MVP PREMIER PLUS SCHEDULE OF BENEFITS Gold 4 MVP Health Plan, Inc. Embedded Deductible Off Exchange

COST-SHARING	Participating Member Responsibility for Cost-Share	Non-Participating Provider Member Responsibility for Cost-Sharing	
Deductible		3	
Individual	\$0		
Family	\$0		
• Fairing	\$5	Non-Participating Provider	
Bracarintian Drug Doductible		services are not covered	
Prescription Drug Deductible	\$0	except as required for	
Individual	\$0 \$0	Emergency Care and Urgent	
Family	Ψ0	Care.	
Out of Docket Limit		Care.	
Out-of-Pocket Limit	\$6,350		
 Individual 	\$12,700		
Family	. ,		
OFFICE VISITS	Participating Member	Non-Participating Provider	Limits
	Responsibility for Cost-	Member Responsibility for	
	Sharing	Cost-Sharing	
Primary Care Office Visits (or	\$25 Copayment	Non-Participating Provider	See Benefit For
Home Visits)		services are not covered	Description
		and You pay the full cost	
Specialist Office Visits (or Home	\$40 Copayment	Non-Participating Provider	See Benefit For
Visits		services are not covered	Description
		and You pay the full cost	•
PREVENTIVE CARE	Participating Member	Non-Participating Provider	Limits
	Responsibility for Cost-	Member Responsibility for	
	Sharing	Cost-Sharing	
Well Child Visits and	Covered in full	Non-Participating Provider	See Benefit For
Immunizations*		services are not covered	Description
mmunizations		and You pay the full cost	Decemption
		and rod pay the full cost	
Adult Annual Physical	Covered in full	Non-Participating Provider	
Examinations*		services are not covered	
		and You pay the full cost	
		and too pay the full cost	
	Covered in full	Non-Participating Provider	
 Adult Immunizations* 		services are not covered	
		and You pay the full cost	
		and fou pay the full cost	
Routine Gynecological	Covered in full	Non Participating Provider	
Services/Well Woman		Non-Participating Provider	
Exams*		services are not covered	
		and You pay the full cost	
	Covered in full	Non Participating Provider	
 Mammography Screenings* 		Non-Participating Provider	
		services are not covered	
		and You pay the full cost	
Sterilization Procedures for		Neg Destining (in a Destinit	
• Sterinzation Procedures for Women*	Covered in full	Non-Participating Provider	
	Covered in full	services are not covered	
	Covered in full		
	Covered in full	services are not covered	

