



Outline of Coverage CO-OP PLUS BRONZE SG

Outline of Coverage 2021			
Benefit Period	January 1 - December 31		
Deductible <small>*Copayments and coinsurance do not accumulate to deductible.</small>	In-Network:	Individual \$7,800	Family \$15,600
	Out-of-Network:	Individual \$21,600	Family \$43,200
Annual Out-of-Pocket Maximum	In-Network:	Individual \$8,550	Family \$17,100
	Out-of-Network:	Individual \$24,450	Family \$48,900
Coinsurance	In-Network: 60%	Out-of-Network: 70%	
Copayment	Copayments may be 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. 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 provider, the Preventive Health Care Services provided will be subject to the Deductible, Coinsurance, Copayments, and Annual Out-of-Pocket Maximum.		70% after deductible
Physician Medical Services		
Physician Office Visits Tier 1 (Non-Specialist)	\$10.00 copay	70% after deductible
Physician Office Visits Tier 2 (Non-Specialist)	60% coinsurance	70% after deductible
Physician Specialist Visits	70% copay	70% after deductible
<i>*The Copay applies to office visits for all Covered Benefits except for Preventive Health Care Services.</i>		
Hospital Services-Facility and Professional		
Inpatient Facility	50% after deductible	70% after deductible



Services	In-Network:	Out-of-Network:
Outpatient Facility	60% after deductible	70% after deductible
Urgent Care Services		
Doctor on Demand	\$20.00 copay	Not Available
Urgent care services at Clinic	70% coinsurance	70% after deductible
Emergency Room Services		
Emergency room visits	70% after deductible	70% after deductible
Prescription Drugs Benefit		
Retail Pharmacy Benefit (30-day supply)		
Preferred Generic Drugs (Tier 1)	\$15.00 copay after deductible	70% after deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	\$125.00 copay after deductible	70% after deductible
Non-Preferred Brand Drugs (Tier 3)	\$160.00 copay after deductible	70% after deductible
Specialty Drugs (Tier 4)	\$185.00 copay after deductible	70% after deductible
If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the deductible and/or coinsurance, as applicable.		
Mail Order Maintenance (90-day supply)		
Preferred Generic Drugs (Tier 1)	\$30.00 copay after deductible	70% after deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	\$250.00 copay after deductible	70% after deductible
Non-Preferred Brand Drugs (Tier 3)	\$320.00 copay after deductible	70% after deductible
Specialty Drugs (Tier 4) (31 Day Supply Only)	\$370.00 copay after deductible	Not Available
If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the deductible and/or coinsurance, as applicable.		
Mental Health/Chemical Dependency Services		
Inpatient/other Outpatient Facility Services	60% after deductible	70% after deductible
Office Visit Tier 1	\$10.00 copay	70% after deductible
Office Visits Tier 2	60% coinsurance	70% after deductible
Other Covered Services <i>(This is not a complete list. Check your policy or plan document for other covered services and your costs for these services.)</i>		
Centers of Excellence (When approved by MOUNTAIN HEALTH CO-OP)		
Chiropractic Care-Maximum Number of Office Visits per Calendar Year- 20 visits	60% coinsurance	Not available
	70% coinsurance	70% after deductible



Services	In-Network:	Out-of-Network:
Convalescent Home Services Maximum <i>Number of Days per Calendar Year-60 days</i>	60% after deductible	70% after deductible
Durable Medical Equipment Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment.	60% after deductible	70% after deductible
Laboratory Services	70% after deductible	70% after deductible
Transplant Services	60% after deductible	70% after deductible
Dental Exam, Cleaning, Fluoride	\$100 reimbursement to apply to exam, cleaning and fluoride once per year.	
Vision Exam	\$60 reimbursement to apply to one routine exam per year.	

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: 2.4%; 2016: 22.90%; 2017: 29%; 2018: 4.5%; 2019: 11%; 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 MOUNTAIN HEALTH CO-OP 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 Mountain Health CO-OP fee allowance for covered services. Although In-Network Providers accept the fee allowance as payment in full, You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by Mountain 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. Mountain 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 Mountain 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 1-855-447-2900 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 MOUNTAIN HEALTH CO-OP 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 MOUNTAIN HEALTH CO-OP 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 MOUNTAIN HEALTH CO-OP 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 MOUNTAIN HEALTH CO-OP 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.) MOUNTAIN HEALTH CO-OP 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 <https://www.mhc.coop/find-a-provider> or contact Customer Service at 1-855-447-2900. Be sure to have your health plan identification number available when you call.

SPA NISH: ATENCION: si habla espanol, tiene a su disposici6n servicios gratuitos de asistencia lingii fstica . 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.

SERB O-CROATION: U ovom obavjestenju su sadrfane vaine informacije. U ovom obavjestenju su sadrfane vaine informacije o Vasoj prijavi iii osiguranju preko MOUNTAIN HEALTH CO-OP. Pogledajte nalaze li se u ovom obavjestenju nekikljucni datumi. Mozda cete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje iii pomoc pri placanju.Imate pravo da ove informacije, kao i pomoc, dobijete besplatno na svom jeziku. Nazovite 1-855-447-2900 .

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VIETNAMESE: CHU Ý: Neu b9n n6i Tieng Viet, c6 cac djch v1,1 ho trq ngon ngll' mi n phidanh cho b9n. Goi so 1-855-447-2900.

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GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfigung . Rufnu mmer: 1-855-447-2900. TAGALØ:

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

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FRENCH: ATTENTION: Si vous parlez fran ais, des services d'aide linguistique vous sont proposes 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 ii numero 1-855-447-2900.

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ROMANIAN: ATENTIE: Daca vorbiti limba romana, va stau la dispozitie servicii de asistenta lingvistica, gratuit . Sunati la 1-855-447-2900 .

SUDANIC-FULFULDE: Anndinoore nde'e e woodi habaru kimmin iidum. TAnndinoore nde'e e woodi habaru kimminiidum dow dereewol tefal maadamaada malla ko yaali dow laawol MOUNTAIN HEALTH CO-OP. Maanda nyalaade lewru nder anndinoorende 'e. Teema a gideteedo ngada goddum bako godde nyalaade ngam ko yaali njamu maada malla walla dow njobdi. Hakke maada annda habaru ngu'u ewalliinde nder wolde maada naa maa a yobii. Noddu 1-855-447-2900.

UKRAINIAN: YBAra! flkl.1.10B11 p03M0B/lllETeyKpa'iHCbK0IO M0B0IO, B11 M0>t<eTe3BePHYT1CII AO 6e3KOWTOBHo'i C/ly>t<611 M0BH0'iniATPI1MK1. Te11ecJJOHYHTe3aH0Mep0M 1-855-447-2900 (Te/leTaHn : 1-855-447-2900).

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SERBO-CROATIAN: OBAVJESTENJE: Ako govorite srpsko-hrvatski, usluge jezicke pomoci dostupne su vam besplatno. Nazovite 1-855-447-2900 (TTY- Telefon za osobe sa ostecenim govorom iii 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: \>..i.;t, ,3 !"-!>9 W. -5!>! O !., <>JL><!! JI>j u ...i.;S,3 µ & J i9 0!>j)! : y1-855-447-2900 (TTY: 1-855-447- 2900),>4 <.rLo;

NORWEGIA N: MERK : Hvis du snakker norsk, er gratis sprakassistansetjenester tilgjengelige for deg. Ring 1-855-447-2900.

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