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: Bronze PPO – Indian No Cost Sharing Benefit Plan

This Benefit Plan is only available for an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, with a household income less than three hundred percent (300%) of the Federal Poverty Level (FPL) and who is determined eligible to enroll in the Benefit Plan by the Health Insurance Marketplace.

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit • Per Covered Person	Unlimited	Unlimited
Deductible • Individual Deductible (*per Covered Person per Calendar Year)* • Family Deductible *(per family per Calendar Year)*	None None	None None
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	N/A N/A
Coinsurance	0%	0%

COVERED BENEFITS

This Policy will pay Covered Medical Expenses incurred for Covered Benefits provided in *Section 5, Covered Benefits* based on the Allowable Fee. The Deductible, Coinsurance, Annual Out-of-Pocket Maximum, and any applicable Copayments do not apply to this Benefit Plan.

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	0%	0%
Autism Spectrum Disorders	0%	0%
Chemical Dependency • Inpatient • Outpatient	0%	0%
Chiropractic Services • Maximum Number of Office Visits per Calendar Year – 20 visits	0%	0%
Convalescent Home Services • Maximum Number of Days per Calendar Year – 60 days	0%	0%
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%	0%
Emergency Room Services	0%	0%
Home Health Care Services • Maximum Number of Home Visits per Calendar Year – 180 visits/year	0%	0%
Hospital Services - Facility and Professional • Inpatient Facility • Outpatient Facility • Observation Room/Bed	0%	0%
Laboratory Services	0%	0%

SCHEDULE OF BENEFITS (continued)

Individual Connected Care Comprehensive Health Insurance Policy

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Mental Health Services • Inpatient • Outpatient	0%	0%
Physician Medical Services • Physician Office Visits (Non-Specialist) • Physician Specialist Visits	0%	0%
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)	 0% 0% 0% 0% 0% 0% 0% 0%	 0% 0% 0% 0% 0% 0% 0% 0% Not available
Preventive Health Care Services	0%	0%
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%	0%
Therapeutic Services – Outpatient	0%	0%
Transplant Services	0%	0%

SCHEDULE OF BENEFITS (continued)

Individual Connected Care 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 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

• **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*

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

***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 ا‍شعار معلومات هامة .يحوي هذا ا‍شعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خ‍ل ابحث عن التواريخ (رقم هاتف الصم والبكم: 1-855-447-2900)، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-447-2900.)

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 gidɛteeɗo 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 yoɓii. 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.