Manager			
 Vasectomy 	\$40 Copayment	Non-Participating Provider	
		services are not covered	
		and You pay the full cost	
 Bone Density Testing* 	Covered in full		
		Non-Participating Provider	
		services are not covered	
		and You pay the full cost	
Screening for Prostate	Covered in full		
Cancer		Non-Participating Provider	
Calloon		services are not covered	
• All other preventive services		and You pay the full cost	
required by USPSTF and	Covered in full		
HRSA.		Non-Participating Provider	
IRSA.		services are not covered	
*1.4.11	Use Cost Sharing for	and You pay the full cost	
*When preventive services	Appropriate Service (Primary		
are not provided in	Care Office Visit; Specialist		
accordance with the	Office Visit; Diagnostic	Non-Participating Provider	
comprehensive guidelines		services are not covered	
supported by USPSTF and	Radiology Services; Laboratory Procedures &		
HRSA.		and You pay the full cost	
EMERGENCY CARE	Diagnostic Testing)	Non Doution ating Drovidor	
	Participating Member	Non-Participating Provider	Limits
	Responsibility for Cost-	Member Responsibility for	
	Sharing	Cost-Sharing	
	\$300 Copayment	\$300 Copayment	See Benefit For
Pre-Hospital Emergency Medical	+ · · · · · · · · · · · ·		
Services (Ambulance Services)			Description
Services (Ambulance Services) Non-Emergency Ambulance	\$300 Copayment	\$300 Copayment	See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services	\$300 Copayment		See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department		\$300 Copayment \$300 Copayment	See Benefit For Description See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital	\$300 Copayment		See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission.	\$300 Copayment \$300 Copayment	\$300 Copayment	See Benefit For Description See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital	\$300 Copayment		See Benefit For Description See Benefit For Description See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center	\$300 Copayment \$300 Copayment \$40 Copayment	\$300 Copayment \$40 Copayment	See Benefit For Description See Benefit For Description See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member	\$300 Copayment \$40 Copayment Non-Participating Provider	See Benefit For Description See Benefit For Description See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost-	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for	See Benefit For Description See Benefit For Description See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing	See Benefit For Description See Benefit For Description See Benefit For Description Limits
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost-	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider	See Benefit For Description See Benefit For Description See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered	See Benefit For Description See Benefit For Description See Benefit For Description Limits
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider	See Benefit For Description See Benefit For Description See Benefit For Description Limits
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered	See Benefit For Description See Benefit For Description See Benefit For Description Limits
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description See Benefit For Description See Benefit For Description Limits
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services Allergy Testing & Treatment	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment \$150 Copayment	 \$300 Copayment \$40 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost 	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment	\$300 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services Allergy Testing & Treatment	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment \$150 Copayment	 \$300 Copayment \$40 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost 	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services Allergy Testing & Treatment • Performed in a PCP Office	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment \$150 Copayment \$25 Copayment	 \$300 Copayment \$40 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost 	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services Allergy Testing & Treatment • Performed in a PCP Office	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment \$150 Copayment	 \$300 Copayment \$40 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost 	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services Allergy Testing & Treatment • Performed in a PCP Office	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment \$150 Copayment \$25 Copayment	 \$300 Copayment \$40 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered 	See Benefit For Description See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description See Benefit For
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services Allergy Testing & Treatment • Performed in a PCP Office	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment \$150 Copayment \$25 Copayment \$40 Copayment \$40 Copayment	 \$300 Copayment \$40 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost 	See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services Allergy Testing & Treatment • Performed in a PCP Office • Performed in a Specialist Office Ambulatory Surgical Center	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment \$150 Copayment \$25 Copayment	 \$300 Copayment \$40 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost 	See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description See Benefit For Description
Services (Ambulance Services) Non-Emergency Ambulance Services Emergency Department Copayment waived if Hospital admission. Urgent Care Center PROFESSIONAL SERVICES AND OUTPATIENT CARE Acupuncture Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services Allergy Testing & Treatment • Performed in a PCP Office	\$300 Copayment \$300 Copayment \$40 Copayment Participating Member Responsibility for Cost- Sharing 50% Coinsurance \$150 Copayment \$150 Copayment \$25 Copayment \$40 Copayment \$40 Copayment	 \$300 Copayment \$40 Copayment \$40 Copayment Non-Participating Provider Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost 	See Benefit For Description See Benefit For Description Limits 12 visits per Plan Year See Benefit For Description See Benefit For Description

