

## SCHEDULE OF BENEFITS

### Large Group Access Care Comprehensive Health Insurance Policy

#### Classes of Employees Insured:

Class 1 – All Active Full-Time Employees

**Monthly Premium Rates:** Individual - \$ 470.59    Two-Person – \$941.19    Family Coverage – \$1,317.65

**Benefit Plan:** Access Care HDHP \$6650

	IN-NETWORK	OUT-OF-NETWORK
<b>BENEFIT INFORMATION</b>		
<b>Maximum Lifetime Benefit</b> <ul style="list-style-type: none"><li>Per Covered Person</li></ul>	Unlimited	Unlimited
<b>Deductible</b> <ul style="list-style-type: none"><li>Individual Deductible (<i>per Covered Person per Calendar Year</i>)</li><li>Family Deductible (<i>per family per Calendar Year</i>)</li></ul>	\$6,650 \$13,300	\$13,300 \$26,600
<b>Annual Out-of-Pocket Maximum</b> <ul style="list-style-type: none"><li>Individual Annual Out-of-Pocket Maximum (<i>per Covered Person per Calendar Year</i>)</li><li>Family Annual Out-of-Pocket Maximum (<i>per family per Calendar Year</i>)</li></ul>	\$6,650 \$13,300	\$13,300 \$26,600
<b>Coinsurance</b>	0%	0%

## SCHEDULE OF BENEFITS (continued)

### Large Group Access Care Comprehensive Health Insurance Policy

#### **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 Schedule of Benefits. 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
All Covered Benefits shown in Section 5, unless otherwise specified below in this Schedule of Benefits	0% After Deductible	0% After Deductible
<b>Autism Spectrum Disorders</b>	0% After Deductible	0% After Deductible
<b>Chemical Dependency</b> <ul style="list-style-type: none"><li>Inpatient/ other Outpatient Facility Services</li><li>Office Visit</li></ul>	0% After Deductible 0% After Deductible	0% After Deductible 0% After Deductible
<b>Chiropractic Services</b> <ul style="list-style-type: none"><li>Maximum Number of Office Visits per Calendar Year – 20 visits</li></ul>	0% After Deductible	0% After Deductible
<b>Convalescent Home Services</b> <ul style="list-style-type: none"><li>Maximum Number of Days per Calendar Year – 60 days</li></ul>	0% After Deductible	0% After Deductible
<b>Durable Medical Equipment</b> <ul style="list-style-type: none"><li>Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment</li></ul> <i>Preauthorization is recommended for original purchase or replacement of Durable Medical Equipment over \$500.</i>	0% After Deductible	0% After Deductible
<b>Emergency Room Services</b>	0% After Deductible	0% After Deductible
<b>Home Health Care Services</b> <ul style="list-style-type: none"><li>Maximum Number of Home Visits per Calendar Year – 180 days</li></ul>	0% After Deductible	0% After Deductible
<b>Hospital Services - Facility and Professional</b> <ul style="list-style-type: none"><li>Inpatient Facility</li><li>Outpatient Facility</li><li>Observation Room/Bed</li></ul>	0% After Deductible	0% After Deductible

**SCHEDULE OF BENEFITS** (continued)  
**Large Group Access Care Comprehensive Health Insurance Policy**

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
<b>Laboratory Services</b>	0% After Deductible	0% After Deductible
<b>Mental Health Services</b> <ul style="list-style-type: none"> <li>Inpatient/ other Outpatient Facility Services</li> <li>Office Visit</li> </ul>	0% After Deductible 0% After Deductible	0% After Deductible 0% After Deductible
<b>Physician Medical Services</b> <ul style="list-style-type: none"> <li>Physician Office Visits (Non-Specialist)</li> <li>Physician Specialist Visits</li> </ul> <p><i>(Office visits for all Covered Benefits except for Preventive Health Care Services apply to the deductible.)</i></p>	0% After Deductible 0% After Deductible	0% After Deductible 0% After Deductible
<b>Prescription Drugs Benefit</b> <ul style="list-style-type: none"> <li><b>Retail Pharmacy Prescriptions</b> (31-day supply) <ul style="list-style-type: none"> <li>Preferred Generic Drugs (Tier 1)</li> <li>Non-Preferred Generic &amp; Preferred Brand Drugs (Tier 2)</li> <li>Non-Preferred Brand Drugs (Tier 3)</li> <li>Specialty Drugs (Tier 4)</li> </ul> </li> <li><b>Mail Order Maintenance</b> (90-day supply) <ul style="list-style-type: none"> <li>Preferred Generic Drugs (Tier 1)</li> <li>Non-Preferred Generic &amp; Preferred Brand Drugs (Tier 2)</li> <li>Non-Preferred Brand Drugs (Tier 3)</li> <li>Specialty Drugs (Tier 4) (31-Day Supply Only)</li> </ul> </li> </ul> <p><i>All prescription drugs are subject to the deductible. You must pay an Ancillary Charge in addition to the Deductible and/or Copayment, as applicable, if You choose a Brand-Name drug when a Generic drug is available.</i></p> <p>518198067</p>	0% After Deductible 0% After Deductible  0% After Deductible 0% After Deductible  0% After Deductible 0% After Deductible  0% After Deductible 0% After Deductible	0% After Deductible 0% After Deductible  0% After Deductible 0% After Deductible  0% After Deductible Not Available
<b>Preventive Health Care Services</b>	100% Covered, No Deductible	0% After Deductible (Out of network-Well Child Care visits covered at 100% before deductible; Mammograms covered at a minimum payment of \$70 before deductible)
<b>Prostheses Benefit (Non-Dental)</b> <ul style="list-style-type: none"> <li>Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics</li> <li>Preauthorization recommended for the original purchase or replacement of prosthetics over \$500</li> </ul>	0% After Deductible	0% After Deductible
<b>Therapeutic Services – Outpatient</b>	0% After Deductible	0% After Deductible

