Connected Care Bronze: Montana Health CO-OP

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mhc.coop or by calling (855) 488-0622.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$5,550** person / **$11,100** family. Out-of-network: **$16,650** person / **$33,300** family. Doesn't apply to preventive care, pediatric vision, or copayments.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$7,150** person / **$14,300** family. Out-of-network: **$21,450** person / **$42,900** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, preventive care, balance-billed charges, and care not covered by the plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.mhc.coop** or call **(855) 488-0622** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call (855) 488-0622 or visit us at www.mhc.coop.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 488-0622 to request a copy.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- 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. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 for first 3 visits, before deductible; then $40/copay after deductible.	70% coinsurance	——————none——————
	Specialist visit	50% coinsurance	70% coinsurance	——————none——————
	Chiropractor	50% coinsurance	70% coinsurance	Chiropractic coverage is limited to 20 visits/year.
	Other practitioner office visit	$40 copay after deductible	70% coinsurance	——————none——————
	Preventive care/screening/immunization	No charge	70% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	70% coinsurance	This benefit does not include diagnostic services, such as biopsies, which are services that are routinely covered under the Surgical Services Benefit.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	70% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **All prescription drugs subject to deductible** More information about **prescription drug coverage** is available at **www.mhc.coop**.	Preferred Generic drugs (Tier 1)	35% coinsurance for 31-day retail order or 90-day mail order.	50% coinsurance	——————none——————
	Preferred Brand drugs (Tier 2)	40% coinsurance for 31-day retail order or 90-day mail order.	50% coinsurance	You must pay an Ancillary Charge in addition to the Deductible and/or Copayment, as applicable, if you choose a Brand-Name drug when a Generic drug is available.
	Non-Preferred Generic & Brand drugs (Tier 3)	60% coinsurance for 31-day retail order or 90-day mail order.	50% coinsurance	You must pay an Ancillary Charge in addition to the Deductible and/or Copayment, as applicable, if you choose a Brand-Name drug when a Generic drug is available.
	Preferred Specialty drugs (Tier 4)	60% coinsurance for 31-day retail order. 90-day mail order not available	50% coinsurance	In-Network coverage limited to CVS retail and Aetna Mail Order
	Non-Preferred Specialty drugs (Tier 5)	60% coinsurance for 31-day retail order. 90-day mail order not available	50% coinsurance	In-Network coverage limited to CVS retail and Aetna Mail Order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	70% coinsurance	——————none——————
	Physician/surgeon fees	50% coinsurance	70% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	50% coinsurance	50% coinsurance	——————none——————
	Emergency medical transportation	50% coinsurance	50% coinsurance	——————none——————
	Urgent care	50% coinsurance	70% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	70% coinsurance	——————none——————
	Physician/surgeon fee	50% coinsurance	70% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Office Visit	$40 for first 3 visits, before deductible; then $40/copay after deductible.	70% coinsurance	——————none——————
	Mental/Behavioral health outpatient facility services	$40 for first 3 visits, before deductible; then $40/copay after deductible.	70% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	50% coinsurance	70% coinsurance	——————none——————
	Substance use disorder outpatient facility services	$40 for first 3 visits, before deductible; then $40/copay after deductible.	70% coinsurance	——————none——————
	Substance use disorder inpatient services	50% coinsurance	70% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	50% coinsurance	70% coinsurance	——————none——————
	Delivery and all inpatient services	50% coinsurance	70% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	50% coinsurance	70% coinsurance	Coverage is limited to 180 days/year.
	Rehabilitation services	50% coinsurance	70% coinsurance	——————none——————
	Habilitation services	50% coinsurance	70% coinsurance	
	Skilled nursing care	50% coinsurance	70% coinsurance	Coverage limited to 60 days/year
	Durable medical equipment	50% coinsurance	70% coinsurance	Preauthorization is required for original purchase or replacement of Durable Medical Equipment over $500.
	Hospice service	50% coinsurance	70% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	25% coinsurance	Coverage is limited to one Vision Examination per Covered Dependent Child per Calendar Year.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Glasses	No charge	25% coinsurance	Coverage is limited to one frame per Covered Dependent Child per Calendar Year.
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupressure
- Acupuncture
- Dental care and treatment
- Hearing Aids
- Holistic Medicine
- Marriage counseling
- Private duty nursing
- Religious counseling
- Reversal of an elective sterilization
- Rolfing therapy
- Self-help programs
- Stress management
- Temporomandibular joint dysfunction
- Transplants of non-human/artificial organs
- Vision Services (Adult)
- Weight reduction or weight control services

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care (Up to 20 visits/year)
- Cosmetic surgery (Only if medically necessary or for certain reconstructive surgeries)
- Most coverage provided outside the United States. See **www.mhc.coop**.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **(855) 488-0622**. You may also contact your state insurance department at **(406) 444-2040**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Montana Commissioner of Securities and Insurance, **(406) 444-2040**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **(855) 447-2900**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $980
- **Patient pays** $6,560

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,550
Copays	$0
Coinsurance	$860
Limits or exclusions	$150
Total	**$6,560**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $50
- **Patient pays** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,350**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

- 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 اية 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