OUTLINE OF COVERAGE

Individual Access Care Comprehensive Health Insurance Policy

Benefit Plan: **Access Care Bronze PPO – Native American Limited 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

THE POLICY PROVIDES A NETWORK THROUGH WHICH INSUREDS CAN RECEIVE SERVICES FROM IN-NETWORK PROVIDERS. IT IS THE INSURED'S RESPONSIBILITY FOR PAYMENT OF BILLED CHARGES BEYOND THE IN-NETWORK CHARGES WHEN THE INSURED USES THE SERVICES OF AN OUT-OF-NETWORK PROVIDER.

(1) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) **Comprehensive Health Insurance Coverage** — Policies of this category are designed to provide to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. *Basic* hospital or *basic* medical insurance coverage is not provided.

(3) **Description of Benefits** – The policy provides Comprehensive Health Preferred Provider Organization (PPO) Insurance coverage. You have the option to receive services from a Preferred Provider or a Non-Preferred Provider. Generally, benefits are paid at a higher level when a Preferred Provider is used. The Outline of Coverage reflects the benefits payable when services for Covered Benefits are provided by a Preferred Provider or a Non-Preferred Provider. The Outline of Coverage and the Covered Benefits provided under the Policy are indicated below in this section.

(4) ***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)*	$8,150	$24,450
• Family Deductible *(per family per Calendar Year)*	$16,300	$48,900
Annual Out-of-Pocket Maximum		
• Individual Annual Out-of-Pocket Maximum *(per Insured per Calendar Year)*	$8,150	$24,450
• Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	$16,300	$48,900
Coinsurance	0%	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 Outline of Coverage. 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 Outline of Coverage	0% after Deductible	0% after Deductible
Daily Hospital Room and Board	0% after Deductible	0% after Deductible
Miscellaneous Hospital Services	0% after Deductible	0% after Deductible
Surgical Services	0% after Deductible	0% after Deductible
Anesthesia Services	0% after Deductible	0% after Deductible
In-Hospital Medical Services	0% after Deductible	0% after Deductible
Out-of-Hospital Care	0% after Deductible	0% after Deductible
Chemical Dependency • Inpatient/Outpatient Facility • Office Visit	 0% after Deductible 0% after Deductible	 0% after Deductible 0% after Deductible
Chiropractic Services • Maximum Number of Office Visits per Calendar Year – 20 visits	0% after Deductible	0% after Deductible
Convalescent Home Services • Maximum Number of Days per Calendar Year – 30 days	0% after Deductible	0% 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*	0% after Deductible	0% after Deductible
Emergency Services	0% after Deductible	0% after Deductible
Home Health Care Services • Maximum Number of Home Visits per Calendar Year – 30 days	0% after Deductible	0% after Deductible

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK *See Out of Network Maximum on page one*
Laboratory Services	0% after Deductible	0% after Deductible
Mental Health Services		
• Inpatient/Outpatient Facility	0% after Deductible	0% after Deductible
• Office Visit	0% after Deductible	0% after Deductible
Physician Medical Services		
• Physician Office Visits (Non-Specialist)	$60 Copay first 3 visits then 0% after Deductible	0% after Deductible
• Physician Specialist Visits	0% after Deductible	0% after Deductible
Prescription Drugs Benefit		
• **Retail Pharmacy Prescriptions** 31-day supply)		
• Tier 0-Preventive Drugs, including contraceptives	$0	$0
• Tier 1-Preferred Generic Drug	$20 Copay per Drug	0% after Deductible
• Tier 2-Preferred Brand and Non-Preferred Generic Drugs	0% after Deductible	0% after Deductible
• Tier 3-Non-Preferred Brand Drugs	0% after Deductible	0% after Deductible
• Tier 4-Preferred Specialty Drugs	0% after Deductible	0% after Deductible
• **Mail Order Maintenance** (90-day supply)		
• Tier 0-Preventive Drugs, including contraceptives	$0	$0
• Tier 1-Preferred Generic Drugs	$40 Copay per Drug	0% after Deductible
• Tier 2-Preferred Brand Drugs	0% after Deductible	0% after Deductible
• Tier 3-Non-Preferred Brand and Generic Drugs	0% after Deductible	0% after Deductible
• Tier 4-Preferred Specialty Drugs	N/A	N/A
Preventive Health Care Services	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	0% after Deductible
Prostheses Benefit (Non-Dental)		
• Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics	0% after Deductible	0% after Deductible
• Preauthorization required for the original purchase or replacement of prosthetics over $500		
Therapeutic Services – Inpatient/Outpatient		
Habilitative: Limit of 20 visits per year for PT, OT and ST combined		0% after Deductible
Rehabilitative: Limit of 20 visits per year for PT, OT and ST combined	0% after Deductible	
Transplant Services	0% after Deductible	0% 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 Insured Dependent Children under age 19.		
• **Vision Care Services**		
• **Vision Examination**	100% Covered	25%
Frequency of Services: One Vision Examination per Insured Dependent Child per Calendar Year		
• **Vision Care Materials**		
• **Lenses**		
• Single Vision	100% Covered*	25%
• Bifocal	100% Covered*	25%
• Trifocal	100% Covered*	25%
• Lenticular	100% Covered*	25%
**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		
• **Vision Care Materials**		
• **Frames**	100% Covered	25%
Frequency of Services: One frame per Insured Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.		
• **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).*

