

Health Care Benefits	MPIHP/ Anthem Blue Cross	Health Net <i>California Only</i>	Kaiser Permanente <i>California Only</i>	Oxford Health Plans <i>New York, New Jersey and Connecticut Only</i>
Out-of-Network Coverage	<ul style="list-style-type: none"> • Yes, as shown below • Balance Billing could occur 	Only in an emergency	Only in an emergency	<ul style="list-style-type: none"> • Yes, as shown below • Balance Billing could occur
Annual Deductible	None	None	None	<ul style="list-style-type: none"> • In Network: None • Out-of-Network: \$500 per person up to \$1,000 per family
Annual Out-of-Pocket Maximum	<ul style="list-style-type: none"> • In Network: \$1,000 per person • Includes Coinsurance; does not include Co-pays • Out-of-Network: Unlimited 	<ul style="list-style-type: none"> • \$1,500 per person up to \$4,500 per family • Includes Coinsurance and Co-pays 	<ul style="list-style-type: none"> • \$1,500 per person up to \$3,000 per family • Includes Coinsurance and Co-pays 	<ul style="list-style-type: none"> • In Network: Not Applicable • Out-of-Network: \$8,000 per person up to \$16,000 per family • Includes Coinsurance and Deductible; does not include Co-pays
Hospital Services <ul style="list-style-type: none"> • Room and Board • Intensive Care • Ancillary Services • Semi-Private Room 	<ul style="list-style-type: none"> • In-Network: 10% Coinsurance plus \$100 per admission • Out-of-Network: 50% Coinsurance plus \$100 per admission 	<ul style="list-style-type: none"> • No Charge 	<ul style="list-style-type: none"> • No Charge 	<ul style="list-style-type: none"> • In Network: No charge • Out-of-Network: Deductible plus 30% Coinsurance

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Extended Care <ul style="list-style-type: none"> • Room and Board in a Skilled Nursing Facility • Other Services and Supplies 	<ul style="list-style-type: none"> • In-Network: 10% Coinsurance • Out-of-network: 50% Coinsurance • Plan coverage ends after <ul style="list-style-type: none"> - 90 days for Participants - 60 days for Dependents 	No charge (up to 100 days per calendar year)	No charge (up to 100 days per calendar year)	<ul style="list-style-type: none"> • In Network: No charge • Out-of-Network: Deductible plus 30% Coinsurance
Emergency Services Within or Outside Service Area	<ul style="list-style-type: none"> • 10% Coinsurance plus \$100 Co-pay (waived if admitted to a hospital) • All covered services when medically necessary are available anywhere in the world from any licensed physician, surgeon or general hospital, • Out-of-Network hospital facility Allowable Amounts (not professional Allowable Amounts) capped at \$1,000 per emergency 	<ul style="list-style-type: none"> • \$35 Co-Pay (waived if admitted to a hospital) • All covered services when medically necessary are available anywhere in the world from any licensed physician, surgeon or general hospital 	<ul style="list-style-type: none"> • \$35 Co-Pay (waived if admitted to a hospital) • All covered services when medically necessary are available anywhere in the world from any licensed physician, surgeon or general hospital 	<ul style="list-style-type: none"> • \$25 Co-Pay (waived if admitted to a hospital) • All covered services when medically necessary are available anywhere in the world from any licensed physician, surgeon or general hospital
Professional Benefits <ul style="list-style-type: none"> • Physician Visits: <ul style="list-style-type: none"> – Hospital/Office – Surgeon – Assistant Surgeon – Co-Pays apply per visit to office visits and inpatient visits unless otherwise noted 	<ul style="list-style-type: none"> • MPTF/TIHN: \$5 Co-Pay • In Network in MPTF area: 10% Coinsurance plus \$30 Co-Pay • In Network out of MPTF area: 10% Coinsurance plus \$15 Co-Pay • Out-of-Network in MPTF area: 50% coinsurance plus \$30 co-pay • Out-of-Network out of MPTF area: 50% Coinsurance plus \$15 Co-Pay 	<ul style="list-style-type: none"> • \$15 Co-Pay for office visits; • No charge for inpatient visits 	<ul style="list-style-type: none"> • \$15 Co-Pay for office visits; • No charge for inpatient visits 	<ul style="list-style-type: none"> • In-Network: \$15 Co-Pay for office visits; no charge for inpatient visits • Out-of-Network: Deductible plus 30% Coinsurance

