Schedule of Medical Benefits

The following Schedule of Medical Benefits shows Covered Services and the amount of the Covered Expenses that are eligible for payment under the Plan. The Plan will pay the percentage of Covered Expenses designated on the Health Care Schedule of Benefits for each Covered Service, minus any applicable co-pays or penalties.

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
Deductibles	None	None
Annual Out of Pocket Maximum for OON only (includes medical copays, but excludes Rx copays)	None	$1,000/$2,500 Eligible charges paid at 100% of MAC after out of pocket has been met
AUTISM SPECTRUM DISORDER (Maximum $20,000 per Plan Year for children under school age; $10,000 per Plan Year for school-age children up to age 18)	No cost to you below cap You are responsible for costs above cap	Not Covered

OBESITY Screening and counseling weight reduction, or weight control in connection with a diagnosis of obesity, hypertension, high cholesterol or diabetes, including medically-supervised dietary or nutritional therapy program lasting not longer than one year. Medical supervision must be provided by a Provider or registered dietician with a National Provider Identifier number. The Plan will pay a maximum of $5,000 per year for this medically-supervised nutrition therapy program." Please contact the Claims Administrator for additional information on centers of excellence for obesity services. The Plan is offering a pilot program called MPTN Healthy Weight Program for plan participants who meet the following criteria. (Individual program eligibility required): a. Body Mass Index ("BMI") of 35 or greater b. At least one obesity-lined co-morbidity (e.g., sleep apnea, high blood pressure, diabetes, fatty liver) c. Over the age of 18 years d. Evidence of obesity for the last five (5) years For participants meeting the above criteria the Plan will pay for anti-obesity medications, prescribed specifically for the treatment of obesity only for the one-year pilot program period and only for prescriptions sent to PRxN by licensed providers under a contractual arrangement with the Plan for the MPTN Healthy Weight program. Anti-obesity medications are not covered when prescribed outside of the MPTN Healthy Weight program by other general practitioners and prescribers. In order for the Plan to pay for these medications, they must be filled exclusively by PRxN and are subject to clinical pharmacy management, utilization review, step therapy, and class substitution, generic requirements as clinically necessary. Continuation of coverage of anti-obesity medications beyond the one-year pilot of the MPTN Healthy Weight Program is not guaranteed and is subject to review and determination at the end of the one-year period. Bariatric surgery (Subject to meeting pre-conditions)	No cost to you below cap You are responsible for costs above cap (Subject to cap)	30% of MAC
PRIOR AUTHORIZATION (TYPE I) PENALTY For failure to prior authorize medically necessary procedures. Penalty does not apply to OON out-of-pocket maximum.	20% of allowable expenses up to $5,000	20% of allowable expenses up to $5,000

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
PREVENTATIVE CARE ❖ Routine Physicals (1 per year) ❖ Well Woman's Exam • 13 years and older, Pelvic Exam and PAP Smear (1 per year) ❖ Routine Mammogram • Ages 40 and older: Annually • Ages 35 – 39: 1 baseline mammogram ❖ Well Man's Exam Prostate cancer screening • Age 40 and over: 1 annual exam ❖ Colorectal cancer screening • Age 40-50 ○ 1 blood test every year • 45 and Over ○ 1 blood test every year ○ 1 sigmoidoscopy every three years ○ 1 colonoscopy every year ❖ Routine Immunizations (up to age 18) • Cervical Cancer Vaccine (Up to age 26) • Pneumococcal Vaccine (Age 65 and Older, 19-64 with certain medical conditions) • Other Vaccines in accordance with AMA guidelines ❖ Routine Pediatric Care (Birth through age 18)	No cost to you	30% of MAC
OUTPATIENT CARE An * means Type I Prior Authorization is Required ❖ Primary Care Office Visits ❖ Urgent Care-Hospital Based* ❖ Walk-In Center (Non-Hospital associated) ❖ X-rays, Ultrasounds, CT, PET Scans, MRIs, and SPECTS; Laboratory Tests and EKGs* ❖ Restorative Physical and Occupational Therapy* (30 visits each, per Plan year additional visits require approval for Medical Necessity) ❖ Chiropractic Care, when deemed Medically Necessary.* (Maximum 20 visits per Plan year) ❖ Cardiac Rehabilitation* (up to 60 visits per Plan year)	No cost to you	30% of MAC

