Minimum Value Plan - MVP GOLD™

Limited Day Medical℠ Plan

The MVP GOLD™ Plan covers Preventive and Wellness Services, Inpatient and Outpatient Hospital, Physician Services and Pharmacy Benefits. Rather than an annual deductible, the plan requires copays for various covered services. Some services are subject to limits† on the number of days or visits for which benefits are payable.

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

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

The following table represents the medical services currently covered under the MVP GOLD™ 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]
			Member Pays	
PHYSICIAN SERVICES				
Primary Care Office Visit Limited to **12 visits** per plan year†		No	**$15 Copay**	**$15 Copay**
Specialist Office Visit Limited to **12 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 Services		No	**$0 Copay**	**Not Applicable**
PREVENTIVE & WELLNESS SERVICES				
(See Schedule of Preventive Health Services)	**Non-Hospital Based**	No	**$0 Copay**	**$0 Copay**
	Hospital Based	No	**Not Covered**	**Not Covered**
***HOSPITAL/FACILITY SERVICES** (Subject to Reference Based Pricing)*				
Inpatient Hospitalization Limited to **10 days** per plan year†		Yes	**$350 Copay per admission** (Subject to Reference Based Pricing)	
Inpatient Visits - Physician Limited to **10 visits** per plan year†		No	Included in Inpatient Hospitalization Copay	
Inpatient Surgery - Physician Charges Second surgical opinion may be required; Limited to **4 surgeries** per plan year†		Yes	Included in Inpatient Hospitalization Copay	
Outpatient Hospital or Freestanding Facility Services and Surgery Limited to **2 visit** per plan year†		Yes	**$350 Copay** (Subject to Reference Based Pricing)	
Anesthesia Limited to **4 inpatient** and **2 outpatient** anesthetic procedures per plan year†		No	Included in Inpatient Hospitalization or Outpatient Hospital or Freestanding Facility Services and Surgery Copay	
Emergency Room Services Limited to **2 visit** per plan year†		No	**$350 Copay** (Subject to Reference Based Pricing)	
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)	

This summary is intended as an overview of plan benefits. In the event of a discrepancy between this summary and the governing plan documents, the Summary Plan Description (SPD) and Schedule of Benefits (SOB) shall prevail.

Plan Provisions		Prior Auth Required[3]	Participating Providers (In-Network)	Non-Participating Providers (Out-of-Network)[2]
			Member Pays	
OUTPATIENT: DIAGNOSTIC SERVICES				
Laboratory Service	**Non-Hospital Based** (Combined limit of **4 visits** per plan year with Radiology)†	No	**$50 Copay**	**$50 Copay**
	Hospital Based)	No	**Not Covered**	**Not Covered**
Radiology	**Non-Hospital Based** (Combined limit of **4 visits** per plan year with Laboratory Service)†	No	**$50 Copay**	**$50 Copay**
	Hospital Based	No	**Not Covered**	**Not Covered**
CT/MRI/MRA/PET Scan Limited to **3** per plan year†	**Non-Hospital Based**	Yes	**$350 Copay** (Subject to Reference Based Pricing)	
	Hospital Based	No	**Not Covered**	**Not Covered**
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/Online Service)		No	**$0 Copay**	**Not Applicable**
Home Health Care Limited to **20 visits** per plan year†		Yes	**$25 Copay**	**$25 Copay**
Treatment for Chemical Abuse & Dependency	**Inpatient or Partial Day** (Limited to **10 days** per plan year)†	Yes	**$250 Copay per day** (Subject to Reference Based Pricing)	
	Outpatient (Limited to **12 visits** per plan year)†	No	**$25 Copay**	**$25 Copay**
Rehabilitation/Habilitation Services Combined limit of **12 visits** per plan year with physical, speech, and occupational therapies†		Yes	**$50 Copay**	**$50 Copay**
Emergency Medical Transportation[6] By land only; limited to **2 transports** per plan year†		No	**$250 Copay** (Subject to Reference Based Pricing)	
VISION BENEFITS[7]				
In-Office Comprehensive Vision Exams		No	**$0 Copay**	Up to $35 benefit
Eyewear Allowance for frames or contacts		No	**$150** every two (2) years	

PHARMACY BENEFITS[8]	Retail *(30-day supply)*	Retail *(90-day supply)*	Mail Order *(90-day supply)*
HBAScripts℠ (Subject to Formulary[9])	**Member Pays**		
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™ 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**	**Not Covered**	**Not Covered**
Tier 5 - Specialty	**Not Covered**	**Not Covered**	**Not Covered**

[1] 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 85th 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 the 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
[7] Vision benefits are provided outside of the Group Health Plan through a service contract and are subject to provisions and limitations in the HBAVision℠ Summary of Benefits.
[8] To be eligible for pharmacy benefits covered prescriptions must be dispensed through participating pharmacies and mail order channels.
[9] The HBAScripts℠ 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.
† Visit, service and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.

