MVP SCHEDULE OF BENEFITS

Subject to the Plan's provisions, limitations and exclusions, the following are covered benefits when receiving at an In-Network.

MVP Summary of Benefits		
	In-Network	**Out-of-Network**
Annual Maximum / Lifetime Maximum Benefit	Unlimited	Not Covered
Deductible (per covered person) Up to a maximum of $11,000 per Family	$5,500	Not Covered
Out of Pocket Maximum	$6,550 Individual $13,100 Family	Not Covered

MVP Summary of Benefits		
	In-Network	**Out-of-Network**
Preventative Care/Screening/Immunizations (Includes all services from MEC Plan schedule) See the ***Appendix for Federally-Required Preventive Care Benefits*** *for additional information.*	Covered at 100% Deductible waived	Not Covered
Urgent Care Visits	Covered at 60%*	Not Covered
Primary Care Visits	Covered at 60%*	Not Covered
Specialist Care Visits	Covered at 60%*	Not Covered
Non-Preventative Well Baby Visits and Care	Covered at 60%*	Not Covered
Laboratory Outpatient and Professional Services	Covered at 60%*	Not Covered
X-rays and Diagnostic Imaging	Covered at 60%*	Not Covered
Emergency Room Services	Covered at 60%*	Not Covered
Inpatient Hospital Services	Covered at 60%*	Not Covered
Outpatient Mental/Behavioral Health and Substance Abuse Services	Covered at 60%*	Not Covered
Advanced Imaging (PT/PET Scans/MRIs)	Not Covered	Not Covered
Rehabilitation Speech Therapy	Not Covered	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy	Not Covered	Not Covered
Skilled Nursing Facility	Not Covered	Not Covered
Durable Medical Equipment	Not Covered	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered at 60%*	Not Covered

* Subject to deductible. The deductible must be paid by the Covered Person before the benefits are paid by the plan