**SCHEDULE OF BENEFITS** (continued)

**Large Group Access Care Comprehensive Health Insurance Policy**

<b>COVERED BENEFIT</b>	<b>YOUR COST IN-NETWORK</b>	<b>YOUR COST OUT-OF NETWORK</b>
<b>Transplant Services</b>	0% After Deductible	0% After Deductible
<b>Vision Care Benefit – Pediatric Vision Care Services</b>  <i>This Vision Care Benefit only applies to Covered Dependent Children under age 19.</i>		
<ul style="list-style-type: none"> <li><b>Vision Care Services</b> <ul style="list-style-type: none"> <li><b>Vision Examination</b></li> </ul> </li> </ul> <i>Frequency of Services: One Vision Examination per Covered Dependent Child per Calendar Year</i>	None, 100% Covered	25% After Deductible
<ul style="list-style-type: none"> <li><b>Vision Care Materials</b> <ul style="list-style-type: none"> <li><b>Lenses</b> <ul style="list-style-type: none"> <li>Single Vision</li> <li>Bifocal</li> <li>Trifocal</li> <li>Lenticular</li> </ul> </li> </ul> </li> </ul> <i>*Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.</i>  <i>Frequency of Services: One set of lenses per Covered Dependent Child per Calendar Year</i>	None, 100% Covered* None, 100% Covered* None, 100% Covered* None, 100% Covered*	25% After Deductible 25% After Deductible 25% After Deductible 25% After Deductible
<ul style="list-style-type: none"> <li><b>Vision Care Materials</b> <ul style="list-style-type: none"> <li><b>Frames</b></li> </ul> </li> </ul> <i>Frequency of Services: One frame per Covered Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.</i>	None, 100% Covered	25% After Deductible
<ul style="list-style-type: none"> <li><b>Contact Lenses</b> <ul style="list-style-type: none"> <li>Necessary Professional Fees and Materials</li> <li>Elective Professional Fees** and Materials</li> </ul> </li> </ul>	None, 100% Covered*** None, 100% Covered***	25% After Deductible 25% After Deductible

**\*\*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).**

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Montana Health CO-OP, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-447-2900.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Montana Health CO-OP, haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-447-2900 an.

如果你，或你正在帮助，拥有约蒙大拿州卫生CO-OP的问题，你有没有成本，以获取帮助和信息在你的语言的权利。交谈口译员，请致电 855-447-2900。

ご本人様、またはお客様の身の回りの方でも、Montana Health CO-OP についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、855-447-2900までお電話ください。

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Montana Health CO-OP, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 855-447-2900.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Montana Health CO-OP, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-447-2900.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Montana Health CO-OP, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-447-2900.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Montana Health CO-OP 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-447-2900 로 전화하십시오.

فلديك الحق في الحصول على المساعدة والمعلومات الضرورية، إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Montana Health CO-OP. بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 2900-447-855.

หากคุณ หรือคนที่คุณ กำลังช่วยเหลือมีคำถามเกี่ยวกับ Montana Health CO-OP คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับสาม โทร 855-447-2900.

Hvis du, eller noen du hjelper, har spørsmål om Montana Health CO-OP, har du rett til å få hjelp og informasjon på ditt språk uten kostnad. For å snakke med en tolk, ring 855-447-2900.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Montana Health CO-OP, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-447-2900.

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Montana Health CO-OP, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 855-447-2900.

“Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut Montana Health CO-OP, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me

Interpreter schwetze witt, kannscht du 855-447-2900 uffrufe.

Se tu o qualcuno che stai aiutando avete domande su Montana Health CO-OP, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 855-447-2900.