Anesthesia Services (all settings	Covered in full	Non-Participating Provider	See Benefit For
		services are not covered	Description
		and You pay the full cost	
Autologous Blood Banking	50% Coinsurance	Non-Participating Provider	See Benefits For
		services are not covered	Description
		and You pay the full cost	
Cardiac & Pulmonary			See Benefits For
Rehabilitation		Non-Participating Provider	Description
Performed in a Specialist	\$40 Copayment	services are not covered	
Office		and You pay the full cost	
 Performed as Outpatient 	\$40 Copayment	Non-Participating Provider	
Hospital Services	¢ to copaymont	services are not covered	
riospital Gervices		and You pay the full cost	
Performed as Inpatient	Included as part of inpatient	Non-Participating Provider	
Hospital Services	Hospital service Cost-Sharing	services are not covered	
		and You pay the full cost	
Chemotherapy	4 25 0	Non-Participating Provider	
Performed in a PCP Office	\$25 Copayment	services are not covered	See Benefit For
		and You pay the full cost	Description
- Dorformed in a Specialist	\$40 Copayment	Non-Participating Provider	
 Performed in a Specialist Office 	φ+0 Copayment	services are not covered	
Office		and You pay the full cost	
Performed as Outpatient	\$40 Copayment	Non-Participating Provider	
Hospital Services		services are not covered	
		and You pay the full cost	
Chiropractic Services	\$40 Copayment	Non-Participating Provider	See Benefit For
		services are not covered	Description
Oliniaal Triala	Lies Cost Obering for	and You pay the full cost	One Develit Fee
Clinical Trials	Use Cost-Sharing for Appropriate Service	Non-Participating Provider services are not covered	See Benefit For Description
		and You pay the full cost	Description
Diagnostic Testing		Non-Participating Provider	See Benefit For
 Performed in a PCP Office 	\$25 Copayment	services are not covered	Description
		and You pay the full cost	
Performed in a Specialist	\$40 Copayment	Non-Participating Provider	
Office		services are not covered	
		and You pay the full cost	
 Performed as Outpatient 	\$40 Copayment	Non-Participating Provider	
Hospital Services	\$40 Copayment	services are not covered	
riospital Gervices		and You pay the full cost	
Dialysis			
 Performed in a PCP Office 	\$25 Copayment	\$25 Copayment	See Benefit For
			Description
• Performed in a Freestanding			
Center or Specialist Office	\$40 Copayment	\$40 Copayment	Dialysis Performed by
Setting			Non-Participating
	\$40 Consument	\$40 Congregation	Providers is Limited to
Performed as Outpatient	\$40 Copayment	\$40 Copayment	10 Visits Per Calendar Year
Hospital Services	\$40 Copolymont	Non Participating Provider	
Habilitation Services (Physical Therapy, Occupational Therapy	\$40 Copayment	Non-Participating Provider services are not covered	54 visits per condition, per lifetime combined
or Speech Therapy)		and You pay the full cost	therapies
			morapios

Home Health Care	\$40 Copayment	Non-Participating Provider	60 Visits per Plan
		services are not covered and You pay the full cost	Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Infusion TherapyPerformed in a PCP Office	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
 Performed in Specialist Office 	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
 Performed as Outpatient Hospital Services 	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Home Infusion Therapy	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Home Infusion counts towards Home Health Care Visit Limits
Inpatient Medical Visits	\$0 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Laboratory ProceduresPerformed in a PCP Office	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
 Performed in a Freestanding Laboratory Facility or Specialist Office 	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
 Performed as Outpatient Hospital Services 	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Maternity & Newborn Care Prenatal Care 	Covered In Full	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
 Inpatient Hospital Services and Birthing Center 	\$500 Copayment per admission	Non-Participating Provider services are not covered and You pay the full cost	1 Home Care Visit is Covered at no Cost- Sharing if mother is discharged from
 Physician and Midwife Services for Delivery 	\$0 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Hospital early
Breast Pump	Covered in Full	Non-Participating Provider services are not covered and You pay the full cost	Covered for duration of breast feeding
Postnatal Care	Included as part of the surgeon's cost share for delivery.	Non-Participating Provider services are not covered and You pay the full cost	

