SCHEDULE OF BENEFITS

Engage Comprehensive Health Insurance Policy

Benefit Plan: Engage Bronze Plus PPO – HSA Qualified HDHP Plan

Out-of-Network Maximum – Be aware that your actual costs for services provided by an out-of-network provider may exceed this policy's maximum out-of-pocket for out-of-network services because out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company. Amounts in excess of the allowed amount are not counted toward the out-of-network deductible or maximum out-of-pocket.

BENEFIT INFORMATION	IN NETWORK	OUT OF NETWORK
Maximum Lifetime Benefit		
• Per Insured	Unlimited	Unlimited
Deductible		
• Individual Deductible (*per Insured per Calendar Year)*	$6,750	$12,000
• Family Deductible *(per family per Calendar Year)*	$13,500	$24,000
Annual Out-of-Pocket Maximum		
• Individual Annual Out-of-Pocket Maximum *(per Insured per Calendar Year)*	$6,750	$24,000
• Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	$13,500	$48,000
Coinsurance	0%	70%

SCHEDULE OF BENEFITS (continued)

Engage Group 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 for IN NETWORK	YOUR COST OUT OF NETWORK *See Out of Network Maximum on page one
All Covered Benefits shown in Section 5, unless otherwise specified below in this Schedule of Benefits	0% after Deductible	70% after Deductible
Daily Hospital Room and Board	0% after Deductible	70% after Deductible
Miscellaneous Hospital Services	0% after Deductible	70% after Deductible
Surgical Services	0% after Deductible	70% after Deductible
Anesthesia Services	0% after Deductible	70% after Deductible
In-Hospital Medical Services	0% after Deductible	70% after Deductible
Out-of-Hospital Care	0% after Deductible	70% after Deductible
Chemical Dependency		
• Inpatient/Outpatient Facility	0% after Deductible	70% after Deductible
• Office Visit	0% after Deductible	70% after Deductible
Chiropractic Services • Limit of 20 Office Visits per Calendar Year	0% after Deductible	70% after Deductible
Convalescent Home Services • Limit of 30 days per Calendar Year	0% after Deductible	70% after Deductible
Durable Medical Equipment (DME) • Rental (up to the purchase price), Purchase and Repair and Replacement of DME *Preauthorization is required for original purchase or replacement of DME over $500*	0% after Deductible	70% after Deductible

COVERED BENEFIT	YOUR COST for IN NETWORK	YOUR COST OUT OF NETWORK *See Out of Network Maximum on page one*
Emergency Services	0% after Deductible	0% after Deductible
Home Health Care Services • Limit of 30 days of Home Visits per Calendar Year	0% after Deductible	70% after Deductible
Laboratory Services	0% after Deductible	70% after Deductible
Mental Health Services		
• Inpatient/Outpatient Facility	0% after Deductible	70% after Deductible
• Office Visit	0% after Deductible	70% after Deductible
Physician Medical Services		
• Physician Office Visits (Non-Specialist)	0% after Deductible	70% after Deductible
• Physician Specialist Visits	0% after Deductible	70% after Deductible
Prescription Drugs Benefit		
• **Retail Pharmacy Prescriptions** (31-day supply)		
• Tier 0-Preventive Drugs including contraceptives	$0	$0
• Tier 1-Preferred Generic Drugs	0% after Deductible per drug	70% after Deductible per drug
• Tier 2-Preferred Brand and Non-Preferred Generic Drugs	0% after Deductible per drug 0% after Deductible per drug	70% after Deductible per drug 70% after Deductible per drug
• Tier 3-Non-Preferred Brand Drugs	0% after Deductible per drug	70% after Deductible per drug
• Tier 4-Preferred Specialty Drugs	$0	70% after Deductible per drug
• **Mail Order Maintenance** (90-day supply)	0% after Deductible per drug	$0
• Tier 0-Preventive Drugs including contraceptives	0% after Deductible per drug	$0
• Tier 1-Preferred Generic Drugs	0% after Deductible per drug	70% after Deductible per drug
• Tier 2-Preferred Brand and Non-Preferred Generic Drugs	0% after Deductible per drug 0% after Deductible per drug	70% after Deductible per drug 70% after Deductible per drug
• Tier 3-Non-Preferred Brand Drugs	0% after Deductible per drug	70% after Deductible per drug

COVERED BENEFIT	YOUR COST for IN NETWORK	YOUR COST OUT OF NETWORK *See Out of Network Maximum on page one*
• Tier 4-Preferred Specialty Drugs NOT available via mail order		
Preventive Health Care Services	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	70% after Deductible
Therapeutic Services – Inpatient/Outpatient • Habilitative: Limit of 20 visits per year for PT, OT, and ST combined • Rehabilitative: Limit of 20 visits per year PT, OT, and ST combined	0% after Deductible	70% after Deductible
Transplant Services	0% after Deductible	70% 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 Insured Dependent Children under age 19.*		
• **Vision Care Services** • **Vision Examination** *Frequency of Services:* One Vision Examination per Insured Dependent Child per Calendar Year	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 Insured Dependent Child per Calendar Year
	100% Covered*
	100% Covered*
	100% Covered*
	100% Covered*
		25%
		25%
		25%
		25%

• **Vision Care Materials** • **Frames** *Frequency of Services:* One frame per Insured Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.	100% Covered	25%

• **Contact Lenses**
  • Necessary Professional Fees and Materials
  • Elective Professional Fees** and Materials
	100% Covered***
	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).*

- Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Mountain Health CO-OP, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-447-2900.
- 如果您，或是您正在協助的對象，有關於[插入 項目的名稱 Mountain Health CO-OP, 方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 855-447-2900.
- Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Mountain Health CO-OP, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 855-447-2900.
- 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Mountain Health CO-OP, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-447-2900로 전화하십시오.
- Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Mountain Health CO-OP, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-447-2900.
- لديك الحق في الحصول على المساعدة والمعلومات في Mountain Health CO-OP، إذا كنت أنت أو شخص ما تحاول مساعدة، لديه تساؤلات حول لغتك دون أي تكلفة. للتحدث مع مترجم، والدعوة
855-447-2900.
- Falls Sie oder jemand, dem Sie helfen, Fragen zum Mountain Health CO-OP, haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-447-2900 an.
- Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Mountain Health CO-OP, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 855-447-2900.
- Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Mountain Health CO-OP, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-447-2900.
- Si vous, ou quelqu'un que vous êtes en train d’aider, a des questions à propos de Mountain Health CO-OP, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-447-2900.
- ご本人様、またはお客様の身の回りの方でも、Mountain Health CO-OP, についてご質問がございました ら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、855-447-2900までお電話ください。
- Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind Mountain Health CO-OP, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 855-447-2990.
- To aan, malla goɗɗo mo mballata, e yaama dow Mountain Health CO-OP, a woodi baawɗe heɓuki habaru malla wallireeki wolde maaɗa naa maa a yoɓii. Mbolda e pirtoowo, nodda 855-447-2900.
- شما حق دریافت کمک و اطلاعات به Mountain Health CO-OP، اگر شما یا کسی که شما در حال تلاش برای کمک به، سوالات در مورد زبان خود را بدون هیچ هزینه داشته باشد. برای صحبت با یک مترجم، 855-447-2900 پاسخ.
- Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Mountain Health CO-OP, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв’язатись з перекладачем, задзвоніть на 855-447-2900.