SCHEDULE OF BENEFITS

Engage Group Comprehensive Health Insurance Policy

Cutting Edge Management
Benefit Plan: Plan K: Engage Silver

***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** **See Out of Network Maximum on page one*
Maximum Lifetime Benefit • Per Insured	Unlimited	Unlimited
Deductible • Individual Deductible (*per Insured per Calendar Year)* • Family Deductible *(per family per Calendar Year)*	$2,250 $4,500	$10,000 $20,000
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)*	$7,350 $14,700	$20,000 $40,000
Coinsurance	40%	60%

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	40% after Deductible	60% after Deductible
Daily Hospital Room and Board	40% after Deductible	60% after Deductible
Miscellaneous Hospital Services	40% after Deductible	60% after Deductible
Surgical Services	40% after Deductible	60% after Deductible
Anesthesia Services	40% after Deductible	60% after Deductible
In-Hospital Medical Services	40% after Deductible	60% after Deductible
Out-of-Hospital Care	40% after Deductible	60% after Deductible
Chemical Dependency • Inpatient/Outpatient Facility • Office Visit	40% after Deductible $40 Copay	60% after Deductible 60% after Deductible
Chiropractic Services • Maximum Number of Office Visits per Calendar Year – 20 visits	40% after Deductible	60% after Deductible
Convalescent Home Services • Maximum Number of Days per Calendar Year – 60 days	40% after Deductible	60% after Deductible
Durable Medical Equipment • Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment *Preauthorization is required for original purchase or replacement of Durable Medical Equipment over $500.*	40% after Deductible	60% after Deductible
Emergency Services	40% after Deductible	40% after Deductible
Home Health Care Services • Maximum Number of Home Visits per Calendar Year – 180 days	40% after Deductible	60% after Deductible
Laboratory Services	40% after Deductible	60% after Deductible

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK *See Out of Network Maximum on page one
Mental Health Services • Inpatient • Outpatient	40% After Deductible $40 Copay per visit	60% after Deductible 60% after Deductible
Physician Medical Services • Physician Office Visits (Non-Specialist) • Physician Specialist Visits	$30 Copay per visit $40 Copay per visit	60% after Deductible 60% after Deductible
Prescription Drugs Benefit • **Retail Pharmacy Prescriptions** (31-day supply) • Tier 1-Preferred Generic Drug • Tier 2-Preferred Brand Drugs • Tier 3-Non-Preferred Brand and Generic Drugs • Tier 4- Preferred Specialty Drugs • **Mail Order Maintenance** (90-day supply) • Tier 1-Generic Drugs • Tier 2-Preferred Brand Drugs • Tier 3-Non-Preferred Brand and Generic Drugs • Tier 4- Preferred Specialty Drugs	 $5 per drug 30% after Deductible 35% after Deductible 40% after Deductible $10 per drug 30% after Deductible 35% after Deductible N/A	 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible N/A
Preventive Health Care Services	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	60% 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*	40% after Deductible	60% 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 for PT, OT and ST combined	40% after Deductible	60% after Deductible
Transplant Services	40% after Deductible	60% after Deductible

SCHEDULE OF BENEFITS (continued)

Engage Group Comprehensive Health Insurance Policy

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.	None, 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).*

- 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، Mountain Health CO-OP إذا كنت أنت أو شخص ما تحاول مساعدة، لديه تساؤلات حول والمعلومات في 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 ɏama 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 Mountain Health CO-OP، اگر شما یا کسی که شما در حال تلاش برای کمک به، سوالات در مورد پاسخ 2900-447-855 ،برای صحبت با یک مترجم، هزینه داشته باشد. اطلاعات به زبان خود را بدون هیچ.
- 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.