

## SCHEDULE OF BENEFITS

### Individual Connected Care Comprehensive Health Insurance Policy

**Policy Number:** [123456]

**Policy Effective Date:** [January 1, 2020]

**Policyowner:** [John Doe]

**Policy Anniversary Date:** [January 1 of each Year]

**Issue Age:** [35]

**Initial Premium:** [\$801.84]

**Type of Coverage:** [Single/Family]

**Mode of Payment:** [Monthly]

**Benefit Period:** Calendar Year

**Premium Due Date:** [The first day of each month]

**Benefit Plan:** PPO Silver Alt 87 – Standard Plan

| BENEFIT INFORMATION                                                                                                                                                                                                                                         | IN-NETWORK         | OUT-OF-NETWORK      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------|
| <b>Maximum Lifetime Benefit</b> <ul style="list-style-type: none"><li>Per Covered Person</li></ul>                                                                                                                                                          | Unlimited          | Unlimited           |
| <b>Deductible</b> <ul style="list-style-type: none"><li>Individual Deductible (<i>per Covered Person per Calendar Year</i>)</li><li>Family Deductible (<i>per family per Calendar Year</i>)</li></ul>                                                       | \$300<br>\$600     | \$900<br>\$1,800    |
| <b>Annual Out-of-Pocket Maximum</b> <ul style="list-style-type: none"><li>Individual Annual Out-of-Pocket Maximum (<i>per Covered Person per Calendar Year</i>)</li><li>Family Annual Out-of-Pocket Maximum (<i>per family per Calendar Year</i>)</li></ul> | \$2,450<br>\$4,900 | \$7,350<br>\$14,700 |
| <b>Coinsurance</b>                                                                                                                                                                                                                                          | 30%                | 50%                 |

## SCHEDULE OF BENEFITS (continued)

### Individual Connected Care Comprehensive Health Insurance Policy

#### **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<br>IN-NETWORK                                                                                         | YOUR COST<br>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                         |
| <b>Autism Spectrum Disorders</b> <ul style="list-style-type: none"> <li>Inpatient/other Outpatient Facility Services</li> <li>Office Visit</li> </ul>                                                                                                                                                    | 30% after Deductible<br>\$30 for first 10 visits, before Deductible; then \$30 copay per visit after Deductible | 50% after Deductible<br>50% after Deductible |
| <b>Chemical Dependency</b> <ul style="list-style-type: none"> <li>Inpatient/other Outpatient Facility Services</li> <li>Office Visit</li> </ul>                                                                                                                                                          | 30% after Deductible<br>\$30 for first 10 visits, before Deductible; then \$30 copay per visit after Deductible | 50% after Deductible<br>50% after Deductible |
| <b>Chiropractic Services</b> <ul style="list-style-type: none"> <li>Maximum Number of Office Visits per Calendar Year – 20 visits</li> </ul>                                                                                                                                                             | \$40 Copay per visit                                                                                            | 50% after Deductible                         |
| <b>Convalescent Home Services</b> <ul style="list-style-type: none"> <li>Maximum Number of Days per Calendar Year – 60 days</li> </ul>                                                                                                                                                                   | 30% after Deductible                                                                                            | 50% after Deductible                         |
| <b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment</li> </ul> <i>Preauthorization recommended for original purchase or replacement of Durable Medical Equipment over \$500.</i> | 30% after Deductible                                                                                            | 50% after Deductible                         |
| <b>Emergency Services</b>                                                                                                                                                                                                                                                                                | 30% after Deductible                                                                                            | 30% after Deductible                         |
| <b>Home Health Care Services</b> <ul style="list-style-type: none"> <li>Maximum Number of Home Visits per Calendar Year – 180 visits/year</li> </ul>                                                                                                                                                     | 30% after Deductible                                                                                            | 50% after Deductible                         |
| <b>Hospital Services - Facility and Professional</b> <ul style="list-style-type: none"> <li>Inpatient Facility</li> <li>Outpatient Facility</li> <li>Observation Room/Bed</li> </ul>                                                                                                                     | 30% after Deductible                                                                                            | 50% after Deductible                         |