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
❖ Acupuncture; see definitions, when deemed medically necessary. (Maximum $600 per Plan year) ❖ Hypnosis/Hypnotherapy Services, when deemed medically appropriate. Must be provided by a licensed hypnotist. (Maximum $500 per Plan year) ❖ Speech Therapy* must be physician approved and related to a sickness or injury occurring while covered under this Plan ❖ Allergy Testing and Injections ❖ All outpatient surgery*		
OUTPATIENT OR OFFICE SURGERY (Hospital-based services require Type I Prior Authorization)	No cost to you	30% of MAC
CHEMOTHERAPY Type I Prior Authorization required	No cost to you	30% of MAC
CONTRACEPTIVE MANAGEMENT- BIRTH CONTROL	Covered under Pharmacy Benefit Plan. See Schedule of Pharmacy Benefits (p. 68).	
DIAGNOSTIC PROCEDURES (PERFORMED IN HOSPITAL) NOTE: Services provided in a Hospital based setting require Prior Authorization	No cost to you	30% of MAC
DIABETIC NUTRITIONAL COUNSELING	No cost to you	30% of MAC
DURABLE MEDICAL EQUIPMENT NOTE: Some DME expenses may require Prior Authorization	No cost to you	30% of MAC
HEARING AIDS $2000 Maximum every 36 months combined In and Out of Network	No cost to you	30% of MAC
ORTHOTICS ❖ Diabetics only	No cost to you	30% of MAC
PRE-ADMISSION TESTING	No cost to you	30% of MAC
SPECIALITY AND SECOND SURGICAL OPINION	No cost to you	30% of MAC
EMERGENCY ROOM ❖ Co-pay waived if admitted to the Hospital ❖ NOTE: Hospital-based services require Prior Authorization within 72 hours or 3 business days	No cost to you after $75 co-pay	$75 co-pay plus 30% of MAC
AMBULANCE SERVICE/ MEDICAL TRANSPORT	No cost to you after $50 co-pay	No cost to you after $50 co-pay

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
PREGNANCY AND MATERNITY CARE ❖ Hospital Services ❖ Pre-Natal and Post-Natal Care ❖ Birthing Facility Fee ❖ Surrogacy ❖ Infertility Services Prior Authorization is **NOT** Required for maternity stays that are 48 hours or less for a vaginal delivery or 96 hours or less for a Cesarean delivery. If additional time in the Hospital is required for mother, baby, or both, these additional days MUST BE CERTIFIED. For patients discharged in less than the authorized time, one follow-up home care visit will be considered medically appropriate and will NOT require Prior Authorization. Type I Prior Authorization required for all other admissions for complications arising from pregnancy.	No cost to you ($15,000 cap for Surrogate Mother)	30% of MAC ($15,000 cap for Surrogate Mother)
INPATIENT CARE Room and Board limited to 120 Days per cause (semi-private room) ❖ Inpatient physician services ❖ Miscellaneous inpatient services and supplies Type I Prior Authorization Type I Required	No cost to you	30% of MAC
EXTENDED CARE FACILITIES ❖ Skilled Nursing, Convalescent or Sub Acute Facility ❖ Medical care only; no custodial care ❖ Limited to 365 days maximum per confinement Type I Prior Authorization Required	No cost to you	30% of MAC
ORGAN AND TISSUE TRANSPLANT Type I Prior Authorization Required	No cost to you	30% of MAC
HOME HEALTHCARE ❖ Limited to 120 days per calendar year Type I Prior Authorization Required	No cost to you	30% of MAC
HOSPICE CARE Type I Prior Authorization Required	No cost to you	No cost to you
Remote Patient Monitoring Type I Prior Authorization Required	No cost to you for device; You are responsible for subscriptions to the extent	30% of MAC

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
	exceeding $30 per month	
SMOKING CESSATION ❖ Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; the American Cancer Society (800-227-2345) can provide assistance in locating counseling services in your area. All Food and Drug Administration (FDA)-approved tobacco cessation medications are covered under Pharmacy Benefit.	No cost to you	No cost to you
WIGS ❖ *When prescribed by a Physician as a prosthetic for hair loss due to permanent burn Alopecia, Chemotherapy, or Radiation therapy*	No cost to you The Plan will pay for one wig per year up to a $500 maximum	30% of MAC The Plan will pay for one wig per year up to a $500 maximum

Schedule of Mental Health/Alcohol/Substance Abuse Benefits

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
MENTAL HEALTH BENEFIT		
OUTPATIENT TREATMENT	**No cost to you**	**30% of MAC**
INPATIENT TREATMENT Limited to semi-private room rate	**No cost to you**	**30% of MAC**
PARTIAL HOSPITAL AND INTENSIVE OUTPATIENT	**No cost to you**	**30% of MAC**
ALCOHOL / SUBSTANCE ABUSE BENEFIT		
OUTPATIENT TREATMENT	**No cost to you**	**30% of MAC**
INPATIENT TREATMENT Limited to semi-private room rate	**No cost to you**	**30% of MAC**
PARTIAL HOSPITAL AND INTENSIVE OUTPATIENT	**No cost to you**	**30% of MAC**

NOTE: ALL BEHAVIORAL HEALTH, MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE TREATMENT THAT IS INPATIENT TREATMENT, PARTIAL HOSPITALIZATION ORINTENSIVE OUTPATIENT MUSTHAVE PRIOR AUTHORIZATION.