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 an 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 or 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 opposite sex and any other treatment or study related to sex change
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 prescriptions
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. Pediatric 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
59. CAR-T therapies

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.

THE HEALTH BENEFIT ALLIANCE
YOUR ALLY IN HEALTH™

Preventive Health Services: Limitations, Intervals, and Requirements[1]

The following table represents the preventive services currently covered under this Plan as well as the permitted interval and any requirements of such preventive services. Benefits are automatically subject to 29 CFR § 2590.715 -2713(a). Amendments to this section through legislative act or regulation are automatically incorporated into this document by reference.

Preventive Health Services		
Benefit	**Interval**	**Requirements**
Abdominal Aortic Aneurysm Screening	1 per lifetime	By ultrasonography in **men** ages 65-75 years who have ever smoked.
Adult Annual Standard Physical	1 per plan year	**Adults**, one (1) physical preventive exam per plan year.
Alcohol Misuse: Unhealthy Alcohol Use Screening and Counseling	1 per plan year	Screenings for unhealthy alcohol use in **adults** 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.
Aspirin: Preventive Medication	As prescribed	**Adults** ages 50 to 59 with high risk of cardiovascular diseases and for the primary prevention of cardiovascular disease and colorectal cancer. Low-dose aspirin (81 mg/d) as preventive medication for **women** after 12 weeks of gestation who are at high risk for preeclampsia.
Bacteriuria Screening	1 per plan year	Screening for asymptomatic bacteriuria with urine culture in **pregnant women** at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
BRCA Risk Assessment and Genetic Counseling/Testing	1 per plan year	Screening to **women** who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes *(BRCA* 1 or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast Cancer Preventive Medications	As prescribed	Risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors for **women** aged 35 years or older who are at increased risk for breast cancer and at low risk for adverse medication effects.
Breast Cancer Screening	Every 1-2 years	Screening mammography, with or without clinical breast examination (CBE), every 1-2 years for **women** aged 40 and older. Coverage limited to 2D mammograms only.
Breastfeeding Support, Supplies and Counseling	In Conjunction with each birth	Interventions during **pregnancy** and **after birth** to support breastfeeding. Costs for renting breastfeeding equipment will be covered in conjunction with each birth.
Cervical Cancer Screening: with Combination of Cytology and Human Papilloma Virus (HPV) testing	1 time every 5 plan years	**Women** age 30 to 65 years with high-risk papillomavirus (hrHPV) testing alone, or in combination with cytology.
Cervical Cancer Screening: with Cytology (Pap Smear)	1 time every 3 plan years	**Women** age 21 to 65 years with cervical cytology alone.
Chlamydia Screening	1 per plan year	Sexually active **women** age 24 and younger and in women 25 years or older who are at increased risk infection.
Colorectal Cancer Screening	1 time every 5 plan years	**All adults aged** 45 to 75 years.
Contraceptive Methods and Counseling	As prescribed	Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for **all women** with reproductive capacity, not including abortifacient drugs.
COVID-19 Tests and Vaccines	As prescribed	COVID-19 testing and vaccinations pursuant to the terms of, and for the duration required under, the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security Act, and applicable guidance thereunder or related thereto.
Dental Caries Prevention: Infants and Children Up to Age 5	1 per plan year	Application of fluoride varnish to the primary teeth of all **infants and children** starting at the age of primary tooth eruption and prescription of oral fluoride supplementation starting at age **6 months for children** whose water supply is fluoride deficient.
Depression Screening	1 per plan year	Screening for major depressive disorder (MDD) in **adolescents** aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up Screening for depression in the general **adult** population, including **pregnant and postpartum women**. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow- up. Pregnant and postpartum persons at increased risk of perinatal depression should be referred to counseling interventions.
Fall Prevention: Older Adults	1 per plan year	Exercise interventions for community-dwelling **adults** age 65 years and older who are at increased risk for falls.
Folic Acid Supplementation for the Prevention of Neural Tube Defects	As prescribed	Daily supplement containing 0.4 to 0.8 mg (400 to 800µg) of folic acid for all **women** planning or capable of pregnancy.
Gestational Diabetes Screening	1 per plan year	Asymptomatic **pregnant women** at 24 weeks of gestation or after.
Gonorrhea Screening	1 per plan year	Sexually active **women** age 24 years or younger and in women 25 years or older who are at increased risk for infection.
Healthy Diet and Physical Activity Counseling to Prevent Cardiovascular Disease	1 per plan year	**Adults** with cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthy diet and physical activity.
Healthy weight and weight gain in pregnancy	1 per plan year	**Pregnant persons**, effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy
Hemoglobinopathies Screening	1 per plan year	Screening for sickle cell disease in **newborns**.
Hepatitis B Virus Infection Screening	1 per plan year	**Adolescent and adults** at increased risk for infection. **Pregnant women** at their first prenatal visit**.**
Hepatitis C Virus (HCV) Infection Screening	1 per plan year	**Adults** aged 18 to 79 years.

