description
Observation Stay	Covered in Full	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	Covered in Full	60 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	Covered in Full	30 consecutive days per Plan Year
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	Covered in Full	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$15 Copayment	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	Covered in Full	See benefit for description
Outpatient Substance Use Services	$15 Copayment	Unlimited; Up to 20 visits per plan year may be used for family counseling

NY1EPC003ZL

MVP Health Insurance Company
Preferred Provider Organization (PPO)
PNEPO001L

Out-of-Network Benefits Rider

This rider amends Your Contract and Riders to provide benefits for Covered Services that are received from Non-Participating Providers and have not been approved by Us to be covered on an in-network basis. These benefits are referred to as "out-of-network benefits" and are subject to greater Copayment, Deductible and Coinsurance amounts than the benefits available if You obtain the same services from Participating Providers.

A. Out-of-Network Benefits.

Benefits under this rider are only available for Medically Necessary services provided by Non-Participating Providers outside Our Service Area which would have been Covered under Your Contract if they had been provided by a Participating Provider. All services must be furnished by Providers appropriately licensed to provide the particular service being rendered. See the Schedule of Benefits section of this Rider for a list of the services covered out-of-network. Some services are only Covered when You go to a Participating Provider.

B. Day and Limit Visitations.

In any case where benefits of the Contract are limited to a certain number of days or visits, such limits shall apply in the aggregate to services provided pursuant to the Contract and this rider. Any days or visits covered pursuant to this rider will reduce the number of days or visits available under the Contract and vice versa.

C. Out-of-Network Services Subject to Preauthorization.

Our Preauthorization is required before You receive certain Covered Services. A list of services requiring Preauthorization can be found on Our website at [www.mvphealthcare.com]

D. Preauthorization Procedure.

If You seek coverage for services that require Preauthorization, You must call Us at the number on Your ID card.

You 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.

- 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.

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.

F. Out-of-Network Deductible.
There is a separate Out-of-Network Deductible in the Schedule of Benefits section of this Rider that You must pay for Covered out-of-network Services during each Plan Year before We provide coverage for out-of-network services. If You have other than individual coverage, the individual Out-of-Network Deductible applies to each person covered under this Rider. However, after Out-of-Network Deductible payments for persons covered under this Rider collectively total the family Out-of-Network Deductible amount in the Schedule of Benefits section of this Rider in a Plan Year, no further Out-of-Network Deductible will be required for any person covered under this Rider for that Plan Year.

You have a separate In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services does not apply toward Your In-Network Deductible. Cost-Sharing for in-network services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Out-of-Network Deductible.**

G. Out-of-Network Out-of-Pocket Limit.
There is a separate Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Rider for out-of-network benefits. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Rider, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the remainder of that Plan Year. If You have other than individual coverage, the individual Out-of-Network Out-of-Pocket Limit applies to each person covered under this Rider. Once a person within a family meets the individual Out-of-Network Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services 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 Rider have collectively met the family Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Rider, We will provide coverage for 100% of

the Allowed Amount for the rest of that Plan Year. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward Your Out-of-Network Out-of-Pocket Limit.**

Cost-Sharing for in-network services does not apply toward Your Out-of-Network Out-of-Pocket Limit.

H. Your Additional Payments for Out-of-Network Benefits.
When You receive Covered services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Rider You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any amounts You pay under Your applicable Copayment, Deductible and Coinsurance may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two surgeons acting as "co-surgeons". Under the payment rules, the claim from each provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment.

I. Allowed Amount.
"Allowed Amount" means the maximum amount we will pay to a Provider for the services or supplies covered under this Rider, before any applicable Deductible, Copayment, and Coinsurance amounts are subtracted. We determine our Allowed Amount for Non-Participating Providers as follows:

The Allowed Amount or Charge for non-Hospital/facility services is the lowest of a fee agreement, 186% of the regionally adjusted Medicare fee schedule or the non-Hospital/facility provider's actual charges. The Allowed Amount or Charge for Inpatient Hospital/facility services is the lowest of a fee agreement, 186% of the regionally adjusted Medicare fee schedule or the Hospital/facility provider's actual charges. The Allowed Amount or Charge for Outpatient Hospital/facility services is the lowest of a fee agreement, 186% of the regionally adjusted Medicare fee schedule or the

Hospital/facility provider's actual charges.

Our Allowed Amount is not based on UCR and the Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit our website for information on Your financial responsibility when You receive services from a Non-Participating Provider.

We reserve the right to negotiate a lower rate with Non-Participating Providers . If the Facility participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, the rate the Facility has agreed to accept from the other insurer or HMO will apply. Medicare based rates referenced in and applied under this Section shall be updated no less than annually.

See section Covered Services of the Contract for the Allowed Amount for an Emergency Condition.

