MVP SILVER

Schedule of Benefits & Plan Design

Medical Services Deductible Information

Deductible [1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2,6]
Individual	$0	
Family	$0	

Out of Pocket Information

Out of Pocket Maximum [1]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2,6]
Individual	$5,000	
Family	$10,000	

Schedule of Benefits

The following table represents the medical services currently covered under the MVP SILVER™ Plan, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

Plan Provisions		Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2,6]
			Member Pays	
PHYSICIAN SERVICES				
Primary Care Office Visit	Limited to 10 visits per plan year	No	$15 Copay	$15 Copay
Specialist Office Visit	Limited to 10 visits per plan year	No	$25 Copay	$25 Copay
Other Physician Services Performed in the Office[4] (Limited to Primary Care/Specialist visits per plan year)		Yes[5]	$25 Copay	$25 Copay
Urgent Care (Limited to 3 visits per plan year)		No	$35 Copay	$35 Copay
Telemedicine Vendor Services		No	$0 Copay	Not Applicable

[1] The Deductible and Out of Pocket amounts are combined across In Network and Out of Network Providers.
[2] In addition to the copay listed, the member will also be responsible for any billed charges in excess of the 85 Percentile of the Usual, Customary, and Reasonable (UCR) charge.
[3] If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after copay.
[4] The plan will only reimburse buy and bill drugs up to the lessor of the allowed amount or network rate or the amount that the Third-Party Administrator or Pharmacy Benefits Manager could source the drug for.
[5] Prior authorization is required for any service or procedure over $1,000.
[6] If the Plan covers Emergency Room and/or Ambulance Services, those services will be covered if they are provided by an Out of Network provider and will be reimbursed at the In Network level of benefits.

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Plan Provisions		Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2,6]
			Member Pays	
PREVENTIVE & WELLNESS SERVICES				
(See Schedule of Preventive Health Services section)	**(Non-Hospital Based)**	No	$0 Copay	$0 Copay
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
HOSPITAL/FACILITY SERVICES (Subject to Referenced Based Pricing)				
Inpatient Hospitalization (Limited to 7 days per plan year)		Yes	$350 Copay per admission (Subject to Reference Based Pricing)	
Inpatient Visits - Physician (Limited to visits up to 7 days per plan year)		No	Included in Inpatient Hospitalization Copay	
Inpatient Surgery - Physician Charges (Second surgical opinion may be required; Limited to 3 surgeries per plan year)		Yes	Included in Inpatient Hospitalization Copay	
Outpatient Hospital or Free-Standing Facility Services and Surgery (Limited to 2 visits per plan year)		Yes	$350 Copay (Subject to Reference Based Pricing)	
Anesthesia (Limited to 3 inpatient and 2 outpatient anesthetic procedures per plan year)		No	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay	
Emergency Room Services (Limited to 1 visit per plan year)		No	$350 Copay (Subject to Reference Based Pricing)	
OUTPATIENT: DIAGNOSTIC SERVICES				
Laboratory Service	**(Non-Hospital Based)** (Combined limit of 3 visits per plan year with Radiology)	No	$50 Copay	$50 Copay
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
Radiology	**(Non-Hospital Based)** (Combined limit of 3 visits per plan year with Laboratory Services)	No	$50 Copay	$50 Copay
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member
CT/MRI/MRA/PET Scan (Limited to 2 per plan year)	**(Non-Hospital Based)**	Yes	$350 Copay (Subject to Reference Based Pricing)	
	(Hospital Based)	No	Not Covered 100% paid by Member	Not Covered 100% paid by Member

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Plan Provisions	Prior Auth Required[3]	Participating Providers (In Network)	Non-Participating Providers (Out of Network)[2,6]
		Member Pays	
PREGNANCY BENEFITS			
Professional Services	No	$350 Copay	$350 Copay
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)	No	$350 Copay per admission (Subject to Reference Based Pricing)	
OTHER SERVICES			
Allergy Services (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit)	No	$25 Copay	$25 Copay
Chiropractic Services **(Limited to 10 visits per plan year)**	No	$25 Copay	$25 Copay
Second Surgical Opinion (Telephonic/On-line Service)	No	$0 Copay	Not Applicable
Home Health Care (Limited to 15 visits per plan year)	Yes	$25 Copay	$25 Copay
Mental Health, Behavioral Health, or Substance Abuse Services **(In-Patient or Partial Day)** (Limited to 7 days per plan year)	Yes	$250 Copay per day (Not to exceed $350 Copay per admission) (Subject to Reference Based Pricing)	
Mental Health, Behavioral Health, or Substance Abuse Services **(Out-Patient)** (Limited to 10 visits per plan year)	No	$25 Copay	$25 Copay
Rehabilitation/Habilitation Services Combined limit of 10 visits per plan year with physical, speech, and occupational therapies. Pre-authorization is required after 6 visits.	Yes	$25 Copay	$25 Copay
Emergency Medical Transportation (By land only; Limited to 1 transport per plan year)	No	$250 Copay (Subject to Reference Based Pricing)	