[1] Preventive Health Services, excluding those for newborn care, are not covered if they are provided at a hospital.

Preventive Health Services

Benefit	Interval	Requirements
High Blood Pressure Screening	1 per plan year	Screening for high blood pressure in **adults** aged 18 or older.
HIV Preexposure Prophylaxis for the Prevention of HIV Infection	As prescribed	**Persons** who are at high risk of HIV acquisition.
HIV Screening	1 per plan year	**Adolescents and adults** aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
		Pregnant persons including those who present in labor, who are untested and whose HIV status is unknown.
Hypertension in Adults	1 per plan year	Screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM).
Hypothyroidism Screening	1 per plan year	Screening for congenital hypothyroidism in **newborns**.
Intimate Partner Violence Screening	1 per plan year	Screening for intimate partner violence, in **women** of reproductive age and provide or refer women who screen positive to ongoing supporting services.
Latent Tuberculosis Screening	1 per plan year	Screening for latent tuberculosis infection in populations at risk.
Lung Cancer Screening	1 per plan year	With low-dose computed tomography in **adults** aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity screening and Counseling	1 per plan year	To **children and adolescents** 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
		Clinicians should offer or refer **adults** with a body mass index (BMI) of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions to prevent obesity-related morbidity and mortality in adults.
Ocular Gonorrhea Prophylactic for Gonococcal Ophthalmia	As prescribed	Prophylactic ocular topical medication for all **newborns** to prevent gonococcal ophthalmia neonatorum.
Osteoporosis Screening	1 per plan year	In **women** aged 65 and older and in postmenopausal **women** younger than 65 years who are at increased risk of osteoporosis.
Phenylketonuria Screening	1 per plan year	Screening for phenylketonuria in **newborns**.
Preeclampsia Screening	1 per plan year	**Pregnant women** with blood pressure measurements throughout pregnancy.
Rh Incompatibility Screening: First Pregnancy Visit	1 per plan year	Rh (D) blood typing and antibody testing for all **pregnant women** during their first visit for pregnancy-related care.
Prediabetes and Type 2 Diabetes Screening	1 per plan year	Screening for prediabetes and type 2 diabetes in **adults** aged 35 to 70 years who are overweight or obese. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.
RH Incompatibility Screening: 24–28 Weeks' Gestation	1 per plan year	Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative **women** at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Sexually Transmitted Infections Counseling	1 per plan year	Intensive behavioral counseling for all sexually active **adolescents and for adults** who are at increased risk for sexually transmitted infections.
Skin Cancer Behavioral Counseling	1 per plan year	Counseling **young adults**, **adolescents**, **children, and parents of young children** about minimizing their exposure to ultraviolet radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk for skin cancer.
Statin Preventive Medication	As prescribed	**Adults** without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
Syphilis Screening	1 per plan year	**Persons** who are at increased risk for infection.
		All **pregnant women**.
Tobacco Use Counseling and Interventions	2 per plan year	Provide behavioral interventions for cessation to all **adults** who use tobacco, advise them to stop using tobacco, and provide behavioral interventions, U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco is covered.
		Provide behavioral interventions for cessation to all **pregnant persons** who use tobacco.
		Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged **children and adolescents**.
Unhealthy Drug Use Screening	1 per plan year	Screening by asking questions about unhealthy drug use in **adults** 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)
Vision Screening	1 time every 2 plan years	All **children** aged 3 to 5 years to detect amblyopia or its risk factors.
Well-Woman Visits	1 per plan year	**Women** under 65 to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care.
Well-Child Visits	1 per plan year	**Children** to obtain the recommended preventive services that are age and developmentally appropriate. (Covers 1 visit except as more frequently recommended for children under the age of 3 years.)