NOTE: ALL OUT-OF-NETWORK BEHAVIORAL HEALTH, MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE TREATMENT IS SUBJECT TO ALTERNATIVE PAYMENT METHODOLOGIES AS DETAILED BELOW. THE PLAN STRONGLY ENCOURAGES YOU TODISCUSS OPTIONS FOR TREATMENT WITH THE PLAN ADMINISTRATOR PRIOR TO ENTERING INTO TREATMENT.

Limitations/Exclusions for Mental Health and Alcohol/ SubstanceAbuse Treatment

Some Mental Health/Alcohol/Substance Abuse treatment is not covered under the Plan. If you have a question about whether a Mental Health/Alcohol/Substance Abuse service is covered, call Pequot PlusHealth Benefit Services at 888-779-6872 to check. The Plan Administrator makes the final determination as whether the service in question is covered or are excluded under the Plan.

Services or treatments for the following are not covered by the Plan:

- Treatment for learning disabilities
- Educational, vocational and/or recreational services provided on an outpatient basis
- Treatment which is determined to be for the Plan Participant's personal growth or enrichment
- Autism, other than as provided in Section 11, Medical Plan Covered Services
- Court-ordered placement for mental health care or substance abuse
- Services for intellectual disability
- Any other treatment which is expressly excluded from the Plan

Outpatient Substance Abuse Treatment Centers are facilities that are primarily engaged in providing detoxification and rehabilitation treatment for alcoholism and/or drug abuse where there is no facility confinement. Inpatient stays at these facilities are not covered by the Plan.

Substance Abuse Treatment Facilities are facilities providing continuous structured twenty-four (24) hour per day programs of inpatient treatment and rehabilitation for drug dependency oralcoholism. A Substance Abuse Treatment Facility must be licensed to provide this type of care by the state in which it operates and be approved by the Plan. The facility must be JCAHO accredited.

All out-of-network behavioral health, mental health, and alcohol/substance abuse coverage under this Section 12 is subject to alternative payment methodologies pursuant to Subpart I of Title 42, Part 136 of the Code of Federal Regulations. Specifically, this means that all out-of-network providers, centers, non-hospital-based intensive outpatient, partial hospitalization, residential services, and other similar facilities, providers, or suppliers will be paid:

1. The rate negotiated by the Plan and the provider or supplier;
2. If no negotiated rate exists, the lowest of: (i) the Medicare-like rate; (ii) the rate negotiated by a repricing agent; and (iii) the provider or supplier's Most Favored Customer rate; or
3. If no payment rate is available under #1 or #2, then 65% of the MAC..

This section is intended to incorporate 42 C.F.R. § 136.203 without alteration.

VISION BENEFITS ❖❖❖❖

Eligibility, participation and enrollment requirements for the Plan's vision coverage are the same as for the Plan's health care coverage.

You and your Dependents can obtain eye care and vision services from any eye care provider. However, it is important for the Participant to ask the provider whether they accept health insurance coverage. If you choose to receive vision care from a Provider that does not accept insurance you must pay that Provider directly for all charges and then submit a claim for reimbursement to Pequot Plus Health Benefit Services. You will be reimbursed up to the maximum allowable amount authorized by the Plan.

Schedule of Vision Benefits

The following Schedule of Vision Benefits shows Covered Services and the amount of the Covered Expenses that are eligible for payment under the Plan.

Tribal Family Health Plan Calendar Year Covered Services (January 1 – December 31)	**Maximum Benefit**	**Maximum Frequency**
Eye Examination	$300 per exam	1 Exam per 12-month period
Eyeglass Lenses	$400 per set	1 set per 12-month period
Eyeglass Frames	$200 per set	1 set per 24-month period
Contact Lenses	$400	1 set per 12-month period
LASIK	$2000 per eye (lifetime maximum)	
This benefit allows for either one (1) set of eyeglass lenses or one (1) set of contact lenses – but not both – in a 12 month period.		

Filing a Claim for Vision Benefits

Filing a claim for Vision Benefits:

1. See your doctor or other vision care provider. Generally, your doctor, if they accept insurance, will submit your claim to the Plan.
2. If your Provider does not accept insurance, you must pay in full for all services received and file a claim with Pequot Plus Health Benefit Services. Your claim must include an itemized bill showing the name and address of the patient, the name of the Provider, the services rendered, and the amount paid.
3. The Plan will reimburse up to the maximum amount allowed for each Plan Year.

LASIK

Refractive/laser eye surgery (LASIK) will be covered, for any reason, up to the maximum lifetime benefit of $2,000.00 per eye.