J. Filing a Claim for Out-of-Network Benefits.
A claim must be filed with Us by You or the out-of-network Provider. Claims forms can be obtained from Us by calling the number on Your ID card or by visiting Our website at www.mvphealthcare.com.

K. Exclusions.
Except as expressly modified by this rider, all of the exclusions of the Contract apply to the benefits covered by this rider. In addition, none of the following services are covered under this rider:

[Transplants]
[Prescription Drugs]
[Neurology and Neurosurgery Care]
[Cardiovascular Surgery]
[Hip Replacement Surgery]
[Knee Replacement Surgery]
[Spinal Surgery]
[Breast Reconstruction Flap Surgery]
[Left Ventricular Assistive Device (LVAD) Surgery]
[Bariatric Surgery]

L. Controlling Contract.
All of the terms, conditions, limitations, and exclusions of Your Contract to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

M. Schedule of Benefits for Out of Network

COST-SHARING	**Non Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual • Family	 $750 $1,500	All covered services are subject to the Deductible and Coinsurance except as stated below:
Coinsurance	20% After Deductible	
Out-of-Pocket Limit • Individual • Family	 [$6,600] [$13,200]	
Well Child Visits and Immunizations	Covered in full	
Emergency Department	Covered the same as In Network	
Home Health Care	20% Coinsurance not subject to Deductible	

MVP Health Insurance Company
20% Coinsurance for Durable Medical Equipment and Braces, Medical Supplies, and External Prosthetic Devices
Rider DNEPO001L

This Rider amends the terms of your MVP Health Insurance Company ("MVP") Group Contract and Certificate of Coverage (the "Contract") as follows:

A. Durable Medical Equipment and Braces, Medical Supplies, and External Prosthetic Devices.
The Schedule of Benefits is amended to change the Durable Medical Equipment and Braces, Medical Supplies, and External Prosthetic Devices Coinsurance amount to twenty percent (20%) of cost, on an IN-NETWORK BASIS ONLY

B. Other Provisions.
All of the terms, conditions and limits in your Contract also apply to this Rider, except where changed by this Rider.

Your group has added this Rider to your Contract. This Rider may be deleted, at your group's option, upon renewal of the group's contract with MVP.

[MVP Health Insurance Company
Schenectady, New York

By: _____
President]

MVP Health Insurance Company
Coverage for 60 visits Physical Therapy / Occupational Therapy / Speech Therapy
Rider MNEPO009L

This Rider amends the terms of your MVP Health Insurance Company ("MVP") Group Contract and Certificate of Coverage (the "Contract") as follows:

A. 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 60 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 physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and
- It is ordered by a Physician;

Covered speech, physical and occupational therapy services must begin within six months of the date of the injury or illness that caused the need for the therapy.

B. Other Provisions.
All of the terms, conditions and limits in your Contract also apply to this Rider, except where changed by this Rider.

Your group has added this Rider to your Contract. This Rider may be deleted, at your group's option, upon renewal of the group's contract with MVP.

[MVP Health Insurance Company
Schenectady, New York

By: _____
President]

MNEPO009L

MVP Health Insurance Company
Coverage for Eye Exam and Eyewear Allowance
Rider YNEPO001L

This Rider amends the terms of your MVP Health Insurance Company ("MVP") Group Contract and Certificate of Coverage (the "Contract") as follows:

A. Eye Exam Coverage.
We will provide Benefits for Participating Provider Charges for one routine eye examination (refraction) every two (2) Plan years.

This Benefit is subject to the Copayment, Deductible, or Coinsurance for Specialist Office Visits set forth on your Schedule of Benefits.

B. Eyeglasses and Contact Lenses Coverage.
We will reimburse you for eighty percent (80%) of the price of one (1) pair of eyeglasses or contact lenses, up to a maximum of $160.00, once in every two (2) Plan year periods, when purchased from any provider. We will not reimburse you for the following:

(1) Prescription Sunglasses.
(2) Replacement of eyeglasses or contact lenses, in whole or in part.
(3) Safety glasses required by employment or sport.

B. Other Provisions.
All of the terms, conditions and limits in your Contract also apply to this Rider, except where changed by this Rider.

Your group has added this Rider to your Contract. This Rider may be deleted, at your group's option, upon renewal of the group's contract with MVP.

[MVP Health Insurance Company
Schenectady, New York

By: _____
President]

MVP Health Insurance Company
Coverage for 200 visits Home Health Care
Rider MNEPO010L

This Rider amends the terms of your MVP Health Insurance Company ("MVP") Group Contract and Certificate of Coverage (the "Contract") as follows:

A. 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 (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the Home Health Agency, and (iv) medical supplies, 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.

Home Health Care is limited to 200 visits per Plan year. Each visit by a member of the Home Health Agency is considered one visit. Please note: Any rehabilitation services received under this benefit will not reduce the amount of services available under "Rehabilitation Services".