[1] Preventive Health Services, excluding those for newborn care, are not covered if they are provided at a hospital.

THE HEALTH BENEFIT ALLIANCE
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Immunizations

Recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for routine use in children, adolescents, or adults*

Birth Through Six Years Old

Abbreviations	Vaccines	Age Requirements and Limitations
HepB	Hepatitis B	Ages 4 weeks -2 months
		Ages 6 months - 18 months
DTaP	Diphtheria, tetanus, and acellular pertussis	Ages 15 months - 18 months
Hib	Haemophilus influenzae type b	Ages 12 months - 15 months
PCV13	Pneumococcal	Ages 12 months - 15 months
IPV	Poliovirus	Ages 6 months - 18 months
Flu	Influenza (yearly)	Ages 6 months - 6 years
MMR	Measles, mumps, and rubella	Ages 12 months - 15 months
VAR	Varicella	Ages 12 months - 15 months
HepA	Hepatitis A	Ages 12 months - 23 months (1st dose)
		Six months after the last dose (2nd dose)
RV	Rotavirus	Ages 2 months - 6 months (if recommended)

Children From Seven Through Eighteen Years Old

Abbreviations	Vaccines	Age Requirements and Limitations
Flu	Influenza (yearly)	Ages 7 - 18 years
Tdap	Tetanus, diphtheria, and pertussis	Ages 11 - 12 years
HPV	Human papillomavirus	Ages 11 - 12 years (2 shots series) Note: A 3-shot series of HPV vaccine is needed for those with weakened immune systems and those who start the series at 15 years or older
MenACWY	Meningococcal	Ages 11-12 years
MenACWY	Meningococcal Booster	Age 16 (recommended)
Dengue	Dengue vaccine	Ages 9-16 years who live in dengue endemic areas and have laboratory confirmation of previous dengue infection

Adults Nineteen Years or Older

Abbreviations	Vaccines	Age Requirements and Limitations
IIV4	Influenza inactivated	Ages 19 ≥ 65 years (1 dose annually)
RIV4	Influenza recombinant	
LAIV4	Influenza live attenuated	Ages 19 - 49 years (1 dose annually)
Tdap or Td	Tetanus, diphtheria, and acellular pertussis	Ages 19 ≥ 65 years (1 dose Tdap, then TD or Tdap booster every 10 years)
MMR	Measles, mumps, and rubella	Ages 19 - 64 years - 1 or 2 doses depending on indication (if born in 1957 or later)
VAR	Varicella	Ages 19 - 37 years - 2 doses (if born in 1980 or later)
RZV	Zoster recombinant	Ages 50 ≥ 65 years - 2 doses
HPV	Human papillomavirus	Ages 19 - 26 years - 2 or 3 doses depending on age at initial vaccination
PCV15, PCV20, PPSV23	Pneumococcal conjugate (PCV15, PCV20) Pneumococcal polysaccharide	Ages ≥ 65 years - 1 dose PCV15 followed by PPSV23 or 1 dose PCV20
HepB	Hepatitis B	Ages 19-60 years (2,3 or 4 doses depending on vaccine or condition)

* Immunization illustrations listed herein are based upon CDC recommendations contained in the following schedules: (i) Recommended Child and Adolescent Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html), and (ii) Recommended Adult Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html). Additional immunization scenarios not included in the aforementioned illustrations (such as catch-up immunization recommendations, immunization recommendations for certain high-risk groups, and immunization recommendations subject to individual clinical decision-making) may also be covered under this Plan pursuant to CDC recommendation. Information concerning these additional covered immunization scenarios (including vaccine type, age requirements, and frequency) is available online under the CDC schedule links listed above. Paper copies of these CDC schedules can also be obtained free of charge by written request to the Plan Administrator.

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