SCHEDULE OF BENEFITS

Individual Engage Comprehensive Health Insurance Policy

Benefit Plan: **Engage Silver 94 PPO**

Policy Effective Date: January 1, 2020

Type of Coverage: Individual/Family

Mode of Payment: Monthly

Benefit Period: Calendar Year

Premium Due Date: The first day of each month

***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)* • Family Deductible *(per family per Calendar Year)*	$0 $0	$0 $0
Annual Out-of-Pocket Maximum • Individual Annual Out-of-Pocket Maximum *(per Insured per Calendar Year)* • Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	$1,100 $2,200	$3,300 $6,600
Coinsurance	20%	30%

SCHEDULE OF BENEFITS (continued)

Individual Engage 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 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	20% after Deductible	30% after Deductible
Daily Hospital Room and Board	20% after Deductible	30% after Deductible
Miscellaneous Hospital Services	20% after Deductible	30% after Deductible
Surgical Services	20% after Deductible	30% after Deductible
Anesthesia Services	20% after Deductible	30% after Deductible
In-Hospital Medical Services	20% after Deductible	30% after Deductible
Out-of-Hospital Care	20% after Deductible	30% after Deductible
Chemical Dependency • Inpatient/Outpatient Facility • Office Visit	20% after Deductible $25 Copay per visit	30% after Deductible 30% after Deductible
Chiropractic Services • Limit of 20 Office Visits per Calendar Year	20% after Deductible	30% after Deductible
Convalescent Home Services • Limit of 30 days per Calendar Year	20% after Deductible	30% 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.*	20% after Deductible	30% after Deductible
Emergency Services	20% after Deductible	20% after Deductible
Hearing Aids (Child Only)	20% after Deductible	30% after Deductible

COVERED BENEFIT	YOUR COST IN NETWORK	YOUR COST OUT OF NETWORK *See Out of Network Maximum on page one*
• Hearing aids and the examination for the fitting, except for hearing loss due to a congenital disease or anomaly, or when medically necessary for the cognitive or speech development of a covered dependent child. *Frequency of Services: One aid every 36 months per ear*		
Home Health Care Services • Limit of 30 days of Home Visits per Calendar Year	20% after Deductible	30% after Deductible
Laboratory Services	20% after Deductible	30% after Deductible
Mental Health Services • Inpatient/Outpatient Facility • Office Visit	20% after Deductible $25 Copay per visit	30% after Deductible 30% after Deductible
Physician Medical Services • Physician Office Visits (Non-Specialist) • Physician Specialist Visits	$15 Copay per visit $25 Copay per visit	30% after Deductible 30% after Deductible
Prescription Drugs Benefit • **Retail Pharmacy Prescriptions** (31-day supply) • Tier 0-Preventive Drugs including contraceptives • Tier 1-Preferred Generic Drugs • Tier 2-Preferred Brand and Non-Preferred Generic Drugs • Tier 3-Non-Preferred Brand Drugs • Tier 4-Preferred Specialty Drugs • **Mail Order Maintenance** (90-day supply) • Tier 0-Preventive Drugs including contraceptives • Tier 1-Preferred Generic Drugs • Tier 2-Preferred Brand and Non-Preferred Generic Drugs • Tier 3-Non-Preferred Brand Drugs	 $0 $5 per drug 20% per drug 25% after Deductible per drug 25% after Deductible per drug $0 $10 per drug 20% per drug 25% after Deductible per drug	 $0 30% after Deductible per drug 30% after Deductible per drug 30% after Deductible per drug 30% after Deductible per drug $0 30% after Deductible per drug 30% after Deductible per drug 30% after Deductible per drug

COVERED BENEFIT	YOUR COST 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 • Includes well baby, child and adult preventive services • Includes covered immunizations	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	30% after Deductible
Prostheses Benefit (Non-Dental) • Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics *Preauthorization required for the original purchase or replacement of prosthetics over $500*	20% after Deductible	30% 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	20% after Deductible 20% after Deductible	30% after Deductible 30% after Deductible
Transplant Services	20% after Deductible	30% 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	100% Covered***	25%
• Elective Professional Fees** and Materials	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.
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- 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 يحوي هذا ا□شعار معلومات هامة. يحوي هذا ا□شعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خ□ل ابحث عن التواريخ: 855-447-2900.) (رقم هاتف الصم والبكم: 1-855-447-2900اللغة، فإن خدمات المساعدة 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.
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- 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 gideteedo ngada goddum bako godde nyalaade ngam ko yaali njamu maada malla walla dow njobdi. Hakke maada annda habaru ngu'u ewalliinde nder wolde maada naa maa a yoɓii. Noddu 1-855-447-2900.
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- 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