SCHEDULE OF BENEFITS

Individual Connected Care Comprehensive Health Insurance Policy

Policy Number: [123456]

Policy Effective Date: [January 1, 2020]

Policyowner: [John Doe]

Policy Anniversary Date: [January 1 of each Year]

Issue Age: [35]

Initial Premium: [$]

Type of Coverage: [Family]

Mode of Payment: [Monthly]

Benefit Period: Calendar Year

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

Benefit Plan: Gold PPO – Standard Indian Health Services Plan

This Benefit Plan is only available for an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, who is determined by Us to be eligible to enroll in this Benefit Plan, and, therefore, is not required to pay any cost sharing on any Covered Benefit for which services are furnished directly by an Indian Health Service, an Indian Tribe, a Tribal Organization, or an Urban Indian Organization (each as defined in 25 U.S.C. 1603).

BENEFIT INFORMATION	INDIAN HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit • Per Covered Person	Unlimited	Unlimited	Unlimited
Deductible • Individual Deductible (*per Covered Person per Calendar Year)* • Family Deductible *(per family per Calendar Year)*	None None	$750 $1,500	$2,250 $4,500
Annual Out-of-Pocket Maximum • Individual Annual Out-of-Pocket Maximum *(per Covered Person per Calendar Year)* • Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	N/A N/A	$5,750 $11,500	$17,250 $34,500
Coinsurance	0%	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 INDIAN HEALTH SERVICES	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	0%, No Deductible	30% after Deductible	50% after Deductible
Autism Spectrum Disorders • Inpatient/other Outpatient Facility Services • Office Visit	0%, No Deductible	30% after Deductible $35 Copay per visit	50% after Deductible 50% after Deductible
Chemical Dependency • Inpatient/other Outpatient Facility Services • Office Visit	0%, No Deductible	30% after Deductible $35 Copay per visit	50% after Deductible 50% after Deductible
Chiropractic Services • Maximum Number of Office Visits per Calendar Year – 20 visits	0%, No Deductible, No Copay	$40 Copay per visit	50% after Deductible
Convalescent Home Services • Maximum Number of Days per Calendar Year – 60 days	0%, No Deductible	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.*	0%, No Deductible	30% after Deductible	50% after Deductible

SCHEDULE OF BENEFITS (continued)

Individual Connected Care Comprehensive Health Insurance Policy

COVERED BENEFIT	YOUR COST INDIAN HEALTH SERVICES	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Emergency Room Services	0%, No Deductible	30% after Deductible	30% after Deductible
Home Health Care Services • Maximum Number of Home Visits per Calendar Year – 180 visits/year	0%, No Deductible	30% after Deductible	50% after Deductible
Hospital Services - Facility and Professional • Inpatient Facility • Outpatient Facility • Observation Room/Bed	0%, No Deductible	30% after Deductible	50% after Deductible
Laboratory Services	0%, No Deductible	30% after Deductible	50% after Deductible
Mental Health Services • Inpatient/other Outpatient Facility Services • Office Visit	0%, No Deductible	30% after Deductible $35 Copay per visit	50% after Deductible 50% after Deductible
Physician Medical Services • Physician Office Visits (Non-Specialist) • Physician Specialist Visits *(The Copay applies to office visits for all Covered Benefits except for Preventive Health Care Services.)*	0%, No Deductible, No Copay	$35 Copay per visit $40 Copay per visit	50% after Deductible 50% after Deductible

SCHEDULE OF BENEFITS (continued)

Individual Connected Care Comprehensive Health Insurance Policy

COVERED BENEFIT	YOUR COST INDIAN HEALTH SERVICES	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK

Prescription Drugs Benefit
• **Retail Pharmacy Prescriptions** (31-day supply)
  • Preferred Generic Drugs (Tier 1)
  • Non-Preferred Generic & Preferred Brand Drugs (Tier 2)
  • Non-Preferred Brand Drugs (Tier 3)
  • Specialty Drugs (Tier 4)
 	
• **Mail Order Maintenance** (90-day supply)
  • Preferred Generic Drugs (Tier 1)
  • Non-Preferred Generic & Preferred Brand Drugs (Tier 2)
  • Non-Preferred Brand Drugs (Tier 3)
  • Specialty Drugs (Tier 4)
  (31-Day Supply Only)
 	
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.
	0%, No Deductible, No Copay
	
	0%, No Deductible, No Copay
		10% per drug
		25% per drug
		
		35% per drug
		45% per drug
		
		10% per drug
		25% per drug
		
		35% per drug
		45% per drug
			50% after Deductible
			50% after Deductible
			
			50% after Deductible
			50% after Deductible
			
			50% after Deductible
			50% after Deductible
			
			50% after Deductible
			Not Available

Preventive Health Care Services	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	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) • Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics • Preauthorization is recommended for the original purchase or replacement of prosthetics over $500.	0%, No Deductible	30% after Deductible	50% after Deductible
Therapeutic Services – Outpatient	0%, No Deductible	$40 Copay per visit	50% after Deductible
Transplant Services	0%, No Deductible	30% after Deductible	50% after Deductible

COVERED BENEFIT	YOUR COST INDIAN HEALTH SERVICES	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** *Frequency of Services:* One Vision Examination per Covered Dependent Child per Calendar Year	None, 100% Covered	None, 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 Covered Dependent Child per Calendar Year
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
		None, 100% Covered*
		None, 100% Covered*
		None, 100% Covered*
		None, 100% Covered*
			25%
			25%
			25%
			25%

• **Vision Care Materials** • **Frames** *Frequency of Services:* One frame per Covered Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.	None, 100% Covered	None, 100% Covered	25%
• **Contact Lenses**			
• Necessary Professional Fees and Materials	None, 100% Covered***	None, 100% Covered***	25%
• Elective Professional Fees** and Materials	None, 100% Covered***	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 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.

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 yoƃii. Noddu 1-855-447-2900.

UKRAINIAN: УВАГА! 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: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको 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.