Outline of Coverage
Co-op Plus-Silver Alt 73

Outline of Coverage | 2020

Benefit Period	January 1 - December 31
Deductible *Copayments and coinsurance do not accumulate to deductible.	In-Network: Individual $3,300 Family $6,600 Out-of-Network: Individual $9,900 Family $19,800
Annual Out-of-Pocket Maximum	In-Network: Individual $6,500 Family $13,000 Out-of-Network: Individual $19,800 Family $39,600
Coinsurance	In-Network: 40% Out-of-Network: 60%
Copayment	Copayments are in addition to deductible and coinsurance. Once the Out-of-Pocket Maximum is satisfied; deductible, coinsurance and copayments do not apply.
Network	PPO: Preferred Provider Organization

Deductible and coinsurance apply to all services listed below, unless otherwise noted. There is no lifetime maximum benefit limit for this plan. This is only a summary of benefits. Benefits and general provisions described herein are subject to the terms of the Member. Prior Authorization is not a guarantee of payment but is recommended for some services, supplies, treatments, and prescription drugs to help the Member identify potential expenses, payment reductions, or claim denials that may occur if these proposed services are not Medically Necessary or not a Covered Medical Expense. Refer to your Member Guide.

The member is responsible for the above deductible and the following copays and coinsurance:

Services	In-Network:	Out-of-Network:
Preventive Care		
Preventive Health Care Services for health care screenings or preventive purposes submitted with a routine diagnosis will be covered at 100% of the Allowable Fee. This means that these Benefits are not subject to the Deductible, Coinsurance, Copayments, or Annual Out-of-Pocket Maximum when services are provided by an In-Network provider. However, if Preventive Health Care Services are rendered for an established medical condition or by a Non-In-Network, the Preventive Health Care Services provided will be subject to the Deductible, Coinsurance, Copayments, and Annual Out-of-Pocket Maximum.		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)
Physician Medical Services		
Physician Office Visits Tier 1 (Non-Specialist)	$5 Copay per visit	60% after Deductible
Physician Office Visits Tier 2 (Non-Specialist)	30% after Deductible	60% after Deductible
Physician Specialist Visits	$50 Copay per visit, after Deductible	60% after Deductible
**The Copay applies to office visits for all Covered Benefits except for Preventive Health Care Services.*		
Hospital Services-Facility and Professional		
Inpatient Facility	40% after Deductible	60% after Deductible

Services	In-Network:	Out-of-Network:
Outpatient Facility	40% after Deductible	60% after Deductible
Emergency Room Services		
Emergency room visits	30% after Deductible	30% after Deductible
Prescription Drugs Benefit		
Retail Pharmacy Benefit (31-day supply)		
Preferred Generic Drugs (Tier 1)	10% per drug	50% after Deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	30% per drug	50% after Deductible
Non-Preferred Brand Drugs (Tier 3)	40% per drug	50% after Deductible
Specialty Drugs (Tier 4)	50% per drug	50% after Deductible
Mail Order Maintenance (90-day supply)		
Preferred Generic Drugs (Tier 1)	10% per drug	50% after Deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	30% per drug	50% after Deductible
Non-Preferred Brand Drugs (Tier 3)	40% per drug	50% after Deductible
Specialty Drugs (Tier 4) (31-Day Supply Only)	50% per drug	Not Available
Mental Health/Chemical Dependency Services		
Inpatient/other Outpatient Facility Services	40% after Deductible	60% after Deductible
Office Visit – Tier 1 Provider	$5 Copay per visit	60% after Deductible
Office Visit – Tier 2 Provider	30% after Deductible	60% after Deductible
Other Covered Services *(This is not a complete list. Check your policy or plan document for other covered services and your costs for these services.)*		
Chiropractic Care-*Maximum Number of Office Visits per Calendar Year – 20 visits*	$65 Copay per visit, 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 $500)*	40% after Deductible	60% after Deductible
Laboratory Services	40% after Deductible	60% after Deductible
Transplant Services	40% after Deductible	60% after Deductible

This is a brief summary of benefits. Refer to your complete policy document for additional information or a further explanation of benefits, limitations, and exclusions.

Rating Factors and Trend: The following factors are used in setting rates: regional information and assumptions regarding our expected population, the projected claims, income, and enrollment for the next 12-month rating period, projected expenses for the plan of the next rating period, and/or age of the application or subscriber, industry, and risk characteristics. The trend of premium increases on average during the preceding year is: 2015: (-10.2%); 2016: 35.40%; 2017: 29.75%; 2018: 3.5%; 2019: 8%; 2020:

Additional Information

What is the annual deductible?

Your plan's deductible is the fixed dollar amount of Covered Medical Expenses that you must incur for certain Covered Benefits before MHC begins paying benefits for them. The Deductible must be satisfied each Calendar Year by each Covered Person, except as provided under *"Family Deductible Limit"* provision. The Deductible is shown in the Schedule of Benefits. Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. The following do not apply towards satisfaction of the Deductible: (1) services, treatments or supplies that are not covered under this Policy; and (2) amounts billed by Out-of-Network Providers, which include the Out-of-Network Provider Differential.

What is the annual out-of-pocket maximum?

The Annual Out-of-Pocket Maximum is the maximum amount that the Covered Person must pay every Calendar Year for Covered Medical Expenses incurred for Covered Benefits. The Annual Out-of-Pocket Maximum is shown in the Schedule of Benefits. It applies to all Covered Benefits except the *Preventive Health Care Services Benefit*.