Health Care Benefits <i>Professional Benefits (continued)</i>	MPIHP/ Anthem Blue Cross	Health Net California Only	Kaiser Permanente California Only	Oxford Health Plans New York, New Jersey and Connecticut Only
<ul style="list-style-type: none"> Urgent Care Visits: 	<ul style="list-style-type: none"> Same as Physician Visits 	<ul style="list-style-type: none"> \$35 Co-Pay 	<ul style="list-style-type: none"> \$15 Co-Pay 	<ul style="list-style-type: none"> \$15 Co-Pay
<ul style="list-style-type: none"> Anesthesia (Note that anesthesiologist can be Out-of-Network even when the hospital and surgeon are In-Network) 	<ul style="list-style-type: none"> In Network: 10% Coinsurance Out-of-Network: 50% Coinsurance 	<ul style="list-style-type: none"> In Network: No charge Out-of-Network: Not covered 	<ul style="list-style-type: none"> In Network: No charge Out-of-Network: Not Covered 	<ul style="list-style-type: none"> In Network: No charge Out-of-Network: 30% Coinsurance
<ul style="list-style-type: none"> Ambulance Services (including air ambulance) 	<ul style="list-style-type: none"> Emergency: 10% Coinsurance Non-emergency and medically necessary In Network: 10% Coinsurance Out-of-Network: 50% Coinsurance 	<ul style="list-style-type: none"> Emergency: No charge Non-emergency: Prior approval is required 	<ul style="list-style-type: none"> Emergency: No charge Non-emergency: Prior approval is required 	<ul style="list-style-type: none"> Emergency: No charge Non-emergency: Prior approval is required Non-emergency Air Transportation is not covered
<ul style="list-style-type: none"> Laboratory Tests and Diagnostic Imaging 	<ul style="list-style-type: none"> In Network: 10% Coinsurance Out-of-Network: 50% Coinsurance 	<ul style="list-style-type: none"> No charge 	<ul style="list-style-type: none"> No charge 	<ul style="list-style-type: none"> In-Network: No charge Out-of-Network: Deductible plus 30% Coinsurance
<ul style="list-style-type: none"> Injectable Drugs (Outpatient) 	<ul style="list-style-type: none"> Allergy Shots and Injectable Drugs not covered by Express Scripts In-Network: 10% Coinsurance Out-of-Network: 50% Coinsurance Covered through Express Scripts. <i>See Express Scripts section</i> 	<ul style="list-style-type: none"> No Charge for injections, allergy injection services or testing (Injections for infertility are paid at 50%) Also covered through Express Scripts. <i>See Express Scripts section</i> 	<ul style="list-style-type: none"> Most injectable drugs, including allergy tests, provided at no charge if administered in the medical office; <i>see Evidence of Coverage</i> Also covered through Express Scripts. <i>See Express Scripts section</i> 	<ul style="list-style-type: none"> Subject to Physician Visit Co-Pay Also covered through Express Scripts. <i>See Express Scripts section</i>

