SCHEDULE OF BENEFITS

Large Group Connected Care Comprehensive Health Insurance Policy

Classes of Employees Insured:

Classified and Administrative employees/Retirees Eligible

Benefit Plan: Plan C-Gold

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit • Per Covered Person	Unlimited	Unlimited
Deductible		
• Individual Deductible (*per Covered Person per Calendar Year)*	$700	$1,400
• Family Deductible *(per family per Calendar Year)*	$1,400	$2,800
Annual Out-of-Pocket Maximum		
• Individual Annual Out-of-Pocket Maximum *(per Covered Person per Calendar Year)*	$4,500	$7,500
• Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	$9,000	$15,000
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	30% after Deductible	50% after Deductible
Chemical Dependency • Inpatient/other Outpatient Facility Services • Office Visit	 30% after Deductible $25 Copay per visit	 50% after Deductible 50% after Deductible
Chiropractic Services • Maximum Number of Office Visits per Calendar Year – 20 visits	$40 Copay per visit	50% after Deductible
Convalescent Home Services • Maximum Number of Days per Calendar Year – 60 days	30% after Deductible	50% after Deductible
Durable Medical Equipment • Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment • Preauthorization is recommended for original purchase or replacement of Durable Medical Equipment over $500.	30% after Deductible	50% after Deductible
Emergency Services	$200 Copay per visit	$200 Copay per visit
Home Health Care Services • Maximum Number of Home Visits per Calendar Year – 180 days	30% after Deductible	50% after Deductible
Hospital Services - Facility and Professional • Inpatient Facility • Outpatient Facility Observation Room/Bed	30% after Deductible	50% after Deductible

SCHEDULE OF BENEFITS (continued)

Large Group 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		
• Inpatient/other Outpatient Facility Services	30% after Deductible	50% after Deductible
• Office Visit	$25 Copay per visit	50% after Deductible
Physician Medical Services		
• Physician Office Visits (Non-Specialist)	$25 Copay per visit	50% after Deductible
• Physician Specialist Visits	$40 Copay per visit	50% after Deductible
(The Copay applies to office visits for all Covered Benefits except for Preventive Health Care Services.)		
Prescription Drugs Benefit		
• **Retail Pharmacy Prescriptions** (30-day supply)		
• Generic Drugs	$10 Copay per drug	50% after Deductible
• Preferred Brand Drugs	$25 Copay per drug	50% after Deductible
• Non-Preferred Brand Drugs	$55 Copay per drug	50% after Deductible
• Specialty Drugs	$80 Copay per drug	50% after Deductible
• **Mail Order Maintenance** (90-day supply)		
• Generic Drugs	$20 Copay per drug	50% after Deductible
• Preferred Brand Drugs	$50 Copay per drug	50% after Deductible
• Non-Preferred Brand Drugs	$110 Copay per drug	50% after Deductible
• Specialty Drugs	Not Available	Not Available
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.		
Preventive Health Care Services	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	50% after Deductible
Prostheses Benefit (Non-Dental)	30% after Deductible	50% after Deductible
• Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics		
• Preauthorization recommended for the original purchase or replacement of prosthetics over $500		
Therapeutic Services – Outpatient	$40 Copay per visit	50% after Deductible
Transplant Services	30% after Deductible	50% 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 Covered Dependent Children under age 19.		
• **Vision Care Services** • **Vision Examination**	None, 100% Covered	25%
Frequency of Services: One Vision Examination per Covered Dependent Child per Calendar Year		

• **Vision Care Materials**
  • **Lenses**
  • Single Vision
  • Bifocal
  • Trifocal
  • Lenticular
	
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
		
		25%
		25%
		25%
		25%

**Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.*		
Frequency of Services: One set of lenses per Covered Dependent Child per Calendar Year		
• **Vision Care Materials** • **Frames**	None, 100% Covered	25%
Frequency of Services: One frame per Covered Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.		

• **Contact Lenses**
  • Necessary Professional Fees and Materials
  • Elective Professional Fees** and Materials
	
	None, 100% Covered***
	None, 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).*