SCHEDULE OF BENEFITS

Individual LINK Comprehensive Health Insurance Policy

Benefit Plan: **LINK Silver Managed Care – Native American Zero Cost Share Plan**

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

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 Insured	Unlimited	Unlimited	Unlimited
Deductible • Individual Deductible (*per Insured per Calendar Year)* • Family Deductible *(per family per Calendar Year)*	None None	None None	None None
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)*	N/A N/A	N/A N/A	N/A N/A
Coinsurance	0%	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. This Benefit Plan has no cost-sharing requirements; therefore, no Deductibles, Coinsurance, Annual Out-of-Pocket Maximums, or Copayments apply to this Benefit Plan.

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%	0%	0%
Daily Hospital Room and Board	0%	0%	0%
Miscellaneous Hospital Services	0%	0%	0%
Surgical Services	0%	0%	0%
Anesthesia Services	0%	0%	0%
In-Hospital Medical Services	0%	0%	0%
Out-of-Hospital Care	0%	0%	0%
Maximum Dollar Amount for Covered Charges	0%	0%	0%
Chemical Dependency • Inpatient/Outpatient Facility • Office Visit	0%	0%	0%
Chiropractic Services • Maximum Number of Office Visits per Calendar Year – 20 visits	0%	0%	0%
Convalescent Home Services • Maximum Number of Days per Calendar Year – 30 days	0%	0%	0%
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*	0%	0%	0%
Emergency Room Services	0%	0%	0%
Hearing Aids (Child Only) • Hearing aids and the examination for the fitting, except for hearing loss due to a	0%	0%	0%

COVERED BENEFIT	YOUR COST INDIAN HEALTH SERVICES	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
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 • Maximum Number of Home Visits per Calendar Year – 30 days	0%	0%	0%
Laboratory Services	0%	0%	0%
Mental Health Services • Inpatient/Outpatient Facility • Office Visit	0%	0%	0%
Physician Medical Services • Physician Office Visits (Non-Specialist) • Physician Specialist Visits	0%	0%	0%
Prescription Drugs Benefit • **Retail Pharmacy Prescriptions** (31-day supply) • Tier 0-Preventive Drugs, including contraceptives • Tier 1-Preferred Generic Drug • 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 • Tier 4-Preferred Specialty Drugs	0% 0% N/A	0% 0% N/A	0% 0% N/A
Preventive Health Care Services	0%	0%	0%
Prostheses Benefit (Non-Dental) • Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics *Preauthorization is required for the original purchase or replacement of prosthetics over $500*	0%	0%	0%
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	0%	0%	0%

COVERED BENEFIT	YOUR COST INDIAN HEALTH SERVICES	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Transplant Services	0%	0%	0%

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 Insured Dependent Children under age 19.*			
• **Vision Care Services** • **Vision Examination** *Frequency of Services:* One Vision Examination per Insured Dependent Child per Calendar Year	0%	0%	0%

• **Vision Care Materials**
  • **Lenses**
  Frequency of Services: One set of lenses per Insured Dependent Child per Calendar Year
  • 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
	0%
	0%
	0%
	0%
		0%
		0%
		0%
		0%
			0%
			0%
			0%
			0%

• **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.	0%	0%	0%
• **Contact Lenses**			
• Necessary Professional Fees and Materials	0%	0%	0%
• Elective Professional • Fees** and Materials	0%	0%	0%

***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 اللغة، فإن 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.) 855-447-2900 (رقم هاتف الصم والبكم: 1-855-447-2900خدمات 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 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.