

**SCHEDULE OF MEDICAL BENEFITS - OPTION 2
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS**

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE
PLAN EXCLUSIONS AND MAXIMUM ELIGIBLE EXPENSE (MEE)
OR UP TO THE PROCEDURE BASED LIMIT

BENEFIT PERIOD IS A TWELVE MONTH PERIOD
(OCTOBER 1 THROUGH SEPTEMBER 30 OF EACH SUCCEEDING YEAR)

COST SHARING PROVISIONS	TIER 1	TIER 2
DEDUCTIBLE (Embedded) Per Covered Person per Benefit Period Per Family per Benefit Period	\$0 \$0	\$2,000 \$4,000
Deductible applies to all benefits unless specifically indicated as waived.		
BENEFIT PERCENTAGE Before Out-of-Pocket Maximum After Out-of-Pocket Maximum	100% 100%	70% 100%
Benefit Percentage applies after applicable Deductible is satisfied and applies to all benefits unless specifically stated otherwise.		
COPAYMENT Deductible is waived if Copayment applies. Copayment applies to all charges billed by the same provider on the same day including, but not limited to: evaluation and management, diagnostic lab, X-ray, office surgery, diagnostic miscellaneous testing and allergy injections. Copayments do not apply towards the Deductible, but do apply towards the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.		
OUT-OF-POCKET MAXIMUM (Embedded) Per Covered Person per Benefit Period Per Family per Benefit Period	\$6,000 \$12,000	
Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. Pharmacy Copayments do apply toward the applicable Pharmacy Benefit Deductible and Out-of-Pocket Maximum. Out-of-Pocket Maximums cross accumulate between the Network and Non-Network Out-of-Pocket Maximums.		
MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES	None	
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	None	

COST SHARING PROVISIONS	TIER 1	TIER 2
<p>PRE-CERTIFICATION/PRE-TREATMENT REVIEW</p> <p>Pre-certification or Pre-treatment Review by the Plan is strongly recommended for certain services. If Pre-certification or Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.</p> <p>Except for Genetic Therapy (Cellular Therapy and Gene Therapy), pre-certification is strongly recommended for Inpatient Hospital admissions or to notify the Plan of an emergency admission.</p> <p>Pre-certification is required for Genetic Therapy (Cellular Therapy and Gene Therapy) within 24 hours before scheduled Inpatient Hospital admission or as soon as is reasonable possible for non-scheduled admissions, including Emergency admissions. Failure to obtain Pre-Certification Genetic Therapy will result in a denial of benefits.</p> <p>See Hospital Admission Certification and Pre-Treatment Review for further details.</p>		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
ACCIDENTAL INJURY BENEFIT		
	100%	100%, Deductible Waived
Does not include charges for Chiropractic Care, Physical, Occupational and Speech Therapy.		
ACUPUNCTURE TREATMENT		
	No Benefit	No Benefit
ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET Imaging, etc.)		
	100%	70% after Deductible
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY		
Inpatient Facility Services	70%	70%, Deductible Waived
Inpatient Professional Provider Services	100%	100%, Deductible Waived
Outpatient Facility Services	100% after \$10 Copayment	100% after \$10 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after \$10 Copayment	100% after \$10 Copayment, Deductible Waived
Office Visit Services	100% after \$10 Copayment	100% after \$10 Copayment, Deductible Waived

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2

ALLERGY TREATMENT

Office Visit	100% after \$10 Primary Care Physician or \$40 Specialty Care Physician Copayment	70% after Deductible
Diagnostic Testing	100%	70% after Deductible
Injection and Serum	100%	70% after Deductible

Copayment is waived when an office visit charge is not assessed.

AMBULANCE SERVICE

Air Ambulance	70% after Tier 2 Deductible
Ground Ambulance	70% after Tier 2 Deductible

AMBULATORY SURGICAL CENTER

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

AUTISM SPECTRUM DISORDER (ASD) AND/OR DOWN SYNDROME BENEFIT

	Not Available	100% after \$10 Copayment, Deductible Waived
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Includes certain treatments associated with Autism Spectrum Disorder (ASD) and/or Down Syndrome for Dependent children eighteen (18) years of age or younger.

BARIATRIC SURGERY

	Not Available	70% after Deductible
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Benefit limits: limited to one (1) procedure, up to \$22,500 Maximum Lifetime Benefit. Includes complications. Benefit is limited to Employees covered under this Plan as either a Participant or a covered Dependent. Covered Dependents who are not Employees are not eligible for this benefit.

BIRTHING CENTER

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

CARDIAC REHABILITATION THERAPY - OUTPATIENT

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2

CHEMOTHERAPY - OUTPATIENT

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

CHIROPRACTIC CARE

	Not Available	100% after \$25 Copayment, Deductible Waived, up to \$50 Maximum Benefit per Treatment
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Benefit Limits:

- ◆ 25 Treatments Maximum Benefit per Benefit Period
- ◆ \$100 Maximum Benefit for Diagnostic X-rays per Benefit Period

Treatment includes all services provided during a calendar day, except for X-rays.

