SCHEDULE OF BENEFITS

Large Group Access Care Comprehensive Health Insurance Policy

Employer Group: Quality Life Concepts

Benefit Period: July 1, 2018-June 30, 2019

Benefit Plan: Plan A – PPO AC1000

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit • Per Covered Person	Unlimited	Unlimited
Deductible		
• Individual Deductible (*per Covered Person per Benefit Period)*	$1,000	$2,000
• Family Deductible *(per family per Benefit Period)*	$2,000	$4,000
Annual Out-of-Pocket Maximum		
• Individual Annual Out-of-Pocket Maximum *(per Covered Person per Benefit Period)*	$4,500	$9,000
• Family Annual Out-of-Pocket Maximum *(per family per Benefit Period)*	$9,000	$18,000
Coinsurance	30%	50%

COVERED BENEFITS

This Policy will pay Covered Medical Expenses incurred for Covered Benefits provided in *Section 5, Covered Benefits*: (1) based on the Allowable Fee; and (2) unless otherwise indicated below, subject to the Deductible, Coinsurance, and Annual Out-of-Pocket Maximum amounts shown under the *Benefit Information* section of this Schedule of Benefits. If a Copayment applies to a Covered Benefit, it will be indicated below in this Covered Benefits section.

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
All Covered Benefits shown in Section 5, unless otherwise specified below in this Schedule of Benefits	30% after Deductible	50% after Deductible
Autism Spectrum Disorders	30% after Deductible	50% after Deductible
Chemical Dependency • Inpatient/other Outpatient Facility Services • Office Visit	 30% after Deductible $35 Copay per visit	 50% after Deductible 50% after Deductible
Chiropractic Services • Maximum Number of Office Visits per Benefit Period – 20 visits	$40 Copay per visit	50% after Deductible
Convalescent Home Services • Maximum Number of Days per Benefit Period – 60 days	30% after Deductible	50% after Deductible
Durable Medical Equipment • Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment • Preauthorization is recommended for original purchase or replacement of Durable Medical Equipment over $500.	30% after Deductible	50% after Deductible
Emergency Services (Including Urgent Care visits)	$100 Copay per visit after deductible	$100 Copay per visit after deductible
Home Health Care Services • Maximum Number of Home Visits per Benefit Period – 180 days	30% after Deductible	50% after Deductible
Hospital Services - Facility and Professional • Inpatient Facility • Outpatient Facility • Observation Room/Bed	30% after Deductible	50% after Deductible

SCHEDULE OF BENEFITS (continued)

Large Group Access Care Comprehensive Health Insurance Policy

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Laboratory Services	30% after Deductible	50% after Deductible
Mental Health Services		
• Inpatient/other Outpatient Facility Services	30% after Deductible	50% after Deductible
• Office Visit	$35 Copay per visit	50% after Deductible
Physician Medical Services		
• Physician Office Visits (Non-Specialist)	$35 Copay per visit	50% after Deductible
• Physician Specialist Visits	$40 Copay per visit	50% after Deductible
(The Copay applies to office visits for all Covered Benefits except for Preventive Health Care Services.)		
Prescription Drugs Benefit		
• **Retail Pharmacy Prescriptions** (31-day supply)		
• Preferred Generics	$10 Copay per drug	50% after Deductible
• Non-Preferred Generics/Preferred Brands	$30 Copay per drug	50% after Deductible
• Non-Preferred Brand Drugs	$150 Copay after Deductible	50% after Deductible
• Specialty Drugs	50% Coinsurance after Deductible	50% after Deductible
• **Mail Order Maintenance** (90-day supply)		
• Preferred Generics	$20 Copay per drug	50% after Deductible
• Non-Preferred Generics/Preferred Brands	$60 Copay per drug	50% after Deductible
• Non-Preferred Brand Drugs	$300 Copay after Deductible	50% after Deductible
• Specialty Drugs (31-day supply only)	50% Coinsurance after Deductible	Not Available
You must pay an Ancillary Charge in addition to the Deductible and/or Copayment, as applicable, if You choose a Brand-Name drug when a Generic drug is available.		
Preventive Health Care Services Including preventive drugs	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	50% after Deductible (Out of network-Well Child Care visits covered at 100% before deductible; Mammograms covered at a minimum payment of $70 before deductible)
Prostheses Benefit (Non-Dental)	30% after Deductible	50% after Deductible
• Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics		
• Preauthorization recommended for the original purchase or replacement of prosthetics over $500		
Therapeutic Services – Outpatient	$35 Copay per visit	50% after Deductible
Transplant Services	30% after Deductible	50% after Deductible

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Vision Care Benefit – Pediatric Vision Care Services *This Vision Care Benefit only applies to Covered Dependent Children under age 19.*		
• **Vision Care Services** • **Vision Examination** *Frequency of Services:* One Vision Examination per Covered Dependent Child per Calendar Year	None, 100% Covered	25%

• **Vision Care Materials**
  • **Lenses**
  • Single Vision
  • Bifocal
  • Trifocal
  • Lenticular
 	
**Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.*
 	
Frequency of Services: One set of lenses per Covered Dependent Child per Calendar Year
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
		25%
		25%
		25%
		25%

• **Vision Care Materials** • **Frames** *Frequency of Services:* One frame per Covered Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.	None, 100% Covered	25%

• **Contact Lenses**
  • Necessary Professional Fees and Materials
  • Elective Professional Fees** and Materials
	None, 100% Covered***
	None, 100% Covered***
		25%
		25%

***15% discount applies to the Provider's usual and customary professional fees for contact lens evaluation and fitting*

****The following service limitations apply to In-Network benefits for Contact Lenses: (1) Standard (one pair annually) = 1 contact lens per eye (total 2 lenses); (2) Monthly (six-month supply) = 6 lenses per eye (total 12 lenses); (3) Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses); and (4) Dailies (one month supply) = 30 lenses per eye (total 60 lenses).*