**SCHEDULE OF BENEFITS** (continued)  
**Individual Connected Care Comprehensive Health Insurance Policy**

| COVERED BENEFIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | YOUR COST<br>IN-NETWORK                                                                                                      | YOUR COST<br>OUT-OF NETWORK                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Laboratory Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 30% after Deductible                                                                                                         | 50% after Deductible                                                                                                                                                                  |
| <b>Mental Health Services</b> <ul style="list-style-type: none"> <li>Inpatient/other Outpatient Facility Services</li> <li>Office Visit</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 30% after Deductible<br>\$30 for first 10 visits, before Deductible; then \$30 copay per visit after Deductible              | 50% after Deductible<br>50% after Deductible                                                                                                                                          |
| <b>Physician Medical Services</b> <ul style="list-style-type: none"> <li>Physician Office Visits (Non-Specialist)</li> <li>Physician Specialist Visits</li> </ul> <i>(The Copay applies to office visits for all Covered Benefits except for Preventive Health Care Services.)</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | \$30 for first 10 visits, before Deductible; then \$30 copay per visit after Deductible<br>\$40 Copay per visit              | 50% after Deductible<br>50% after Deductible                                                                                                                                          |
| <b>Prescription Drugs Benefit</b> <ul style="list-style-type: none"> <li><b>Retail Pharmacy Prescriptions</b> (31-day supply)               <ul style="list-style-type: none"> <li>Preferred Generic Drugs (Tier 1)</li> <li>Non-Preferred Generic &amp; Preferred Brand Drugs (Tier 2)</li> <li>Non-Preferred Brand Drugs (Tier 3)</li> <li>Specialty Drugs (Tier 4)</li> </ul> </li> <li><b>Mail Order Maintenance</b> (90-day supply)               <ul style="list-style-type: none"> <li>Preferred Generic Drugs (Tier 1)</li> <li>Non-Preferred Generic &amp; Preferred Brand Drugs (Tier 2)</li> <li>Non-Preferred Brand Drugs (Tier 3)</li> <li>Specialty Drugs (Tier 4)</li> </ul> </li> </ul> <i>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.</i> | 10% per drug<br>25% per drug<br>30% per drug<br>40% per drug<br>10% per drug<br>25% per drug<br>30% per drug<br>40% per drug | 50% after Deductible<br>50% after Deductible<br>50% after Deductible<br>50% after Deductible<br>50% after Deductible<br>50% after Deductible<br>50% after Deductible<br>Not Available |
| <b>Preventive Health Care Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply                                                       | 50% after Deductible<br>(Out of network-Well Child Care visits covered at 100% before deductible; Mammograms covered at a minimum payment of \$70 before deductible)                  |
| <b>Prostheses Benefit (Non-Dental)</b> <ul style="list-style-type: none"> <li>Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics</li> <li>Preauthorization recommended for the original purchase or replacement of prosthetics over \$500</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 30% after Deductible                                                                                                         | 50% after Deductible                                                                                                                                                                  |
| <b>Therapeutic Services – Outpatient</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$40 Copay per visit                                                                                                         | 50% after Deductible                                                                                                                                                                  |
| <b>Transplant Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 30% after Deductible                                                                                                         | 50% after Deductible                                                                                                                                                                  |

