Outline of Coverage
Connected Care-Gold

Outline of Coverage | 2016

Benefit Period	January 1 - December 31
Deductible *Copayments and coinsurance do not accumulate to deductible.	In-Network: Individual $750 Family $1,500 Out-of-Network: Individual $2,250 Family $4,500
Annual Out-of-Pocket Maximum	In-Network: Individual $4,850 Family $9,700 Out-of-Network: Individual $14,550 Family $29,100
Coinsurance	In-Network: 30% Out-of-Network: 50%
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. 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 or 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.		50% after Deductible
Physician Medical Services		
Physician Office Visits (Non-Specialist)	$25 Copay per visit	50% after Deductible
Physician Specialist Visits	$40 Copay per visit	50% 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	30% after Deductible	50% after Deductible
Outpatient Facility	30% after Deductible	50% after Deductible
Emergency Room Services		
Emergency room visits	$200 Copay per visit	$200 Copay per visit

MONTANA HEALTH CO-OP

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Services	In-Network:	Out-of-Network:
Prescription Drugs Benefit		
Retail Pharmacy Benefit (31-day supply)		
Preferred Generic Drugs (Tier 1)	$10 Copay per drug	Not Covered
Preferred Brand Drugs (Tier 2)	$30 Copay per drug	
Non-Preferred Generic & Brand Drugs (Tier 3)	$55 Copay per drug	
Specialty Drugs (Tier SP)	$80 Copay per drug	
Mail Order Maintenance (90-day supply)		
Preferred Generic Drugs (Tier 1)	$20 Copay per drug	Not Covered
Preferred Brand Drugs (Tier 2)	$60 Copay per drug	
Non-Preferred Generic & Brand Drugs (Tier 3)	$110 Copay per drug	
Specialty Drugs (Tier SP)	Not Available	
Mental Health/Chemical Dependency Services		
Inpatient/other Outpatient Facility Services	30% after Deductible	50% after Deductible
Office Visit	$25 Copay per visit	50% 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*	$40 Copay per visit	50% after Deductible
Convalescent Home Services *Maximum Number of Days per Calendar Year-60 days*	30% after Deductible	50% 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)*	30% after Deductible	50% after Deductible
Laboratory Services	30% after Deductible	50% after Deductible
Transplant Services	30% after Deductible	50% 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: 2.85%; 2016: 57.65%

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 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) 488-0622 to request an estimate.