COLONOSCOPY

Routine Colonoscopy	100%	100%, Deductible Waived
Diagnostic Colonoscopy Facility Services	100% after \$10 Copayment	70% after Deductible
Diagnostic Colonoscopy Professional Provider Services	100% after \$10 Copayment	70% after Deductible

Benefit Limits: Diagnostic Colonoscopy limited to \$1,900 Maximum Benefit per procedure. **Benefit limits are for services received from all Providers.**

CONTRACEPTIVES (Including Contraceptive Management)

Administered during Office Visit	100%	100%, Deductible Waived
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See Pharmacy Benefit for details if obtained from a Pharmacy.

DIABETIC EDUCATION

	100%	70% after Deductible
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Benefit Limits: \$250 Maximum Benefit per Benefit Period. Benefit includes Outpatient self-management training and education for the treatment of diabetes. Such training and education must be provided by a Provider with expertise in diabetes. **Benefit limits are for services received from all Providers.**

DIAGNOSTIC TESTS - OUTPATIENT

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2

DIALYSIS TREATMENTS - OUTPATIENT

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

EATING DISORDER BENEFIT

	100%	70% after Deductible
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Benefit Limits:

- ◆ \$2,000 Maximum Benefit per Benefit Period
- ◆ \$6,000 Maximum Lifetime Benefit per Covered Person

Benefit limits do not apply to psychological/psychiatric services. **Benefit limits are for services received from all Providers.**

EMERGENCY ROOM SERVICES

Facility Services for Emergency	100% after \$250 Copayment, Deductible Waived	
Professional Provider Services for Emergency	Tier 2 Deductible, then 100% after \$10 Copayment	
Facility Services for non-emergency	No Benefit	No Benefit
Professional Provider Services for non-emergency	100% after \$10 Copayment	70% after Deductible

Copayment is waived if admitted as Inpatient immediately following the emergency room. If admitted as Inpatient from the Emergency Room, Inpatient Hospital benefits will apply.

GENETIC THERAPY DRUGS

	100%	75% after Deductible
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HEARING AIDS / BAHA (Includes exam and fitting)

Preventive Hearing Exam	100%	100%, Deductible Waived
Diagnostic Hearing Services	100%	70% after Deductible
Hearing Aid	100%	70% after Deductible
Bone Anchored Hearing Aid (BAHA)	100%	70% after Deductible

Benefit Limits:

- ◆ Hearing Aids limited to one (1) per ear per 3 Benefit Periods up to \$2,500. Includes exam and fitting).
- ◆ Bone Anchored Hearing Aid (BAHA) limited to one (1) per ear up to \$10,000 Maximum Lifetime Benefit.

Benefit limits are for services received from all Providers. See Medical Benefits for further details.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
HOME HEALTH CARE		
	100%	50%, Deductible Waived
Benefit Limits: 2 visits per day, up to \$50 per visit Maximum Benefit per Benefit Period. Benefit limits are for services received from all Providers.		
HOSPICE CARE		
Inpatient Facility Services	70%	70% after Deductible
Inpatient Professional Provider Services	100%	70% after Deductible
Outpatient Facility Services	100% after \$10 Copayment	70% after Deductible
Outpatient Professional Provider Services	100% after \$10 Copayment	70% after Deductible
HOSPITAL SERVICES		
Inpatient Facility Services	70%	70% after Deductible
Inpatient Professional Provider Services	100%	70% after Deductible
Outpatient Facility Services	100% after \$10 Copayment	70% after Deductible
Outpatient Professional Provider Services	100% after \$10 Copayment	70% after Deductible
INFERTILITY		
Diagnostic testing to determine infertility	100%	70% after Deductible
Infertility Treatment	No Benefit	No Benefit
INFUSION SERVICES - OUTPATIENT		
Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible
MAMMOGRAMS		
Routine Mammograms	100%	100%, Deductible Waived
Diagnostic Mammograms Facility Services	100% after \$10 Copayment	70% after Deductible
Diagnostic Mammograms Professional Provider Services	100% after \$10 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
MEDICAL EQUIPMENT/SUPPLIES		
Durable Medical Equipment	100%	70%, Deductible Waived
Prosthetic Appliances	100%	70%, Deductible Waived
Orthopedic Devices	100%	70%, Deductible Waived
Other Medical Supplies	100%	70% after Deductible
Repair or Replacement	100%	50% after Deductible
MENTAL ILLNESS		
Inpatient Facility Services	70%	70%, Deductible Waived
Inpatient Professional Provider Services	100%	100%, Deductible Waived
Outpatient Facility Services	100% after \$10 Copayment	100% after \$10 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after \$10 Copayment	100% after \$10 Copayment, Deductible Waived
Office Visit Services	100% after \$10 Copayment	100% after \$10 Copayment, Deductible Waived
NATUROPATHY/HOMEOPATHIC		
	No Benefit	No Benefit
NON-AMBULANCE TRAVEL BENEFIT		
	#70% after Tier 2 Deductible	
<p>Benefit Limits: \$5,000 Maximum Lifetime Benefit, limited to:</p> <ul style="list-style-type: none"> ◆ Coach airfare. ◆ If driving, IRS standard mileage rate reimbursement. ◆ Meals limited to \$50 per day per person. ◆ Lodging not to exceed \$125 per day. <p>For the patient and one companion, limited to travel to a Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable) if treatment at a Cigna LifeSOURCE Facility (or Supplemental Network or Optum Network if applicable) is more cost effective than the same treatment if received from other providers.</p>		
OCCUPATIONAL THERAPY - OUTPATIENT		
Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2