**SCHEDULE OF BENEFITS** (continued)

## Individual Connected Care Comprehensive Health Insurance Policy

| COVERED BENEFIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | YOUR COST<br>IN-NETWORK                                                                  | YOUR COST<br>OUT-OF NETWORK |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------|
| <b>Vision Care Benefit – Pediatric Vision Care Services</b><br><br><i>This Vision Care Benefit only applies to Covered Dependent Children under age 19.</i>                                                                                                                                                                                                                                                                                                                                      |                                                                                          |                             |
| <ul style="list-style-type: none"> <li><b>Vision Care Services</b> <ul style="list-style-type: none"> <li><b>Vision Examination</b></li> </ul> </li> </ul> <i>Frequency of Services: One Vision Examination per Covered Dependent Child per Calendar Year</i>                                                                                                                                                                                                                                    | None, 100% Covered                                                                       | 25%                         |
| <ul style="list-style-type: none"> <li><b>Vision Care Materials</b> <ul style="list-style-type: none"> <li><b>Lenses</b> <ul style="list-style-type: none"> <li>Single Vision</li> <li>Bifocal</li> <li>Trifocal</li> <li>Lenticular</li> </ul> </li> </ul> </li> </ul> <i>*Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.</i><br><br><i>Frequency of Services: One set of lenses per Covered Dependent Child per Calendar Year</i> | None, 100% Covered*<br>None, 100% Covered*<br>None, 100% Covered*<br>None, 100% Covered* | 25%<br>25%<br>25%<br>25%    |
| <ul style="list-style-type: none"> <li><b>Vision Care Materials</b> <ul style="list-style-type: none"> <li><b>Frames</b></li> </ul> </li> </ul> <i>Frequency of Services: One frame per Covered Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.</i>                                                                                                                                                                                             | None, 100% Covered                                                                       | 25%                         |
| <ul style="list-style-type: none"> <li><b>Contact Lenses</b> <ul style="list-style-type: none"> <li>Necessary Professional Fees and Materials</li> <li>Elective Professional Fees** and Materials</li> </ul> </li> </ul>                                                                                                                                                                                                                                                                         | None, 100% Covered***<br>None, 100% Covered***                                           | 25%<br>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).**

SPANISH: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-447-2900.

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-447-2900。

SERBO-CROATION: U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko MHC. Pogledajte nalaze li se u ovom obavještenju nekiključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 1-855-447-2900.

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)번으로 전화해 주십시오. 1-855-447-2900

VIETNAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-447-2900.

ARABIC: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة يحوي هذا الشعار معلومات هامة. يحوي هذا الشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خال البحث عن التواريخ: 855-447-2900 (رقم هاتف الصم والبكم: 1-855-447-2900) اللغوية تتوافر لك بالمجان. اتصل برقم 1-

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-447-2900.

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-447-2900.

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-447-2900.

FRENCH: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-447-2900.

ITALIAN: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-447-2900.

JAPANESE: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-447-2900 (TTY:1-855-447-2900) まで、お電話にてご連絡ください。

THAI: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-447-2900 (TTY: 1-855-447-2900).

ROMANIAN: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-447-2900.

SUDANIC-FULFULDE: Anndinoore nde'e e woodi habaru kimminiidum. TAnndinoore nde'e e woodi habaru kimminiidum dow dereewol tefal maadamaada malla ko yaali dow laawol MHC. Maanda nyalaade lewru nder anndinoorende'e. Teema a gideteeɗo ngada godɗum bako godɗe nyalaade ngam ko yaali njamu maada malla walla dow njobdi. Hakke maada annda habaru ngu'u ewalliinde nder wolde maada naa maa a yobii. Noddu 1-855-447-2900.

UKRAINIAN: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-447-2900 (телетайп: 1-855-447-2900).

NEPALI: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-447-2900 (टिटिवाइ: 1-855-447-2900)

SERBO-CROATIAN: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-447-2900 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-855-447-2900).

BANTU: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-447-2900 (TTY: 1-855-447-2900).

FARSI: تماس بگیرید. 1-855-447-2900 (TTY: 1-855-447-2900) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با

NORWEGIAN: MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-447-2900.

PENNSYLVANIA DUTCH: Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englich Schprooch. Ruf selli Nummer uff: Call 1-855-447-2900.