# SCHEDULE OF BENEFITS

## Individual Connected Care Comprehensive Health Insurance Policy

**Policy Number:** [123456]

**Policyowner:** [John Doe]

**Issue Age**: [35]

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

**Benefit Period:** Calendar Year

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

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

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

**Initial Premium:** [$801.84]

**Mode of Payment:** [Monthly]

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

| BENEFIT INFORMATION | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Maximum Lifetime Benefit**<br>• Per Covered Person | Unlimited | Unlimited |
| | | |
| **Deductible**<br>• Individual Deductible (*per Covered Person per Calendar Year)*<br>• Family Deductible *(per family per Calendar Year)* | $500<br>$1,000 | $1,500<br>$3,000 |
| **Annual Out-of-Pocket Maximum**<br>• Individual Annual Out-of-Pocket Maximum *(per Covered Person per Calendar Year)*<br>• Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)* | $2,200<br>$4,400 | $6,600<br>$13,200 |
| **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**<br>• Inpatient/other Outpatient Facility Services<br>• Office Visit | 30% after Deductible<br>$15 for first 10 visits, before deductible; then $15 copay per visit after deductible | 50% after Deductible<br>50% after Deductible |
| **Chemical Dependency**<br>• Inpatient/other Outpatient Facility Services<br>• Office Visit | 30% after Deductible<br>$15 for first 10 visits, before deductible; then $15 copay per visit after deductible | 50% after Deductible<br>50% after Deductible |
| **Chiropractic Services**<br>• Maximum Number of Office Visits per Calendar Year – 20 visits | $45 Copay per visit, after Deductible | 50% after Deductible |
| **Convalescent Home Services**<br>• Maximum Number of Days per Calendar Year – 60 days | 30% after Deductible | 50% after Deductible |
| **Durable Medical Equipment**<br>• Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment<br>*Preauthorization recommended for original purchase or replacement of Durable Medical Equipment over $500.* | 30% after Deductible | 50% after Deductible |
| **Emergency Services** | 30% after Deductible | 30% after Deductible |
| **Home Health Care Services**<br>• Maximum Number of Home Visits per Calendar Year – 180 visits/year | 30% after Deductible | 50% after Deductible |
| **Hospital Services - Facility and Professional**<br>• Inpatient Facility<br>• Outpatient Facility<br>• Observation Room/Bed | 30% after Deductible | 50% after Deductible |

## SCHEDULE OF BENEFITS (continued)

## Individual Connected 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**<br>• Inpatient/other Outpatient Facility Services<br>• Office Visit | 30% after Deductible<br>$15 for first 10 visits, before deductible; then $15/ copay per visit after deductible | 50% after Deductible<br>50% after Deductible |
| **Physician Medical Services**<br>• Physician Office Visits (Non-Specialist)<br>• Physician Specialist Visits<br>*(The Copay applies to office visits for all Covered Benefits except for Preventive Health Care Services.)* | $15 for first 10 visits, before deductible; then $15 copay per visit after deductible<br>$45 Copay per visit, after Deductible | 50% after Deductible<br>50% after Deductible |
| **Prescription Drugs Benefit**<br>• **Retail Pharmacy Prescriptions** (31-day supply)<br>• Preferred Generic Drugs (Tier 1)<br>• Non-Preferred Generic & Preferred Brand Drugs (Tier 2)<br>• Non-Preferred Brand Drugs (Tier 3)<br>• Specialty Drugs (Tier 4)<br>• **Mail Order Maintenance** (90-day supply)<br>• Preferred Generic Drugs (Tier 1)<br>• Non-Preferred Generic & Preferred Brand Drugs (Tier 2)<br>• Non-Preferred Brand Drugs (Tier 3)<br>• Specialty Drugs (Tier 4) (31-Day Supply Only)<br>*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.* | <br>10% per drug<br>25% per drug<br>30% per drug<br>40% per drug<br><br>10% per drug<br>25% per drug<br>30% per drug<br>40% per drug | <br>50% after Deductible<br>50% after Deductible<br>50% after Deductible<br>50% after Deductible<br><br>50% after Deductible<br>50% after Deductible<br>50% after Deductible<br>Not Available |
| **Preventive Health Care Services** | 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)**<br>• Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics<br>• Preauthorization recommended for the original purchase or replacement of prosthetics over $500 | 30% after Deductible | 50% after Deductible |
| **Therapeutic Services – Outpatient** | $45 Copay per visit, after Deductible | 50% after Deductible |

| COVERED BENEFIT | YOUR COST IN-NETWORK | YOUR COST OUT-OF NETWORK |
|---|---|---|
| **Transplant Services** | 30% after Deductible | 50% after Deductible |

## SCHEDULE OF BENEFITS (continued)

## Individual Connected Care Comprehensive Health Insurance Policy

| COVERED BENEFIT | YOUR COST IN-NETWORK | YOUR COST OUT-OF NETWORK |
|---|---|---|
| **Vision Care Benefit – Pediatric Vision Care Services**<br><br>*This Vision Care Benefit only applies to Covered Dependent Children under age 19.* | | |
| • **Vision Care Services**<br>  • **Vision Examination**<br>*Frequency of Services:* One Vision Examination per Covered Dependent Child per Calendar Year | None, 100% Covered | 25% |
| • **Vision Care Materials**<br>  • **Lenses**<br>  • Single Vision<br>  • Bifocal<br>  • Trifocal<br>  • Lenticular<br><br>**Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.*<br><br>*Frequency of Services:* One set of lenses per Covered Dependent Child per Calendar Year | None, 100% Covered*<br>None, 100% Covered*<br>None, 100% Covered*<br>None, 100% Covered* | 25%<br>25%<br>25%<br>25% |
| • **Vision Care Materials**<br>  • **Frames**<br><br>*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 | 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).*

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 ا شعار معلومات هامة بخصوص طلبك للحصول على التغطية من خ ل ابحث عن التواريخ. 855-447-2900.) (رقم هاتف الصم والبكم: 1-855-447-2900اللغوية 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 kimminiiɗum. TAnndinoore nde'e e woodi habaru kimminiiɗum dow ɗereewol tefal maaɗamaaɗa malla ko yaali dow laawol MHC. Maanda nyalaaɗe lewru nder anndinoorende'e. Teema a giɗeteeɗo ngaɗa goɗɗum bako goɗɗe nyalaaɗe ngam ko yaali njamu maaɗa malla walla dow njobdi. Hakke maaɗa annda habaru ngu'u ewalliinde nder wolde maaɗa naa maa a yoɓii. Noddu 1-855-447-2900.

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

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

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