EXCLUSIONS AND LIMITATIONS

All benefits provided under this Policy are subject to the exclusions and limitations in this Section and as stated under Section 5, Covered Benefits. No benefits will be paid under this Policy that are incurred by or results from any of the following:

1. Inpatient or outpatient custodial care, rest cures, or transportation if not medically necessary;

2. Any condition, disease, illness or accidental injury to the extent that the Insured is entitled to benefits under occupational coverage provided through an employer, or under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries, conditions, or occupational disease. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party;

3. War, or act of war, whether declared or not, rebellion, or insurrection;

4. Service in the Armed Forces or any auxiliary units of the Armed Forces;

5. Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;

6. Vision services, including, but not limited to, (a) eye examinations for the prescription or fitting of eyeglasses or contact lenses; (b) purchase of eyeglasses and contact lenses; (c) Lasik surgery; or (d) radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism). This exclusion does not apply to the Pediatric Vision Care benefit provided under this Policy;

7. Hearing aids and examinations for the prescription or fitting of hearing aids;

8. Cosmetic Surgery - Surgery primarily for the purpose of improving appearance, except for reconstructive surgery. Such reconstructive surgery must be: (a) incidental to or following surgery resulting from trauma, infection or other diseases of the involved part; or (b) because of congenital disease or anomaly of a covered Dependent Child;

9. For cosmetic foot care, and other foot care including but not limited to, treatment of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain and toenails (except for surgical care of ingrown or diseased toenails);

10. Foot orthotic appliance provided for the treatment of any medical condition;

11. Treatment for infertility and fertilization procedures, including, but not limited to, ovulation induction procedure and pharmaceuticals, artificial insemination, invitro fertilization, embryo transfer or similar procedures, including but not limited to laboratory services, radiology services or similar services, drugs or devices related to treatment for fertility or fertilization procedures;

12. Any injury incurred while committing a felony;

13. Treatment provided in a government hospital, except Idaho residents who are confined in state medical institutions; benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employers' liability or occupational disease law;

14. Services performed by You or a member of Your Immediate Family;

15. Services for which there is no legal obligation for the Insured to pay or for which no charge would be made if insurance did not exist, unless such charge is regularly and customarily made in similar amount by the provider of such to other non-indigent patients, or unless, in either case, We are required by law to pay to the Government of the United States;

16. Nonsurgical Treatment for malocclusion of the jaw, including services for anterior or internal dislocation, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances;

17. Unless otherwise included under this Policy as a Covered Benefit, dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;

18. Private duty nursing;

19. Reversal of an elective sterilization;

20. Transplants of a non-human organ or artificial organ transplant;

21. Any services, supplies, drugs and devices which are: (a) investigational/Experimental Service; (b) not accepted medical practice; and (c) not a Covered Medical Expense. We may consult with Physicians or national medical specialty organizations for advice determining whether the service or supply is accepted medical practice;

22. For travel by the Insured or a provider, except as specified elsewhere in this contract under Transplant benefits;

23. Orthodontics;

24. Services, supplies and devices relating to any of the following treatments or related procedures: (a) acupuncture; (b) acupressure; (c) homeotherapy; (d) rolfing; (e) holistic medicine; (f) marriage counseling; (g) religious counseling; (h) self-help programs; or (i) stress management;

25. Vitamins. NOTE: Certain vitamins may be covered for specific conditions in accordance with published Medical Policy;

26. Food supplements and/or medical foods, except when used for Inborn Errors of Metabolism or Enteral Nutrition services as defined in the Medial Policy;

27. Surgery for weight control or treatment of obesity or morbid obesity, except that services to treat medical conditions such as diabetes, high blood pressure, etc., related to obesity are covered;

28. Reversals or revisions of surgery for obesity, except when required to correct an immediate life-endangering condition;

29. Education services, unless otherwise specified as a Covered Benefit, or tutoring services;

30. Any services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature;

31. Non-medically necessary durable medical equipment, communication devices and prosthetic limbs;

32. Services, supplies, drugs and devices which are not listed as a Covered Benefit as provided in this Policy unless medically necessary;

33. Elective abortions except if recommended by a consulting physician that an abortion is necessary to save the life of the mother, or if the pregnancy is a result of rape, as defined in section 18-6101, Idaho Code, or incest as determined by the courts; or

34. Non Emergent Medical Service outside the United States are not covered.

35. For any of the following:

    a. Appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service in this Policy;
    b. Orthognathic surgery, including services and supplies to augment or reduce the upper or lower jaw;
    c. Implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
    d. Alveolectomy or alveoloplasty when related to tooth extraction;
    e. Continuous passive motion devices;
    f. TENS units.

- 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.

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- 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.

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- THAI: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-447-2900 (TTY: 1-855-447-2900).

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- 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: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-447-2900 (टिटिवाइ: 1-855-447-2900)

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