Outpatient Hospital Surgery	\$300 Copayment	Non-Participating Provider	See Benefit For
Facility Charge		services are not covered	Description
		and You pay the full cost	
Preadmission Testing	Covered in full	Non-Participating Provider	See Benefit For
-		services are not covered	Description
		and You pay the full cost	
Diagnostic Radiology Services		Non-Participating Provider	See Benefit For
Performed in a PCP Office	\$25 Copayment	services are not covered	Description
		and You pay the full cost	
Performed in a Freestanding Dedialogy Facility or	\$150 Copayment	Non-Participating Provider	
Radiology Facility or	\$150 Copayment	services are not covered	
Specialist Office		and You pay the full cost	
 Performed as Outpatient 		and rou pay the full cost	
 Performed as Outpatient Hospital Services 	\$150 Copayment	Non-Participating Provider	
Hospital Services	¢	services are not covered	
		and You pay the full cost	
Therapeutic Radiology Services		Non-Participating Provider	See Benefit For
• Performed in a Freestanding		services are not covered	Description
Radiology Facility or	\$40 Copayment	and You pay the full cost	-
Specialist Office			
		Non-Participating Provider	
 Performed as Outpatient 	\$40 Copayment	services are not covered	
Hospital Services		and You pay the full cost	
Rehabilitation Services (Physical		Non-Participating Provider	54 visits per condition,
Therapy, Occupational Therapy	\$40 Copayment	services are not covered	per lifetime combined
or Speech Therapy)		and You pay the full cost	therapies.
Second Opinions on the	¢40 Conservations	Non-Participating Provider	See Benefit For
Diagnosis of Cancer, Surgery & Other	\$40 Copayment	services are not covered	Description
Other		and You pay the full cost	
Surgical Services (Including Oral			See Benefit For
Surgery; Reconstructive Breast			Description
Surgery; Other Reconstructive &			
Corrective Surgery; Transplants;		No. Destrict of the Destriction	
& Interruption of Pregnancy)	to Consumant	Non-Participating Provider	All Trepenlente Must
 Inpatient Hospital Surgery 	\$0 Copayment	services are not covered	All Transplants Must be Performed at
		and You pay the full cost	Designated Facilities
Outpatient Hospital Surgery	\$0 Copayment	Non-Participating Provider	Designated racinties
	to copagnion	services are not covered	
		and You pay the full cost	
Surgery Performed at an	\$0 Copayment	Non-Participating Provider	
Ambulatory Surgical Center		services are not covered	
		and You pay the full cost	
Specialist Office Ourset			
Specialist Office Surgery	\$40 Copayment	Non-Participating Provider	
		services are not covered	
		and You pay the full cost	
PCP Office Surgery	\$25 Copayment	Non-Participating Provider	
	φ20 Ουραγιτιστιί	services are not covered	
		and You pay the full cost	
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ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Member Responsibility for Cost- Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
 Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) 	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Diabetic Education	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Durable Medical Equipment & Braces	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
External Hearing Aid	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	Single Purchase Once Every 3 Years
Cochlear Implants	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	One Per Ear Per Time Covered
Hospice CareInpatient	\$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	210 Days per Plan Year
Outpatient	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	5 Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Prosthetic DevicesExternal	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	One prosthetic device, per limb, per lifetime
Internal	\$0 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Unlimited See Benefit For Description
Out of Service Area	Use Cost Sharing for Appropriate Service	Up to \$1000 in out of service area covered benefits per Dependent Child per plan year.	See Benefit For Description
INPATIENT SERVICES & FACILITIES	Participating Member Responsibility for Cost- Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	\$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description

Observation Stay	\$300 Copayment	\$300 Copayment	See Benefit For
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	\$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Description 200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	\$500 Copayment Participating Member Responsibility for Cost- Sharing	Non-Participating Provider services are not covered and You pay the full costNon-Participating Provider Member Responsibility for Cost-Sharing	60 Consecutive Days Per Condition, Per Lifetime Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	\$500 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Outpatient Substance Use Services	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Unlimited; Up to 20 Visits a Calendar Year May Be Used For Family Counseling
PRESCRIPTION DRUGS	Participating Member Responsibility for Cost- Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
	Responsibility for Cost-	Member Responsibility for	See Benefit For Description
Retail Pharmacy 30 Day Supply	Responsibility for Cost- Sharing	Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered	See Benefit For
Retail Pharmacy 30 Day Supply Tier 1 Tier 2 Tier 3	Responsibility for Cost- Sharing \$5 Copayment	Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
Retail Pharmacy 30 Day Supply Tier 1 Tier 2	Responsibility for Cost- Sharing \$5 Copayment \$45 Copayment	Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered	See Benefit For Description See Benefit For Description Mail Order Not
Retail Pharmacy 30 Day Supply Tier 1 Tier 2 Tier 3 Enteral Formula 30 Day Supply	Responsibility for Cost- Sharing \$5 Copayment \$45 Copayment 50% Coinsurance	Member Responsibility for Cost-Sharing Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered	See Benefit For Description See Benefit For Description

WELLNESS BENEFITS	Participating Member Responsibility for Cost- Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Gym Reimbursement	Up to \$125 reimbursement per contract for gym and fitness club membership, youth sports and fitness fees or healthy weight support.	Non-Participating Provider services are not covered and You pay the full cost	See Benefit For Description
PEDIATRIC VISION CARE	Participating Member Responsibility for Cost- Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Vision CareExams	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	One Exam Per 12- Month Period; One Prescribed Standard Lenses & Frames in a
Lenses & Frames	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	12-Month Period
Contact Lenses	50% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	