HEALTH CO-OP

# Outline of Coverage
## CONNECTED CARE SILVER SG

| Outline of Coverage \| 2021 | | | |
|---|---|---|---|
| **Benefit Period** | January 1 - December 31 | | |
| **Deductible**<br>*Copayments and coinsurance do not accumulate to deductible. | In-Network:<br>Out-of-Network: | Individual $4,000<br>Individual $9,000 | Family $8,000<br>Family $18,000 |
| **Annual Out-of-Pocket Maximum** | In-Network:<br>Out-of-Network: | Individual $8,550<br>Individual $24,450 | Family $17,100<br>Family $48,900 |
| **Coinsurance** | In-Network: 40% | Out-of-Network: 60% | |
| **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. | | 60% after deductible |
| **Physician Medical Services** | | |
| Physician Office Visits | $35.00 copay | 60% after deductible |
| Physician Specialist Visits | $75.00 copay | 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 |
| **Urgent Care Services** | | |
| Doctor on Demand | $20.00 copay | Not Available |

| Services | In-Network: | Out-of-Network: |
|---|---|---|
| Urgent care services at Clinic | $110.00 copay | 60% after deductible |
| **Emergency Room Services** | | |
| Emergency room visits | 50% after deductible | 50% after deductible |
| **Prescription Drugs Benefit** | | |
| **Retail Pharmacy Benefit (30-day supply)** | | |
| Preferred Generic Drugs (Tier 1) | $10.00 copay | 60% after deductible |
| Non-Preferred Generic & Preferred Brand Drugs (Tier 2) | $50.00 copay | 60% after deductible |
| Non-Preferred Brand Drugs (Tier 3) | $100.00 copay | 60% after deductible |
| Specialty Drugs (Tier 4) | $150.00 copay | 60% 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) | $20.00 copay | 60% after deductible |
| Non-Preferred Generic & Preferred Brand Drugs (Tier 2) | $100.00 copay | 60% after deductible |
| Non-Preferred Brand Drugs (Tier 3) | $200.00 copay | 60% after deductible |
| Specialty Drugs (Tier 4)<br>(31 Day Supply Only) | Not Available | 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 | 40% after deductible | 60% after deductible |
| Office Visit | $35.00 copay | 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.)* | | |
| **Centers of Excellence (When approved by MHC)** | 40% | Not available |
| Chiropractic Care-*Maximum Number of Office Visits per Calendar Year – 20 visits* | $75.00 copay | 60% after deductible |
| Convalescent Home Services<br>Maximum *Number of Days per Calendar Year-60 days* | 40% after deductible | 60% after deductible |
| Durable Medical Equipment<br>Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment. | 40% after deductible | 60% after deductible |
| Laboratory Services | 50% after deductible | 60% after deductible |
| Transplant Services | 40% after deductible | 60% after deductible |
| Dental Exam, Cleaning, Fluoride | $100 reimbursement to apply to exam, cleaning and fluoride once per year. | |

| Services | In-Network: | Out-of-Network: |
|---|---|---|
| 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.

# 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, 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.

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## 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.

# 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 يحوي هذا ا شعار معلومات هامة يحوي هذا ا شعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خ ل ابحث عن التواريخ. اتصل برقم 1-855-447-2900اللغوية تتوافر لك بالمجان. (رقم هاتف الصم والبكم: 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: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको 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.