B. Other Provisions.
All of the terms, conditions and limits in your Contract also apply to this Rider, except where changed by this Rider.

Your group has added this Rider to your Contract. This Rider may be deleted, at your group's option, upon renewal of the group's contract with MVP.

[MVP Health Insurance Company
Schenectady, New York

By: _____
President]

MNEPO010L

MVP Health Insurance Company
Coverage for WellStyle Rewards
Rider MNEPO028L

This Rider amends the terms of your MVP Health Insurance Company ("MVP") Group Contract and Certificate of Coverage (the "Contract") as follows:

A. WellStyle Rewards.
This program is designed to help you take an active approach in managing your lifestyle by providing incentives for meeting health recommendations, participating in health coaching programs or completing healthy activities online. The program is easily accessible through the member webpage at www.mvphealthcare.com or by calling the Customer Care Center at [1-888-MVP-MBRS (1-888-687-6277).]

a. Wellstyle Rewards.

(i) You can receive up to [300] points per Contract per Calendar Year for completing healthy activities through the Wellstyle Rewards section of the MVP Health Care website. Activities for which you can earn Wellstyle Reward points include: [completion of a Health Risk Assessment], [submission of a validated Health Risk Screening Form], [completion of Lifestyle Coaching Sessions] and [Completion of online courses]. A description of each of these activities is included as part of your membership materials. You can also request a copy by calling the Customer Care Center at [1-888-MVP-MBRS (1-888-687-6277).] Each point earned is equal to one dollar. Once you have earned at least one hundred fifty (150) reward points, you can begin redeeming Wellstyle Rewards. Wellstyle Rewards can only be redeemed in increments of one hundred fifty (150). MVP encourages you to redeem and use Wellstyle Rewards for products or services that promote good health and wellness.

(ii) Wellstyle Rewards are available to you as [a Visa gift card,][or][an American Express gift card] [or] [a reward check]. The above list may change from time to time. For an up to date listing please visit MVP's website at www.mvphealthcare.com or contact the Customer Care Center at [1-888-MVP-MBRS (1-888-687-6277).]

b. Health Coaching Program.

The Health Coaching program offers personalized one-on-one coaching for tobacco cessation, weight management, and other healthy living programs. You are entitled to get up to fifty-two (52) coaching sessions a year. You can earn points for every [four] [(4)] sessions completed up to [200] points for the year. For more information contact the Customer Care Center at [1-888-MVP-MBRS (1-888-687-6277).]

c. Additional Program Provisions
The Wellstyle Reward points you and/or your covered dependents earn are tracked

online automatically. You can go online to the MVP website or contact the Customer Care Center at [1-888-MVP-MBRS (1-888-687-6277)] at anytime to find out how many reward points you and your covered dependents have earned. Covered dependents eligible to earn Wellstyle Reward points include the Subscriber's covered spouse or domestic partner and any dependent age 18 or older. Only the Subscriber will be able to redeem Wellstyle Rewards. The Subscriber will not be able to see the actual activities completed by the covered dependents.

Wellstyle Reward 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. [All activities must be completed by December 31st, and rewards redeemed by March 31st.]

If you do not redeem your points prior to disenrollment you will lose any accumulated points unless you move from an MVP plan with Wellstyle Rewards to another MVP plan with Wellstyle Rewards in the same Calendar Year. In this situation your Wellstyle Rewards 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 Wellstyle Reward points.

d. 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 the Customer Care Center at [1-888- MVP-MBRS (1-888-687-6277)] and we will work with you to develop a way for you to qualify for the reward..

B. Other Provisions.
All of the terms, conditions and limits in your Contract also apply to this Rider, except where changed by this Rider.

Your group has added this Rider to your Contract. This Rider may be deleted, at your group's option, upon renewal of the group's contract with MVP.

[MVP Health Insurance Company
Schenectady, New York

Dennis V Gorski

By: _____
President]

MNEPO028L

Prescription Drug Coverage Rider
MVP Health Insurance Company
RXNY1EPO603ZL

Please refer to the Schedule of Benefits section of this Rider 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; Recognized as safe and effective for the treatment of the prescribed indication
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; 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 supplements (formulas) of the therapeutic treatment of Phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- 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 for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.

- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of Your Contract.
- 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 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.
- Prescription Drugs for smoking cessation.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

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

B. Refills.

We Cover Refills of most Prescription Drugs only when dispensed at a retail or 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 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 Rider.

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 Rider when Covered Prescription Drugs are obtained from a retail or mail order or Designated pharmacy.

   You have a three 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.

