

SCHEDULE OF BENEFITS

Large Group Co-Op Plus Comprehensive Health Insurance Policy

Southwest Montana Community Health Center

Benefit Plan: Co-Op Plus \$500

	IN-NETWORK	OUT-OF-NETWORK
BENEFIT INFORMATION		
Maximum Lifetime Benefit <ul style="list-style-type: none">Per Covered Person	Unlimited	Unlimited
Deductible <ul style="list-style-type: none">Individual Deductible (<i>per Covered Person per Plan Year</i>)Family Deductible (<i>per family per Plan Year</i>)	\$500 \$1,000	\$1,000 \$2,000
Annual Out-of-Pocket Maximum <ul style="list-style-type: none">Individual Annual Out-of-Pocket Maximum (<i>per Covered Person per Plan Year</i>)Family Annual Out-of-Pocket Maximum (<i>per family per Plan Year</i>)	\$4,000 \$8,000	\$4,000 \$8,000
Coinsurance	20%	40%

SCHEDULE OF BENEFITS (continued)

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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	20% after Deductible	40% after Deductible
Autism Spectrum Disorders	20% after Deductible	40% after Deductible
Chemical Dependency <ul style="list-style-type: none"> Inpatient/ other Outpatient Facility Services Office Visit 	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Chiropractic Services <ul style="list-style-type: none"> Maximum Number of Office Visits per Calendar Year – 20 visits 	20% after Deductible	40% after Deductible
Convalescent Home Services <ul style="list-style-type: none"> Maximum Number of Days per Calendar Year – 60 days 	20% after Deductible	40% after Deductible
Durable Medical Equipment <ul style="list-style-type: none"> Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment <i>Preauthorization is recommended for original purchase or replacement of Durable Medical Equipment over \$1,000.</i>	20% after Deductible	40% after Deductible
Emergency Room Services	\$100 Copay	40% after Deductible
Home Health Care Services <ul style="list-style-type: none"> Maximum Number of Home Visits per Calendar Year – 180 days 	20% after Deductible	40% after Deductible
Hospital Services - Facility and Professional <ul style="list-style-type: none"> Inpatient Facility Outpatient Facility Observation Room/Bed 	20% after Deductible	40% after Deductible

SCHEDULE OF BENEFITS (continued)

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COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Laboratory Services	20% after Deductible	40% after Deductible
Mental Health Services <ul style="list-style-type: none"> Inpatient/ other Outpatient Facility Services Office Visit – Tier 1 Provider Office Visit – Tier 2 Provider 	20% after Deductible \$10 Copay \$30 Copay	40% after Deductible 40% after Deductible 40% after Deductible
Physician Medical Services <ul style="list-style-type: none"> Physician Office Visits (Non-Specialist) – Tier 1 Provider Physician Office Visits (Non-Specialist) – Tier 2 Provider Physician Specialist Visits <p><i>(Office visits for all Covered Benefits except for Preventive Health Care Services apply to the deductible.)</i></p>	\$10 Copay \$30 Copay \$30 Copay	40% after Deductible 40% after Deductible 40% after Deductible
Prescription Drugs Benefit <ul style="list-style-type: none"> Retail Pharmacy Prescriptions (up to a 31-day supply) <ul style="list-style-type: none"> Preferred Generic Drugs (Tier 1) Non-Preferred Generic & Preferred Brand Drugs (Tier 2) Non-Preferred Brand Drugs (Tier 3) Specialty Drugs (Tier 4) Mail Order Pharmacy Benefit (up to a 90-day supply) <ul style="list-style-type: none"> Preferred Generic Drugs (Tier 1) Non-Preferred Generic & Preferred Brand Drugs (Tier 2) Non-Preferred Brand Drugs (Tier 3) Specialty Drugs (Tier 4) (31-Day Supply Only) Preventive Maintenance Drugs – Limited Drug Categories <ul style="list-style-type: none"> Preferred Generic Drugs (Tier 1) Non-Preferred Generic & Preferred Brand Drugs (Tier 2) <p><i>All prescription drugs are subject to the deductible. Generic medications required or you will pay the copay/coinsurance plus cost difference between brand and generic medication.</i></p>	\$20 Copay \$80 Copay \$200 Copay \$100 Copay \$40 Copay \$160 Copay \$400 Copay \$200 Copay N/A N/A	40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible Not Available N/A N/A
Preventive Health Care Services	100% Covered, No Deductible	40% after Deductible (Out of network-Well Child Care visits covered at 100% before deductible; Mammograms)

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
		covered at a minimum payment of \$70 before deductible)
Prostheses Benefit (Non-Dental) <ul style="list-style-type: none"> Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics Preauthorization recommended for the original purchase or replacement of prosthetics over \$1,000 	20% after Deductible	40% after Deductible
Therapeutic Services – Outpatient	20% after Deductible	40% after Deductible
Transplant Services	20% after Deductible	40% after Deductible

SCHEDULE OF BENEFITS (continued)

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COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Vision Care Reimbursement	Balance after Vision Reimbursement	Balance after Vision Reimbursement
Vision Care Benefit – Pediatric Vision Care Services <i>This Vision Care Benefit only applies to Covered Dependent Children under age 19.</i>		
<ul style="list-style-type: none"> Vision Care Services <ul style="list-style-type: none"> Vision Examination <i>Frequency of Services: One Vision Examination per Covered Dependent Child per Calendar Year</i>	None, 100% Covered	25%
<ul style="list-style-type: none"> Vision Care Materials <ul style="list-style-type: none"> Lenses <ul style="list-style-type: none"> Single Vision Bifocal Trifocal Lenticular <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% 25% 25% 25%
<ul style="list-style-type: none"> Vision Care Materials <ul style="list-style-type: none"> Frames <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%
<ul style="list-style-type: none"> Contact Lenses 		
<ul style="list-style-type: none"> Necessary Professional Fees and Materials 	None, 100% Covered***	25%
<ul style="list-style-type: none"> Elective Professional Fees** and Materials 	None, 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).**

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.

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

หากคุณ หรือคนที่คุณ กำลังช่วยเหลือมีค ำถามเกี่ยวกับ 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 grieve, 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.