OUTLINE OF COVERAGE

Individual LINK Comprehensive Health Insurance Policy

Benefit Plan: **LINK Silver Option 2 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)*	None	None	None
• Family Deductible *(per family per Calendar Year)*	None	None	None
Annual Out-of-Pocket Maximum			
• Individual Annual Out-of-Pocket Maximum *(per Insured per Calendar Year)*	N/A	N/A	N/A
• Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	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	INDIAN HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
All Covered Benefits shown in Section 5, unless otherwise specified below in this Outline of Coverage	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	0%	0%	0%

COVERED BENEFIT	INDIAN HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Preauthorization is required for original purchase or replacement of Durable Medical Equipment over $500			
Emergency Room Services	0%	0%	0%
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	0%	0%	0%
• **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% N/A	0% N/A	0% N/A

COVERED BENEFIT	INDIAN HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
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%
Transplant Services	0%	0%	0%
Vision Care Benefit - Pediatric Vision Care Services *This Vision Care Benefit only applies to Insured Dependent Children under age 19.*			

COVERED BENEFIT	INDIAN HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
• **Vision Care Services** • **Vision Examination** *Frequency of Services:* One Vision Examination per Insured Dependent Child per Calendar Year	100% Covered	100% Covered	
• **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	 100% Covered* 100% Covered* 100% Covered* 100% Covered*	 100% Covered* 100% Covered* 100% Covered* 100% Covered*	
• **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.	100% Covered	100% Covered	
• **Contact Lenses** • Necessary Professional Fees and Materials • Elective Professional • Fees** and Materials	 100% Covered*** 100% Covered***	 100% Covered 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).*

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;

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. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition that occurs within 30 days of the initial surgery;

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.
- 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: إذاكنت 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 (رقم هاتف الصم والبكم: 1-855-447-2900خدمات 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 kimminiidum. TAnndinoore nde'e e woodi habaru kimminiidum dow dereewol tefal maadamaada malla ko yaali dow laawol MHC. Maanda nyalaade lewru nder anndinoorende'e. Teema a gidteedo ngada goddum bako godde nyalaade ngam ko yaali njamu maada malla walla dow njobdi. Hakke maada annda habaru ngu'u ewalliinde nder wolde maada naa maa a yobii. 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: तपाईंले 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.