SCHEDULE OF BENEFITS

Individual Connected Care Comprehensive Health Insurance Policy

Policy Number: [123456]

Policyowner: [John Doe]

Issue Age: [35]

Type of Coverage: [Family]

Benefit Period: Calendar Year

Policy Effective Date: [January 1, 2019]

Policy Anniversary Date: [January 1 of each Year]

Initial Premium: [$]

Mode of Payment: [Monthly]

Premium Due Date: [The first day of each month]

Benefit Plan: Expanded Bronze PPO – Standard Indian Health Services Plan

This Benefit Plan is only available for an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, who is determined by Us to be eligible to enroll in this Benefit Plan, and, therefore, is not required to pay any cost sharing on any Covered Benefit for which services are furnished directly by an Indian Health Service, an Indian Tribe, a Tribal Organization, or an Urban Indian Organization (each as defined in 25 U.S.C. 1603).

BENEFIT INFORMATION	INDIAN HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Maximum Lifetime Benefit • Per Covered Person	Unlimited	Unlimited	Unlimited
Deductible • Individual Deductible (*per Covered Person per Calendar Year)* • Family Deductible *(per family per Calendar Year)*	None None	$5,500 $11,000	$16,500 $33,000
Annual Out-of-Pocket Maximum • Individual Annual Out-of-Pocket *Maximum (per Covered Person per Calendar Year)* • Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	N/A N/A	$7,900 $15,800	$23,700 $47,400
Coinsurance	0%	50%	70%

SCHEDULE OF BENEFITS (continued)

Individual Connected 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 INDIAN HEALTH SERVICES	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%, No Deductible	50% after Deductible	70% after Deductible
Autism Spectrum Disorders	0%, No Deductible	50% after Deductible	70% after Deductible
Chemical Dependency			
• Inpatient/other Outpatient Facility Services	0%, No Deductible	50% after Deductible	70% after Deductible
• Office Visit	0%, No Deductible	$50 Copay per visit	70% after Deductible
Chiropractic Services • Maximum Number of Office Visits per Calendar Year – 20 visits	0%, No Deductible, No Copay	$60 Copay per visit	70% after Deductible
Convalescent Home Services • Maximum Number of Days per Calendar Year – 60 days	0%, No Deductible	50% after Deductible	70% after Deductible
Durable Medical Equipment • Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment *Preauthorization recommended for original purchase or replacement of Durable Medical Equipment over $500*	0%, No Deductible	50% after Deductible	70% after Deductible

SCHEDULE OF BENEFITS (continued)

Individual Connected Care Comprehensive Health Insurance Policy

COVERED BENEFIT	YOUR COST INDIAN HEALTH SERVICES	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Emergency Room Services	0%, No Deductible	50% after Deductible	50% after Deductible
Home Health Care Services • Maximum Number of Home Visits per Calendar Year – 180 visits/year	0%, No Deductible	50% after Deductible	70% after Deductible
Hospital Services - Facility and Professional • Inpatient Facility • Outpatient Facility • Observation Room/Bed	0%, No Deductible	50% after Deductible	70% after Deductible
Laboratory Services	0%, No Deductible	50% after Deductible	70% after Deductible
Mental Health Services • Inpatient/other Outpatient Facility Services • Office Visit	0%, No Deductible 0%, No Deductible	50% after Deductible $50 Copay per visit	70% after Deductible 70% after Deductible
Physician Medical Services • Physician Office Visits (Non-Specialist) • Physician Specialist Visits *(The Copay applies to office visits for all Covered Benefits except for Preventive Health Care Services.)*	0%, No Deductible 0%, No Deductible	$50 Copay per visit $60 Copay per visit	70% after Deductible 70% after Deductible

SCHEDULE OF BENEFITS (continued)

Individual Connected Care Comprehensive Health Insurance Policy

COVERED BENEFIT	YOUR COST INDIAN HEALTH SERVICES	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Prescription Drugs Benefit • **Retail Pharmacy Prescriptions** (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 Maintenance** (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) *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.*	0%, No Deductible, No Copay	 $15 Copay after Deductible $125 Copay after Deductible $160 Copay after Deductible $185 Copay after Deductible $30 Copay after Deductible $250 Copay after Deductible $320 Copay after Deductible $185 Copay after Deductible	 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible Not Available
Preventive Health Care Services	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	70% after Deductible (Out of network-Well Child Care visits covered at 100% before deductible; Mammograms covered at a minimum payment of $70 before deductible)
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 $500	0%, No Deductible	50% after Deductible	70% after Deductible
Therapeutic Services – Outpatient	0%, No Deductible	$60 Copay	70% after Deductible
Transplant Services	0%, No Deductible	50% after Deductible	70% after Deductible

SCHEDULE OF BENEFITS (continued)

Individual Connected Care Comprehensive Health Insurance Policy

COVERED BENEFIT	YOUR COST INDIAN HEALTH SERVICES	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
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	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*
		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	None, 100% Covered	25%
• **Contact Lenses**			
• Necessary Professional Fees and Materials	None, 100% Covered***	None, 100% Covered***	25%
• Elective Professional Fees** and Materials	None, 100% Covered***	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.

فلديك الحق في الحصول على المساعدة والمعلومات. الضرورية بلغتك، Montana Health CO-OP إن كان لديك أو لدى شخص تساعده أسئلة بخصوص
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.