The Annual Out-of-Pocket Maximum includes the following:

1. Calendar Year Deductible;
2. Copayments; and
3. Coinsurance.

When the Annual Out-of-Pocket Maximum is satisfied in the Calendar Year, we will then pay 100% of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Calendar Year. The Annual Out-of-Pocket Maximum must be satisfied each Calendar Year.

The exception to this is in regard to out-of-network charges. The amount the plan pays for covered services is based on the allowed amount. **If an out-of-network provider charges more than the allowed amount, you may have to pay the difference**. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference which does not apply to the deductible, coinsurance, or Out of Pocket Maximum. (This is called balance billing.)

Payments to providers

Payment to providers is based on the prevailing or contracted Montana Health CO-OP fee allowance for covered services. Although In-Network Providers accept the fee allowance as payment in full, Out-of-Network Providers may not. Services of Out-of-Network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by Montana Health CO-OP before the services are performed. This process is called 'preauthorization'. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. You'll find the most current preauthorization list in your complete policy document.

The Patient's right to know the costs of medical procedures.

The insured, or the insured's agent, may request an estimate of the member's portion of provider charges for any service or course of treatment that exceeds $500. Montana Health CO-OP shall make a good faith effort to provide accurate information based on cost estimates and procedure codes obtained by the insured from the insured's health care provider. The estimate may be provided in writing or electronically. It is not a binding contract between Montana Health CO-OP and the member and is not a guarantee that the estimated amount will be the charged amount, or that it will include charges for unforeseen conditions. Contact Customer Service at (844) 262-1560 to request an estimate.

[Estimated Monthly Premium Rates: Individual - [$ 398.34] Family Coverage – [$1,210.66]]

Provider Networks

Organization (PPO) (In-Network) - An innovative health care partnership developed by MHC and our Preferred Hospital Providers to offer health care services to Members at lower premiums. This network is composed of hospitals or surgery centers across the state that accept lower payments for each hospital or surgery center service or inpatient stay.

Participating Providers accept the MHC allowable fee, in addition to the deductible, coinsurance and copayment, as payment in full for covered services. These providers will submit claims for you, and MHC will pay the participating provider directly. There is no billing to you over your deductible, coinsurance and copayment.

Nonparticipating Provider (Out-of-Network) - Nonparticipating Providers have not contracted with MHC to provide services at negotiated rates, and your out of pocket expenses can be significantly higher. Nonparticipating providers are under no obligation to submit claims for you. You may receive payment for claims received from a nonparticipating provider.

If a Primary Care Provider (PCP), Primary Care Provider Specialist (PCPS), Common Specialty Care Provider (CSCP) or a Less Common Sub-Specialty Care Provider (LCSP) is not located within 60 miles, the member can go outside of the 60 miles to a network Provider (an authorization may be required.) MHC will pay as participating and the member may be balanced billed. If the member sees a provider outside of that 60 miles and the provider is not in network the benefits will go towards the out-of-network deductible and out-of-pocket maximum.

Out-of-network emergency room services to treat an emergency medical condition are reimbursed as if obtained in-network, if an in-network emergency room cannot be reasonably reached. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the fetus.

Finding Participating Providers– To locate Participating Providers and PPO hospitals and surgery centers in Montana check our on-line provider directory at www.mhc.coop/provider-finder/ or contact Customer Service at 1-855-447-2900. Be sure to have your health plan identification number available when you call.

SPANISH: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-447-2900.

CHINESE: **注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電** 1-855-447-2900.

SERBO-CROATION: U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko MHC. Pogledajte nalaze li se u ovom obavještenju nekiključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju.Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 1-855-447-2900.

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)번으로 전화해 주십시오. 1-855-447-2900

VIETNAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-447-2900.

ARABIC: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية يحوي هذا ا شعار معلومات هامة بخصوص طلبك للحصول على التغطية من خ ل ابحث عن التواريخ: 855-447-2900 (رقم هاتف الصم والبكم: 1-855-447-2900تتوافر لك بالمجان. اتصل برقم 1-855-447-2900.)

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-447-2900.

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-447-2900.

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-447-2900.

FRENCH: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-447-2900.

ITALIAN: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-447-2900.

JAPANESE: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-447-2900（TTY:1-855-447-2900）まで、お電話にてご連絡ください。

THAI: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-447-2900 (TTY: 1-855-447-2900).

ROMANIAN: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-447-2900.

SUDANIC-FULFULDE: Anndinoore nde'e e woodi habaru kimminiiɗum. TAnndinoore nde'e e woodi habaru kimminiiɗum dow ɗereewol tefal maaɗamaaɗa malla ko yaali dow laawol MHC. Maanda nyalaaɗe lewru nder anndinoorende'e. Teema a giɗeteeɗo ngaɗa goɗɗum bako goɗɗe nyalaaɗe ngam ko yaali njamu maaɗa malla walla dow njobdi. Hakke maaɗa annda habaru ngu'u ewalliinde nder wolde maaɗa naa maa a yobii. Noddu 1-855-447-2900.

UKRAINIAN: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-447-2900 (телетайп: 1-855-447-2900).

NEPALI: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-447-2900 (टिटिवाइ: 1-855-447-2900)

SERBO-CROATIAN: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-447-2900 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-855-447-2900).

BANTU: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-447-2900 (TTY: 1-855-447-2900).

FARSI: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-447-2900 (TTY: 1-855-447-2900) تماس بگیرید.

NORWEGIAN: MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-447-2900.

PENNSYLVANIA DUTCH: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-447-2900.