Health Care Benefits <i>Professional Benefits (continued)</i>	MPIHP/ Anthem Blue Cross	Health Net California Only	Kaiser Permanente California Only	Oxford Health Plans New York, New Jersey and Connecticut Only
<ul style="list-style-type: none"> • Eye Examinations 	<ul style="list-style-type: none"> • \$20 Co-Pay for routine eye examinations and corrective lenses are covered through VSP (<i>see Vision Service Plan section</i>) • Non-routine same as Physician Visit 	<ul style="list-style-type: none"> • \$15 Co-Pay per visit • Routine exams are also covered through VSP at a \$20 Co-Pay (<i>see Vision Service Plan section</i>) 	<ul style="list-style-type: none"> • \$15 Co-Pay per visit • Routine exams are also covered through VSP at a \$20 Co-Pay (<i>see Vision Service Plan section</i>) 	<ul style="list-style-type: none"> • \$20 Co-Pay for routine eye examinations and corrective lenses are covered through VSP (<i>see Vision Service Plan section</i>) • Non-routine same as Physician Visit
<ul style="list-style-type: none"> • Chiropractic Services 	<ul style="list-style-type: none"> • In-Network: No Charge • Out-of-Network: Maximum Allowable Amounts and other limitations apply (<i>see "Benefits and Limitations" section</i>) • Maximum of 20 visits per calendar year for both In and Out-of-Network 	<ul style="list-style-type: none"> • \$15 Co-Pay per visit Available through ASH Networks only (<i>see page 79</i>) 	<ul style="list-style-type: none"> • \$15 Co-Pay per visit Available through ASH Networks only (<i>see page 85</i>) 	<ul style="list-style-type: none"> • In-Network: \$15 Co-Pay per visit • Out-of-Network: 30% Coinsurance plus Deductible
<ul style="list-style-type: none"> • Physical Therapy 	<ul style="list-style-type: none"> • Same as Physician Visits • Out-of-Network: Maximum Allowable Amounts and other limitation apply (<i>see "Benefits and Limitations" section</i>) • Maximum of 16 visits per year per injury; 2nd injury needs approval; visit limit applies to both In and Out-of-Network 	<ul style="list-style-type: none"> • No charge 	<ul style="list-style-type: none"> • \$15 Co-Pay per visit 	<ul style="list-style-type: none"> • In-Network: \$15 Co-Pay per visit (through OptumHealth/UHC); • Out-of-Network: 30% Coinsurance plus Deductible • Maximum of 90 visits per condition per lifetime for both in and Out-of-Network • Maximum of 60 inpatient days per condition per lifetime for both in and Out-of-Network

Health Care Benefits <i>Professional Benefits (continued)</i>	MPIHP/ Anthem Blue Cross	Health Net California Only	Kaiser Permanente California Only	Oxford Health Plans New York, New Jersey and Connecticut Only
<ul style="list-style-type: none"> Physical Examination (annual) 	<ul style="list-style-type: none"> Newborn through age 17: No charge. All well child care visits through age 4 are covered. Annual physical exam for ages 5 and above is covered. MPTF/TIHN: \$5 Co-Pay In MPTF area: Visits for age 18 and older only MPTF/TIHN Providers are covered Out-of- MPTF area: Visits for age 18 and older are covered like other Physician Visits 	<ul style="list-style-type: none"> \$15 Co-Pay 	<ul style="list-style-type: none"> \$15 Co-Pay 	<ul style="list-style-type: none"> In Network: No charge Out-of-Network: Not covered except for children under age 19. The benefit is paid after the Deductible plus 30% Coinsurance
Home Health Services <ul style="list-style-type: none"> Physician Home Visits 	<ul style="list-style-type: none"> Same as Physician Visit 	<ul style="list-style-type: none"> \$30 Co-Pay per visit 	<ul style="list-style-type: none"> No charge; limited to 100 visits per year and three visits per day. 	<ul style="list-style-type: none"> In Network: \$15 Co-Pay Out-of-Network: Deductible plus 30% Coinsurance
<ul style="list-style-type: none"> Home Health Nurse 	<ul style="list-style-type: none"> No Co-Pays Coinsurance applies 	<ul style="list-style-type: none"> \$10 Co-Pay on and after the 31st calendar day 	<ul style="list-style-type: none"> No charge; same limits as Physician Home Visits. 	<ul style="list-style-type: none"> In-Network: \$15 for initial visit. Only 60 visits per year with maximum of 4 hours per visit. Out-of-Network: 20% Coinsurance; only 60 visits per year with maximum of 4 hours per visit
<ul style="list-style-type: none"> Hospice 	No charge	<ul style="list-style-type: none"> No charge 	<ul style="list-style-type: none"> No charge 	<ul style="list-style-type: none"> Same as other Home Health Services

