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

Health Care Benefits	MPIHP/ Anthem Blue Cross	Health Net *California Only*	Kaiser Permanente *California Only*	Oxford Health Plans *New York, New Jersey and Connecticut Only*
Extended Care • Room and Board in a Skilled Nursing Facility • Other Services and Supplies	• In-Network: 10% Coinsurance • Out-of-network: 50% Coinsurance • Plan coverage ends after - 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)	• In Network: No charge • Out-of-Network: Deductible plus 30% Coinsurance
Emergency Services Within or Outside Service Area	• 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	• $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	• $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	• $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 • Physician Visits: – Hospital/Office – Surgeon – Assistant Surgeon – Co-Pays apply per visit to office visits and inpatient visits unless otherwise noted	• 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	• $15 Co-Pay for office visits; • No charge for inpatient visits	• $15 Co-Pay for office visits; • No charge for inpatient visits	• In-Network: $15 Co-Pay for office visits; no charge for inpatient visits • Out-of-Network: Deductible plus 30% Coinsurance

Health Care Benefits *Professional Benefits (continued)*	**MPIHP/ Anthem Blue Cross**	**Health Net** *California Only*	**Kaiser Permanente** *California Only*	**Oxford Health Plans** *New York, New Jersey and Connecticut Only*
• Urgent Care Visits:	• Same as Physician Visits	• $35 Co-Pay	• $15 Co-Pay	• $15 Co-Pay
• Anesthesia (Note that anesthesiologist can be Out-of-Network even when the hospital and surgeon are In-Network)	• In Network: 10% Coinsurance • Out-of-Network: 50% Coinsurance	• In Network: No charge • Out-of-Network: Not covered	• In Network: No charge • Out-of-Network: Not Covered	• In Network: No charge • Out-of-Network: 30% Coinsurance
• Ambulance Services (including air ambulance)	• Emergency: 10% Coinsurance • Non-emergency and medically necessary • In Network: 10% Coinsurance • Out-of-Network: 50% Coinsurance	• Emergency: No charge • Non-emergency: Prior approval is required	• Emergency: No charge • Non-emergency: Prior approval is required	• Emergency: No charge • Non-emergency: Prior approval is required • Non-emergency Air Transportation is not covered
• Laboratory Tests and Diagnostic Imaging	• In Network: 10% Coinsurance • Out-of-Network: 50% Coinsurance	• No charge	• No charge	• In-Network: No charge • Out-of-Network: Deductible plus 30% Coinsurance
• Injectable Drugs (Outpatient)	• Allergy Shots and Injectable Drugs not covered by Express Scripts • In-Network: 10% Coinsurance • Out-of-Network: 50% Coinsurance • Covered through Express Scripts. *See Express Scripts section*	• No Charge for injections, allergy injection services or testing (Injections for infertility are paid at 50%) • Also covered through Express Scripts. *See Express Scripts section*	• Most injectable drugs, including allergy tests, provided at no charge if administered in the medical office; *see Evidence of Coverage* • Also covered through Express Scripts. *See Express Scripts section*	• Subject to Physician Visit Co-Pay • Also covered through Express Scripts. *See Express Scripts sectionvv*

Health Care Benefits *Professional Benefits (continued)*	**MPIHP/ Anthem Blue Cross**	**Health Net** *California Only*	**Kaiser Permanente** *California Only*	**Oxford Health Plans** *New York, New Jersey and Connecticut Only*
• Eye Examinations	• $20 Co-Pay for routine eye examinations and corrective lenses are covered through VSP *(see Vision Service Plan section)* • Non-routine same as Physician Visit	• $15 Co-Pay per visit • Routine exams are also covered through VSP at a $20 Co-Pay *(see Vision Service Plan section)*	• $15 Co-Pay per visit • Routine exams are also covered through VSP at a $20 Co-Pay *(see Vision Service Plan section)*	• $20 Co-Pay for routine eye examinations and corrective lenses are covered through VSP *(see Vision Service Plan section)* • Non-routine same as Physician Visit
• Chiropractic Services	• In-Network: No Charge • Out-of-Network: Maximum Allowable Amounts and other limitations apply *(see "Benefits and Limitations" section)* • Maximum of 20 visits per calendar year for both In and Out-of-Network	• $15 Co-Pay per visit Available through ASH Networks only *(see page 79)*	• $15 Co-Pay per visit Available through ASH Networks only *(see page 85)*	• In-Network: $15 Co-Pay per visit • Out-of-Network: 30% Coinsurance plus Deductible
• Physical Therapy	• Same as Physician Visits • Out-of-Network: Maximum Allowable Amounts and other limitation apply *(see "Benefits and Limitations" section)* • Maximum of 16 visits per year per injury; 2nd injury needs approval; visit limit applies to both In and Out-of-Network	• No charge	• $15 Co-Pay per visit	• 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 *Professional Benefits (continued)*	**MPIHP/ Anthem Blue Cross**	**Health Net** *California Only*	**Kaiser Permanente** *California Only*	**Oxford Health Plans** *New York, New Jersey and Connecticut Only*
• Physical Examination (annual)	• 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	• $15 Co-Pay	• $15 Co-Pay	• 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 • Physician Home Visits	• Same as Physician Visit	• $30 Co-Pay per visit	• No charge; limited to 100 visits per year and three visits per day.	• In Network: $15 Co-Pay • Out-of-Network: Deductible plus 30% Coinsurance
• Home Health Nurse	• No Co-Pays • Coinsurance applies	• $10 Co-Pay on and after the 31st calendar day	• No charge; same limits as Physician Home Visits.	• 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
• Hospice	No charge	• No charge	• No charge	• Same as other Home Health Services

Health Care Benefits *Family Planning Services (continued)*	**MPIHP/ Anthem Blue Cross**	**Health Net** *California Only*	**Kaiser Permanente** *California Only*	**Oxford Health Plans** *New York, New Jersey and Connecticut Only*
Maternity Benefits	• 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	• $15 Co-Pay per visit • No charge in hospital	• $15 Co-Pay per visit • No charge in hospital	• In-Network: $15 Co-Pay for initial visit, no charge for subsequent care • Out-of-Network: Covered only in an emergency
Family Planning Services •Vasectomy	• Not covered	• $50 Co-pay	• Outpatient: $15 Co-Pay • Inpatient: No charge	• In Network: No charge, reversal not covered • Out-of-Network: Deductible plus 30% Coinsurance
• Tubal Ligation	• Not Covered	• $150 Co-Pay	• Outpatient: $15 Co-pay • Inpatient: No charge	• In-Network: No charge, reversal not covered • Out-of-Network: Deductible plus 30% Coinsurance, reversal not covered
• Elective Abortion	• Covered under specific conditions. See Abortion in the Benefits and Limitations Section	• No Charge for medically necessary abortion • $150 for elective abortion	• Outpatient: $15 Co-Pay • Inpatient: No charge	• 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 *Family Planning Services (continued)*	**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.]	• 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	• $15 Co-Pay for the insertion and removal of the IUD only; the IUD is not covered	• $15 Co-Pay	• Not covered
Mental Health Outpatient	• In Network: $5 Co-Pay per visit • Out-of-Network: 50% Coinsurance	• $15 Co-Pay per visit	• $15 Co-Pay per visit • $7 Co-Pay per visit for group therapy	• In Network: $15 Co-Pay per visit • Out-of-Network: Deductible plus 30% Coinsurance
Mental Health Inpatient	• In-Network: No charge • Out-of-Network: $100 per admission, then 50% Coinsurance	• No charge	• No charge	• In Network: No charge • Out-of-Network: Deductible plus 30% Coinsurance