Outline of Coverage
Plan B: Silver Access Care

Outline of Coverage | 2019

Benefit Period	July 1 – June 30, 2020
Deductible *Copayments and coinsurance do not accumulate to deductible.	In-Network: Individual $1,750 Family $3,500 Out-of-Network: Individual $3,500 Family $7,000
Annual Out-of-Pocket Maximum	In-Network: Individual $6,350 Family $12,700 Out-of-Network: Individual $12,000 Family $15,000
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 Guide and Group Contract. 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 (Non-Specialist)	$35 Copay per visit	60% after Deductible
Physician Specialist Visits	$60 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
Outpatient Facility	40% after Deductible	60% after Deductible
Emergency Room Services		
Emergency room visits	$200 Copay per visit, after Deductible	$200 Copay per visit, after Deductible

Services	In-Network:	Out-of-Network:
Prescription Drugs Benefit		
Retail Pharmacy Benefit (31-day supply)		
Preferred Generic Drugs (Tier 1)	$15 Copay per drug	50% after Deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	$30 Copay per drug	50% after Deductible
Non-Preferred Brand Drugs (Tier 3)	$65 Copay per drug	50% after Deductible
Specialty Drugs (Tier 4)	$90 Copay per drug	50% after Deductible
Mail Order Maintenance (90-day supply)		
Preferred Generic Drugs (Tier 1)	$30 Copay per drug	50% after Deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	$60 Copay per drug	50% after Deductible
Non-Preferred Brand Drugs (Tier 3)	$130 Copay per drug	50% after Deductible
Specialty Drugs (Tier 4) (31-Day Supply Only)	Not Available	Not Available
Mental Health/Chemical Dependency Services		
Inpatient/other Outpatient Facility Services	40% after Deductible	60% after Deductible
Office Visit	$35 Copay per visit	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 Benefit Period – 20 visits*	$60 Copay per visit, after Deductible	60% after Deductible
Convalescent Home Services *Maximum Number of Days per Benefit Period-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: (-2.75%); 2016: 51.30%; 2017: 5%; 2018: 2%; 2019

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 Benefit Period 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 Benefit Period 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. Benefit Period Deductible;
2. Copayments; and
3. Coinsurance.

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

The exception to this is in regards 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 (855) 447-2900 to request an estimate.

[Estimated Monthly Premium Rates: Individual - [$] Family Coverage – [$]

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.

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 أية 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.