# SCHEDULE OF BENEFITS

## Large Group Connected Care Comprehensive Health Insurance Policy

**Troy Public Schools**

**Benefit Plan: $5000 HDHP Connected Care**

| BENEFIT INFORMATION | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Maximum Lifetime Benefit**<br>• Per Covered Person | Unlimited | Unlimited |
| | | |
| **Deductible**<br>• Individual Deductible (*per Covered Person per [Calendar,Plan] Year)*<br>• Family Deductible *(per family per [Calendar,Plan] Year)* | $5,000<br>$10,000 | $10,000<br>$20,000 |
| **Annual Out-of-Pocket Maximum**<br>• Individual Annual Out-of-Pocket Maximum *(per Covered Person per [Calendar,Plan] Year)*<br>• Family Annual Out-of-Pocket Maximum *(per family per [Calendar,Plan] Year)* | $5,000<br>$10,000 | $10,000<br>$20,000 |
| **Coinsurance** | 0% | 0% |

## 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 |
| **Autism Spectrum Disorders** | 0% after Deductible | 0% after Deductible |
| **Chemical Dependency**<br>• Inpatient/ other Outpatient Facility Services<br>• Office Visit | <br>0% after Deductible<br>0% after Deductible | <br>0% after Deductible<br>0% after Deductible |
| **Chiropractic Services**<br>• Maximum Number of Office Visits per Calendar Year – 20 visits | 0% after Deductible | 0% after Deductible |
| **Convalescent Home Services**<br>• Maximum Number of Days per Calendar Year – 60 days | 0% after Deductible | 0% after Deductible |
| **Durable Medical Equipment**<br>• Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment<br>*Preauthorization is recommended for original purchase or replacement of Durable Medical Equipment over $1,000.* | 0% after Deductible | 0% after Deductible |
| **Emergency Room Services** | 0% after Deductible | 0% after Deductible |
| **Home Health Care Services**<br>• Maximum Number of Home Visits per Calendar Year – [180] days | 0% after Deductible | 0% after Deductible |
| **Hospital Services - Facility and Professional**<br>• Inpatient Facility<br>• Outpatient Facility<br>• Observation Room/Bed | 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 |
|---|---|---|
| **Laboratory Services** | 0% after Deductible | 0% after Deductible |
| **Mental Health Services**<br>• Inpatient/ other Outpatient Facility Services<br>• Office Visit | 0% after Deductible<br>0% after Deductible | 0% after Deductible<br>0% after Deductible |
| **Physician Medical Services**<br>• Physician Office Visits (Non-Specialist)<br>• Physician Specialist Visits<br><br>*(Office visits for all Covered Benefits except for Preventive Health Care Services apply to the deductible.)* | 0% after Deductible<br>0% after Deductible | 0% after Deductible<br>0% after Deductible |
| **Prescription Drugs Benefit**<br>• **Retail Pharmacy Prescriptions** (up to a 31-day supply)<br>• Preferred Generic Drugs (Tier 1)<br>• Non-Preferred Generic & Preferred Brand Drugs (Tier 2)<br>• Non-Preferred Brand Drugs (Tier 3)<br>• Specialty Drugs (Tier 4)<br><br>• **Mail Order Pharmacy Benefit** (up to a 90-day supply)<br>• Preferred Generic Drugs (Tier 1)<br>• Non-Preferred Generic & Preferred Brand Drugs (Tier 2)<br>• Non-Preferred Brand Drugs (Tier 3)<br>• Specialty Drugs (Tier 4) (31-Day Supply Only)<br><br>• **Preventive Maintenance Drugs – Limited Drug Categories**<br>• Preferred Generic Drugs (Tier 1M)<br>• Non-Preferred Generic & Preferred Brand Drugs (Tier 2M)<br><br>*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.* | 0% after Deductible<br><br>0% after Deductible<br>0% after Deductible<br>0% after Deductible<br><br>0% after Deductible<br><br>0% after Deductible<br>0% after Deductible<br>0% after Deductible<br><br>0% before Deductible<br>0% before Deductible | 0% after Deductible<br><br>0% after Deductible<br>0% after Deductible<br>0% after Deductible<br><br>0% after Deductible<br><br>0% after Deductible<br>0% after Deductible<br>Not Available<br><br>0% after Deductible<br>0% after Deductible |
| **Preventive Health Care Services** | 100% Covered, No Deductible | 0% after Deductible<br>(Out of network-Well Child Care visits covered at 100% before deductible; Mammograms covered at a minimum payment of $70 before deductible) |
| | | |

| COVERED BENEFIT | YOUR COST IN-NETWORK | YOUR COST OUT-OF NETWORK |
|---|---|---|
| **Prostheses Benefit (Non-Dental)**<br>• Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics<br>• Preauthorization recommended for the original purchase or replacement of prosthetics over $1,000 | 0% after Deductible | 0% after Deductible |
| **Therapeutic Services – Outpatient** | 0% after Deductible | 0% after Deductible |
| **Transplant Services** | 0% after Deductible | 0% after Deductible |

| 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**<br><br>*This Vision Care Benefit only applies to Covered Dependent Children under age 19.* | | |
| • **Vision Care Services**<br>  • **Vision Examination**<br>*Frequency of Services:* One Vision Examination per Covered Dependent Child per Calendar Year | None, 100% Covered | 0% after Deductible |
| • **Vision Care Materials**<br>  • **Lenses**<br>  • Single Vision<br>  • Bifocal<br>  • Trifocal<br>  • Lenticular<br><br>**Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.*<br><br>*Frequency of Services:* One set of lenses per Covered Dependent Child per Calendar Year | None, 100% Covered*<br>None, 100% Covered*<br>None, 100% Covered*<br>None, 100% Covered* | 0% after Deductible<br>0% after Deductible<br>0% after Deductible<br>0% after Deductible |
| • **Vision Care Materials**<br>  • **Frames**<br><br>*Frequency of Services:* One frame per Covered Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection. | None, 100% Covered | 0% after Deductible |
| • **Contact Lenses** | | |
| • Necessary Professional Fees and Materials | None, 100% Covered*** | 0% after Deductible |
| • Elective Professional Fees** and Materials | None, 100% Covered*** | 0% 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.

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

หากคุณ หรือคนที่คุณก าลังช่วยเหลือมีค าถามเกี่ยวกับ Montana Health CO-OP คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม 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 helfscht, 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.