OFFICE VISIT

Primary Care Physician	100% after \$10 Copayment	70% after Deductible
Specialty Care Physician	100% after \$40 Copayment	70% after Deductible

ORGAN AND TISSUE TRANSPLANT SERVICES

Inpatient Facility Services	70%	70% after Deductible
Inpatient Professional Provider Services	100%	70% after Deductible

PHYSICAL THERAPY - OUTPATIENT

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

PREGNANCY/MATERNITY SERVICES

Office Visit (if not part of a global fee)	100% after \$10 Copayment	70% after Deductible
Inpatient Facility Services	70%	70% after Deductible
Inpatient Professional Provider Services	100%	70% after Deductible
Outpatient Facility Services	100% after \$10 Copayment	70% after Deductible
Outpatient Professional Provider Services	100% after \$10 Copayment	70% after Deductible

See Preventive Care Benefit for well-women prenatal visits.

PREMIER JOINT REPLACEMENT PROVIDER BENEFIT

	100%, Deductible Waived	
Applies only to non-complicated scheduled knee and hip replacement procedures.		
This is bundled service offered by some hospitals in Montana. The fees for this service are generally less than from other providers for the same services. Please contact Allegiance for further information about specific hospitals and prices.		

PRESCRIPTION DRUGS

	See Pharmacy Benefit for Details	
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PREVENTIVE CARE

	100%	100%, Deductible Waived
If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2

RADIATION THERAPY - OUTPATIENT

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

RESIDENTIAL TREATMENT FACILITY, PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT SERVICES

Inpatient Facility Services	Not Available	70%, Deductible Waived
Inpatient Professional Provider Services	Not Available	100%, Deductible Waived
Outpatient Facility Services	Not Available	100% after \$10 Copayment, Deductible Waived
Outpatient Professional Provider Services	Not Available	100% after \$10 Copayment, Deductible Waived

RESPIRATORY THERAPY - OUTPATIENT

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

ROUTINE FOOT CARE

Facility Services	70%	70% after Deductible
Professional Provider Services	100%	70% after Deductible

Benefit Limits: \$2,000 Maximum Benefit per Benefit Period. **Benefit limits are for services received from all Providers.**

ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE

Facility Services	70%	70% after Deductible
Professional Provider Services	100%	70% after Deductible

Non-Routine Newborn Care applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section. See Preventive Care Benefit for Well-Child Care.

SKILLED NURSING FACILITY

Facility Services	70%	70% after Deductible
Professional Provider Services	100%	70% after Deductible

SPEECH THERAPY - OUTPATIENT

Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	TIER 1	TIER 2
STERILIZATION PROCEDURES		
Female Sterilization Procedures	100%	100%, Deductible Waived
Vasectomy Inpatient Facility Services	70%	70% after Deductible
Vasectomy Inpatient Professional Provider Services	100%	70% after Deductible
Vasectomy Outpatient Facility Services	100% after \$10 Copayment	70% after Deductible
Vasectomy Outpatient Professional Provider Services	100% after \$10 Copayment	70% after Deductible
SURGERY - OUTPATIENT		
Facility Services	100% after \$10 Copayment	70% after Deductible
Professional Provider Services	100% after \$10 Copayment	70% after Deductible
SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES		
Facility Services	70%	70% after Deductible
Professional Provider Services	100%	70% after Deductible
TELEMEDICINE		
	100%, Deductible Waived	
TMJ/JAW DISORDERS		
	No Benefit	No Benefit
URGENT CARE FACILITY		
	100% after \$25 Copayment	70% after Deductible
VOLUNTARY SECOND AND THIRD SURGICAL OPINION BENEFIT		
	100%	100%, Deductible Waived
Benefit Limits: \$100 Maximum Benefit per Eligible Surgical Opinion.		
WALK-IN RETAIL HEALTH CLINIC		
	100% after \$25 Copayment	No Benefit