SCHEDULE OF BENEFITS

Large Group Access Care Comprehensive Health Insurance Policy

Pasta Montana

Benefit Plan: Plan B Silver Access Care

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit • Per Covered Person	Unlimited	Unlimited
Deductible • Individual Deductible (*per Covered Person per Plan Year)* • Family Deductible *(per family per Plan Year)*	$1,750 $3,500	$3,500 $7,000
Annual Out-of-Pocket Maximum • Individual Annual Out-of-Pocket Maximum *(per Covered Person per Plan Year)* • Family Annual Out-of-Pocket Maximum *(per family per Plan Year)*	$6,350 $12,700	$12,000 $15,000
Coinsurance	40%	60%

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	40% after Deductible	60% after Deductible
Autism Spectrum Disorders	40% after Deductible	60% after Deductible
Chemical Dependency • Inpatient/ other Outpatient Facility Services • Office Visit	 40% after Deductible 40% after Deductible	 60% after Deductible 60% after Deductible
Chiropractic Services • Maximum Number of Office Visits per Calendar Year – 20 visits	$60 Copayment after Deductible	60% after Deductible
Convalescent Home Services • Maximum Number of Days per Calendar Year – [60] days	40% after Deductible	60% after Deductible
Durable Medical Equipment • Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment *Preauthorization is recommended for original purchase or replacement of Durable Medical Equipment over $1,000.*	40% after Deductible	60% after Deductible
Emergency Room Services	$200 Copay after Deductible	$200 Copay after Deductible
Home Health Care Services • Maximum Number of Home Visits per Calendar Year – 180 days	40% after Deductible	60% after Deductible
Hospital Services - Facility and Professional • Inpatient Facility • Outpatient Facility • Observation Room/Bed	40% after Deductible	60% 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	40% after Deductible	60% after Deductible
Mental Health Services • Inpatient/ other Outpatient Facility Services • Office Visit	40% after Deductible $20 Copayment	60% after Deductible 60% after Deductible
Physician Medical Services • Physician Office Visits (Non-Specialist) • Physician Specialist Visits *(Office visits for all Covered Benefits except for Preventive Health Care Services apply to the deductible.)*	$35 Copayment $60 Copayment after Deductible	60% after Deductible 60% after Deductible

Prescription Drugs Benefit
• **Retail Pharmacy Prescriptions** (up to a 31-day supply)
  • 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)
  • 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**
  • Preferred Generic Drugs (Tier 1M)
  • Non-Preferred Generic & Preferred Brand Drugs (Tier 2M)
 	
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.
	
	$15 Copayment
	$30 Copayment
	
	$65 Copayment
	$90 Copayment
	
	$30 Copayment
	$60 Copayment
	
	$130 Copayment
	Not Available
	
	N/A
	N/A
		
		50% after Deductible
		50% after Deductible
		
		50% after Deductible
		50% after Deductible
		
		50% after Deductible
		50% after Deductible
		
		50% after Deductible
		Not Available
		
		N/A
		N/A

Preventive Health Care Services	100% Covered, No Deductible	60% after Deductible (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) • Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics • Preauthorization recommended for the original purchase or replacement of prosthetics over $1,000	40% after Deductible]	60% after Deductible
Therapeutic Services – Outpatient	40% after Deductible	60% after Deductible
Transplant Services	40% after Deductible	60% 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 *This Vision Care Benefit only applies to Covered Dependent Children under age 19.*		
• **Vision Care Services** • **Vision Examination** *Frequency of Services:* One Vision Examination per Covered Dependent Child per Calendar Year	None, 100% Covered	25%

• **Vision Care Materials**
  • **Lenses**
  • 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 Covered Dependent Child per Calendar Year
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
		25%
		25%
		25%
		25%

• **Vision Care Materials** • **Frames** *Frequency of Services:* One frame per Covered Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.	None, 100% Covered	25%
• **Contact Lenses**		
• Necessary Professional Fees and Materials	None, 100% Covered***	25%
• 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.

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.