   An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent

Prescription Drug is available on a lower tier unless We approve coverage at the higher tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance. The cost difference does not apply toward Your Deductible or 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 or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the 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 [1-888-MVP-MBRS] or visit Our website at [www.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 that are included in this program:

- Age related macular edema;
- Anemia, neutropenia, thrombocytopenia;
- Contraceptives;
- 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;
- Oral 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
- Chronic Hives

5. Mail Order. Certain Prescription Drugs may be ordered through Our mail order supplier. 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 Physician to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You will be charged the mail order Cost-Sharing for any

Prescription Orders or Refills sent to the mail order supplier 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.

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

6. **Tier Status.** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per calendar year, based on Our periodic 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 (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website [at www.mvphealthcare.com] or by calling the Customer Service number on Your ID card.

7. **When a Brand-Name Drug Becomes Available as a Generic.** When a Brand-Name Drug becomes available as a Generic, 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 excluded due to a generic becoming available, You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in the Utilization Review and External Appeal sections of Your Contract.

8. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You may request a Formulary exception for a clinically-appropriate Prescription Drug. Visit Our website at [www.mvphealthcare.com] to find out more about this process.

9. **Supply Limits.** 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 Cost-Sharing amount for up to a 30-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 www.mvphealthcare.com] or by calling the Customer Service number on Your 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 Your Contract.

10. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Orally-Administered Anti-Cancer Drugs are covered in full.

D. Medical Management.
This Rider 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 Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. 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.

   For a list of Prescription Drugs that need Preauthorization, please visit Our website [at www.mvphealthcare.com] or by calling the Customer Service number on Your 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 Contract. 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 type of Prescription Drug before We will Cover another as Medically Necessary. 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.

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 www.mvphealthcare.com] or by calling the Customer Service number on Your 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 may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Compounded Prescription Drugs will be Covered only when they contain at least one ingredient that; is a Covered legend Prescription Drug, and are obtained from a pharmacy that is approved for compounding.

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 are not Covered under this section but are Covered under other sections of Your Contract.

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 Your Contract.

7. We do not Cover drugs that do not by law require a prescription, except as otherwise provided in this Rider.

8. 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.

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

10. 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.

11. 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 Your Contract.

F. General Conditions.

1. You must show Your 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.

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. Instead, 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 Copayment or Coinsurance 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 Your Contract).

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 Rider. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website [at www.mvphealthcare.com] or by calling the Customer Service number on Your 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.

7. **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.

8. **Prescription Drug Cost:** The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Rider 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.

9. **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.

10. **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 Section 6826-a of the New York Education Law.

H. Schedule Of Benefits.

PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy		
30-day supply Tier 1 Tier 2 Tier 3	 $5 Copayment $20 Copayment $40 Copayment	See benefit for description
Mail Order Pharmacy		
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $12.50 Copayment $50 Copayment $100 Copayment	See benefit for description
Enteral Formulas	Subject to the applicable pharmacy copayments and days' supply per dispensing	See benefit for description
Out-of-Pocket Limit* • Individual • Family	 [$2,000] [$4,000]	
Preauthorization	Refer to the Formulary by visiting Our website [at www.mvphealthcare.com] or by calling the Customer Service number on Your ID card	

*Refer to the Definitions Section of your Contract.

By: _____
President]

MVP Health Insurance Company
Change to Mail Order Cost Share
Rider RXNY1EPO703L

This Rider amends the terms of your MVP Health Insurance Company ("MVP") Group Contract, Certificate of Coverage (the "Contract") or Prescription Drug Rider as follows:

A. Change to Mail Order Pharmacy Cost Share.
This Rider changes the Participating Provider Member Responsibility for Cost Sharing of the Mail Order Pharmacy Up to a 90 Day Supply to be two (2) times that of the Member Responsibility for Cost Sharing of the Retail Pharmacy 30 Day Supply for each Tier.

B. Other Provisions.
All of the terms, conditions and limits in your Contract also apply to this Rider, except where changed by this Rider.

Your group has added this Rider to your Contract. This Rider may be deleted, at your group's option, upon renewal of the group's contract with MVP.

[MVP Health Insurance Company
Schenectady, New York

By: _____
President]

MVP Health Insurance Company
Exclusion of Brand Generic Difference
Rider RXNY1EPO702L

This Rider amends the terms of your MVP Health Insurance Company ("MVP") Group Contract, Certificate of Coverage (the "Contract") or Prescription Drug Rider as follows:

A. Exclusion of Brand Generic Difference.
The following is deleted from your Contract or Prescription Drug Rider:

> An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent Prescription Drug is available on a lower tier unless We approve coverage at the higher tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance. The cost difference does not apply toward Your Out-of-Pocket Limit.

B. Other Provisions.
All of the terms, conditions and limits in your Contract also apply to this Rider, except where changed by this Rider.

Your group has added this Rider to your Contract. This Rider may be deleted, at your group's option, upon renewal of the group's contract with MVP.

[MVP Health Insurance Company
Schenectady, New York

By: _____
President]