Schedule of Dental Benefits

The following Schedule of Dental Benefits shows Covered Services and the amount of the covered expenses eligible for payment under the Plan. The percentages of covered expenses designated on the Schedule of Dental Benefits for listed Covered Services will be paid under the Plan minus any applicable co-pays or penalties.

Tribal Family Health Plan **Calendar Year Covered Services** (January 1 – December 31)	**In-Network** (Amounts listed below are what you pay)	**Out-of-Network** (Amounts listed below are what you pay)
Deductibles	None	None
Annual Benefit Limitation	$10,000 per individual	
Preventive and Diagnostic • Routine Oral Exams - once every 6 months • Cleanings – once every 6 months • Fluoride – one treatment every 6 months • Bitewing X-rays – one set of 2 or 4 films every 12 months • Panorex - once every 3 years • Full mouth series of x-rays – once every 3 years • Periapical X-rays • Space Maintainers – one per space to age 16 • Emergency Exam	No cost to you, subject to annual maximum	100% of Dental Fee Schedule Participant pays amount over Fee Schedule
Restorative Benefits: (subject to frequency limits) • Fillings • Root Canals (Endodontic) • Oral Surgery • Periodontal Surgery/treatment • Denture Relines and Repairs • Anesthesia ******Multiple extractions at the same visit (7 or more) and removal of impacted teeth are **NOT** subject to annual maximum.	No cost to you, subject to annual maximum	100% of Dental Fee Schedule Participant pays amount over Fee Schedule
Major Services:(once every 5 years) • Inlays • Onlays • Crowns • Post and Core • Repair crowns, bridgework and dentures • Full and Partial Removable Dentures • Implants	No cost to you, subject to annual maximum	100% of Dental Fee Schedule Participant pays amount over Fee Schedule
*Orthodontic Treatment and Appliances	Subject to Plan Year Maximum. ($10,000.00 lifetime maximum, per individual).	
*IHS PRC supplement may be available on a per case basis for this benefit.		

Schedule of Pharmacy Benefits

The following Schedule of Pharmacy Benefits shows Covered Services and the amount of the Covered Expenses eligible for payment under the Plan. The percentages of Covered Expenses designated on the Schedule of Pharmacy Benefits for listed Covered Services will be paid under the Plan minus any applicable co-pays or penalties.

Prescription Drugs	**Retail Pharmacy**	**PRxN Pharmacy and Mail Service**	
	Up to 30-day Supply	Up to 30-day Supply	Up to 90-day Supply
Generic	First Three (3) Fills Free (All subsequent fills must be through PRxN – see Mandatory Mail policy on p. 66)	Free	Free
Preferred Brand	First Three (3) Fills Free (All subsequent fills must be through PRxN—see Mandatory Mail policy on p. 66)	Free	Free
Non-Preferred Brand	$75 co-pay	$25 Co-pay	$50 Co-pay
PRxN Compliance Rx: Covered under your Plan at no charge regardless of their placement on the PRxN formulary. Medications in this class include prescriptions for: Blood Pressure, Cholesterol, Heart Disease, COPD/Asthma, Diabetes and Anti-psychotics		Free	Free
Oral Contraceptives (If prescribed by a Physician)	Free	Free	Free
Blood Pressure Cuffs/Monitors	Covered only under prescription drug coverage. Restricted to Plan Participants age 55 years and older; one (1) device every three (3) years. With valid prescription and filled at PRxN only.		
SMOKING CESSATION Includes both prescription and over-the-counter medications), when prescribed by a health care provider without prior authorization, for a maximum		Free	Free

of a 160 day supply per calendar year.			
Prior Authorization required for Specialty/Biotech Product coverage **Providers and Participants call 888-779-6638 for Prior Authorization**			
Annual Maximum	Not Applicable	Not Applicable	Not Applicable

Limitations/Exclusions for Pharmacy

Some medications are not covered under the Plan. If you have a question about whether a medication is covered, please call PRxN Customer Service at 888-779-6638. The following prescription drugs or other medications or treatments cannot be purchased under the Plan.

A. Over-the-counter medications.

B. Experimental or ***off-label*** non-Food and Drug Administration approved use.

C. Medications related to a non-covered medical//visual/dental condition are excluded under the Plan.

D. Drugs used to enhance physical growth or athletic performance or appearance.

E. Drugs or medications that are prescribed for treatment of an injury or illness that is covered under a Worker's Compensation Program.

F. Medications classified under the Drug Efficiency Study Implementation Program by the FDA as medications that are possibly ineffective.

G. Products ordered by persons not lawfully empowered to prescribe medication.

H. Contraceptive medications such as implants, IUDs are covered under the medical plan . See Contraceptive Management Services, Section 11.

I. Anti-obesity medications not prescribed as part of the pilot MPTN Healthy Weight program or not through PRxN.