PHARMACY BENEFITS		Participating Pharmacies	Non-Participating Pharmacies
		Member Pays	
Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Generic - $0 Copay (Limited to Preventive Generic)	Not Covered 100% paid by Member
Non-Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30-day supply		Generic & Preferred – 20% Coinsurance Non-Preferred - Not Covered	Not Covered 100% paid by Member
Pharmacy Mail Order – 90-day supply		Generic & Preferred – 20% Coinsurance Non-Preferred -Not Covered	Not Covered 100% paid by Member
Specialty Drugs		Not Covered 100% paid by Member	Not Covered 100% paid by Member

TELEHEALTH

HBAEHEALTH is your gateway to comprehensive healthcare, offering you convenient access to a diverse team of board-certified Primary Care Physicians and licensed Mental Health Therapists who cater to the needs of your entire family.

GET STARTED:

- Register with HBAeHealth by **CLICKING HERE**
- Add all covered dependents
- Once registered, you are ready to use HBAeHealth

(877) 422-6331

PRESCRIPTION COVERAGE

The **HBAScripts program** helps control costs by offering 90% of the most utilized acute and chronic generic medications at no cost to you or your covered family members. A generic brand drug is a medication with the same exact active ingredients as their brand-name counterparts but is more cost effective.

Fairos Rx is your pharmacy benefit manager who is responsible for:

- ✓ **Processing All Pharmacy Claims**
- ✓ **Formulary Management**
- ✓ **Patient Education and Support**
- ✓ **Pharmacy Network Management**
- ✓ **Handling all the above for the HBAScripts Program**

WHAT DO I HAVE TO DO TO RECEIVE THESE COST SAVINGS?

All you have to do is present your medical ID card at your local in-network pharmacy. Click here to register on the Fairos Rx portal to find a local in-network pharmacy and to look-up your prescriptions.

All Prescription Related Questions should be directed to Fairos Rx:

(833) 464-9600

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Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
   a. Sports,
   b. Camp,
   c. Employment,
   d. Travel,
   e. Insurance,
   f. Marriage,
   g. Legal proceedings
2. Routine foot care for treatment of the following:
   a. Flat feet,
   b. Corns,
   c. Bunions,
   d. Calluses,
   e. Toenails,
   f. Fallen arches,
   g. Weak feet,
   h. Chronic foot strain
3. Dental procedures
4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits
5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by any appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
6. Claims unrelated to treatment of medical care or treatment
7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
9. Any claim related to an injury arising out of or in the course of any employment for wage or profit that would be covered by other coverage for which the member is eligible
10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
13. Claims due to an act of war, declared or undeclared, not including acts of terrorism
14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
15. Elective, voluntary abortions, except in the case of rape, incest, or congenital deformities of the fetus as determined through pre-natal testing, or when the life of the mother would be threatened if the fetus were carried to term
16. Travel, unless specifically provided in the schedule of benefits
17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
20. Services or supplies which are primarily educational
21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the oppositesex and any other treatment or study related to sex change

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Exclusions

24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
25. Any claims for fertility or infertility treatment.
26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
27. Claims for disability resulting from reversal of sterilization
28. Claims for the completion of forms, or failure to keep scheduled appointments
29. Recreational or diversional therapy
30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
32. Claims that arise primarily due to medical tourism
33. Supportive devices of the foot
34. Treatments for sexual dysfunction
35. Aquatic or massage therapy
36. Biofeedback training
37. Skilled nursing facilities
38. Durable medical equipment and prosthetics
39. Hospice care, private duty nursing, or long-term care
40. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
41. Claims for temporomandibular joint syndrome
42. Claims for biotech or specialty drugs, including biologics and hemophiliac drugs
43. Genetic testing unless explicitly covered in the schedule of benefits
44. Human Cell, Tissue, and Organ transplantation
45. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.
46. Radiation and chemotherapy
47. Dialysis
48. Acupuncture
49. Alternative medicine/homeopathy
50. Children dental and vision
51. Routine eye care (Adult)
52. Inpatient facility claims for surgery after the inpatient hospital day limit per plan year has been exhausted
53. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands
54. All maternity coverage for dependent children, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded.
55. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship).
56. Use of emergency room for non-emergency care.
57. Emerging gene and cell therapies
58. Diagnosis and treatment for sleep apnea

"The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan."