

MVP SILVER

Schedule of Benefits & Plan Design Medical Services Deductible Information

<i>Deductible</i> ¹	Participating Providers (In Network)	Non-Participating Providers (Out of Network) ^{2,6}
Individual	\$0	
Family	\$0	

Out of Pocket Information

<i>Out of Pocket Maximum</i> 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 deductible, coinsurance, and/or copay listed, the member will be responsible for any billed charges in excess of 120% of the Medicare rate.

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 lesser 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 Hospitalization or Partial Day) (Limited to 7 days per plan year)	Yes	\$350 Copay per admission (Subject to Reference Based Pricing)	
Mental Health, Behavioral Health, or Substance Abuse Services	Outpatient Hospital or Free-Standing Facility Services and Surgery (Limited to 2 visits per plan year)	Yes	\$350 Copay (Subject to Reference Based Pricing)	
Mental Health, Behavioral Health, or Substance Abuse Services	Office Visits (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 ⁷	Retail (30-day supply)	Retail (90-day supply)	Mail Order (90-day supply)
Member Pays			
HBAScriptsSM (Subject to Formulary⁸)			
Acute (up to 30-day supply)	\$0 Copay	N/A	N/A
Chronic (limited to two (2) 30-day fills, then 90-day fills required)	\$0 Copay	\$0 Copay	\$0 Copay
Insulin (ReliOn TM Novolin 70/30 and NovoLog [®])	Vials \$10 / Pens \$25	Vials \$20 / Pens \$50	Vials \$20 / Pens \$50
All Other Prescriptions (Subject to Formulary)			
Tier 1 - ACA Preventive Drugs	\$0 Copay	\$0 Copay	\$0 Copay
Tier 2 - Generic (non-preventive)	20% Coinsurance	N/A	20% Coinsurance
Tier 3 - Preferred Brand	20% Coinsurance	N/A	20% Coinsurance
Tier 4 - Non-Preferred Brand	Not Covered	N/A	Not Covered
Tier 5 - Specialty	Not Covered	N/A	Not Covered

⁷ To be eligible for pharmacy benefits covered prescriptions must be dispensed through participating pharmacies and mail order channels.

⁸ The HBAScriptsSM formulary consists of acute and chronic generic drugs that represent over 90% of the most commonly-dispensed prescriptions in the U.S., as well as specific (non-insulin) diabetic supplies available at no cost to covered participants.

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Exclusions

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

1. Routine physical exams, office visits, immunizations and/or tests that do not directly treat an actual illness, injury, or condition. This includes reports, evaluations, or hospitalization not required for health reasons; physical exams/tests required for or by an employer, school, sports physicals, insurance or government authority, camp, marriage, travel, and court ordered, forensic, legal proceedings or custodial evaluations, except as otherwise specifically stated in this document.
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 was carried to term, are subject to the laws and regulations of the state in which the procedure is performed. It is the responsibility of the service provider to ensure compliance with all applicable state laws and regulations regarding abortion.
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 opposite sex 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 for the care and/or treatment of an injury or illness resulting from engaging in a hazardous pursuit, hobby, or activity. A pursuit, hobby, or activity is hazardous if it is characterized by a constant threat of danger or by an increased risk of bodily harm. Examples of hazardous pursuits, hobbies, or activities include, but are not limited to, adventure sports such as skydiving, hang gliding, rappelling, rock climbing, bungee jumping, parasailing, use of all-terrain vehicles, motorcycle, boat or automobile racing, skiing off-piste, snowboarding off-piste, and activities such as reckless operation of a vehicle or other machinery, and motorcycle riding without a helmet.
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. Cell & gene therapies
58. Diagnosis and treatment for sleep apnea
59. CAR T therapies
60. Private room unless medically necessary or if a semi-private room is not available

"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."