Health Care Benefits <i>Family Planning Services (continued)</i>	MPIHP/ Anthem Blue Cross	Health Net California Only	Kaiser Permanente California Only	Oxford Health Plans New York, New Jersey and Connecticut Only
Maternity Benefits	<ul style="list-style-type: none"> Physician applicable Coinsurance plus at least one Physician Co-Pay (number of Co-Pays depends on the specific Provider's contract) Hospital applicable Coinsurance and Co-Pay Dependent children not covered 	<ul style="list-style-type: none"> \$15 Co-Pay per visit No charge in hospital 	<ul style="list-style-type: none"> \$15 Co-Pay per visit No charge in hospital 	<ul style="list-style-type: none"> In-Network: \$15 Co-Pay for initial visit, no charge for subsequent care Out-of-Network: Covered only in an emergency
Family Planning Services <ul style="list-style-type: none"> Vasectomy 	<ul style="list-style-type: none"> Not covered 	<ul style="list-style-type: none"> \$50 Co-pay 	<ul style="list-style-type: none"> Outpatient: \$15 Co-Pay Inpatient: No charge 	<ul style="list-style-type: none"> In Network: No charge, reversal not covered Out-of-Network: Deductible plus 30% Coinsurance
<ul style="list-style-type: none"> Tubal Ligation 	<ul style="list-style-type: none"> Not Covered 	<ul style="list-style-type: none"> \$150 Co-Pay 	<ul style="list-style-type: none"> Outpatient: \$15 Co-pay Inpatient: No charge 	<ul style="list-style-type: none"> In-Network: No charge, reversal not covered Out-of-Network: Deductible plus 30% Coinsurance, reversal not covered
<ul style="list-style-type: none"> Elective Abortion 	<ul style="list-style-type: none"> Covered under specific conditions. See Abortion in the Benefits and Limitations Section 	<ul style="list-style-type: none"> No Charge for medically necessary abortion \$150 for elective abortion 	<ul style="list-style-type: none"> Outpatient: \$15 Co-Pay Inpatient: No charge 	<ul style="list-style-type: none"> In Network: No charge Out-of-Network: Deductible plus 30% Coinsurance Maximum Allowable Amount of \$350 per abortion for both In- and Out-of-Network

Health Care Benefits <i>Family Planning Services (continued)</i>	MPIHP/ Anthem Blue Cross	Health Net California Only	Kaiser Permanente California Only	Oxford Health Plans (Preferred Provider Org.) New York, New Jersey and Connecticut Only
Intrauterine Device (IUD) [Provided in a physician's office.]	<ul style="list-style-type: none"> • MPTF/TIHN: \$5 Co-Pay • In-Network in MPTF area: 10% Coinsurance plus \$30 Co-Pay • In-Network out of MPTF area: 10% Coinsurance plus \$15 Co-Pay • Out-of-Network in MPTF area: 50% Coinsurance plus \$30 Co-Pay • Out-of-Network out of MPTF area: 50% Coinsurance plus \$15 Co-Pay 	<ul style="list-style-type: none"> • \$15 Co-Pay for the insertion and removal of the IUD only; the IUD is not covered 	<ul style="list-style-type: none"> • \$15 Co-Pay 	<ul style="list-style-type: none"> • Not covered
Mental Health Outpatient	<ul style="list-style-type: none"> • In Network: \$5 Co-Pay per visit • Out-of-Network: 50% Coinsurance 	<ul style="list-style-type: none"> • \$15 Co-Pay per visit 	<ul style="list-style-type: none"> • \$15 Co-Pay per visit • \$7 Co-Pay per visit for group therapy 	<ul style="list-style-type: none"> • In Network: \$15 Co-Pay per visit • Out-of-Network: Deductible plus 30% Coinsurance
Mental Health Inpatient	<ul style="list-style-type: none"> • In-Network: No charge • Out-of-Network: \$100 per admission, then 50% Coinsurance 	<ul style="list-style-type: none"> • No charge 	<ul style="list-style-type: none"> • No charge 	<ul style="list-style-type: none"> • In Network: No charge • Out-of-Network: Deductible plus 30% Coinsurance