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 C – HDHP AC6650

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit • Per Covered Person	Unlimited	Unlimited
Deductible		
• Individual Deductible (*per Covered Person per Benefit Period)*	$6,650	$13,300
• Family Deductible *(per family per Benefit Period)*	$13,300	$26,600
Annual Out-of-Pocket Maximum		
• Individual Annual Out-of-Pocket Maximum *(per Covered Person per Benefit Period)*	$6,650	$13,300
• Family Annual Out-of-Pocket Maximum *(per family per Benefit Period)*	$13,300	$26,600
Coinsurance	0%	0%

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	0% after Deductible	0% after Deductible
Autism Spectrum Disorders	0% after Deductible	0% after Deductible
Chemical Dependency • Inpatient • Outpatient	0% after Deductible	0% after Deductible
Chiropractic Services • Maximum Number of Office Visits per Benefit Period – 20 visits	0% after Deductible	0% after Deductible
Convalescent Home Services • Maximum Number of Days per Benefit Period – 60 days	0% after Deductible	0% 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.	0% after Deductible	0% after Deductible
Emergency Services (Including Urgent Care visits)	0% after Deductible	0% after Deductible
Home Health Care Services • Maximum Number of Home Visits per Benefit Period – 180 days	0% after Deductible	0% after Deductible
Hospital Services - Facility and Professional • Inpatient Facility • Outpatient Facility • Observation Room/Bed	0% after Deductible	0% 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	0% after Deductible	0% after Deductible
Mental Health Services • Inpatient • Outpatient	0% after Deductible	0% after Deductible
Physician Medical Services • Physician Office Visits (Non-Specialist) • Physician Specialist Visits *(The Copay applies to office visits for all Covered Benefits except for Preventive Health Care Services.)*	0% after Deductible 0% after Deductible	0% after Deductible 0% after Deductible
Prescription Drugs Benefit • **Retail Pharmacy Prescriptions** (31-day supply) • Preferred Generics • Non-Preferred Generics/Preferred Brands • Non-Preferred Brand Drugs • Specialty Drugs	 0% after Deductible 0% after Deductible 0% after Deductible 0% after Deductible	 0% after Deductible 0% after Deductible 0% after Deductible 0% after Deductible
• **Mail Order Maintenance** (90-day supply) • Preferred Generics • Non-Preferred Generics/Preferred Brands • Non-Preferred Brand Drugs • Specialty Drugs (31-day supply only) *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.*	 0% after Deductible 0% after Deductible 0% after Deductible 0% after Deductible	 0% after Deductible 0% after Deductible 0% after Deductible Not Available
Preventive Health Care Services Including Preventive drugs	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	0% 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) • Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics • Preauthorization recommended for the original purchase or replacement of prosthetics over $500	0% after Deductible	0% after Deductible
Therapeutic Services – Outpatient	0% after Deductible	0% after Deductible
Transplant Services	0% after Deductible	0% 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**	None, 100% Covered	25%
Frequency of Services: One Vision Examination per Covered Dependent Child per Calendar Year		
• **Vision Care Materials** • **Lenses**		
• Single Vision	None, 100% Covered*	25%
• Bifocal	None, 100% Covered*	25%
• Trifocal	None, 100% Covered*	25%
• Lenticular	None, 100% Covered*	25%
**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		
• **Vision Care Materials** • **Frames**	None, 100% Covered	25%
Frequency of Services: One frame per Covered Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.		
• **Contact Lenses**		
• Necessary Professional Fees and Materials	None, 100% Covered***	25%
• Elective Professional Fees** and Materials	None, 100% Covered***	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).*