MONTANA HEALTH CO-OP

Connected Care

Emphasizing preventive healthcare. (Limited provider choices in Billings and Missoula).

Individuals & Families 2017 Plans	Bronze		Bronze Plus *HSA-compatible		Silver		Gold	
Your Monthly Cost Find out at mhc.coop	$		$		$		$	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible	Individual: $5,550 Family: $11,100	Individual: $16,650 Family: $33,300	Individual: $6,550 Family: $13,100	Individual: $19,650 Family: $39,300	Individual: $2,150 Family: $4,300	Individual: $6,450 Family: $12,900	Individual: $750 Family: $1,500	Individual: $2,250 Family: $4,500
Annual Out-of-Pocket Maximum	Individual: $7,150 Family: $14,300	Individual: $21,450 Family: $42,900	Individual: $6,550 Family: $13,100	Individual: $19,650 Family: $39,300	Individual: $7,150 Family: $14,300	Individual: $21,450 Family: $42,900	Individual: $5,750 Family: $11,500	Individual: $17,250 Family: $34,500
Co-insurance	You pay 50%	You pay 70%	You pay 0% after deductible	You pay 0% after deductible	You pay 40%	You pay 60%	You pay 30%	You pay 50%
Primary Care Provider & Non-specialist Office Visits	First 3 visits before deductible: $40 copay per visit; after deductible: $40 copay per visit	You pay 70% after deductible	You pay 0% after deductible	You pay 0% after deductible	First 3 visits before deductible: $35 copay per visit; after deductible: $35 copay per visit	You pay 60% after deductible	$25 copay per visit	You pay 50% after deductible
Specialist Office Visits	You pay 50% after deductible				$65 copay after deductible		$40 copay per visit	
Emergency Room Visits	You pay 50% after deductible		You pay 0% after deductible		$200 copay after deductible		$200 copay per visit	
Prescription Drugs – Tier 0	You pay $0	You pay 50% after deductible	You pay $0	You pay 0% after deductible	You pay $0	You pay 50% after deductible	You pay $0	You pay 50% after deductible
Prescription Drugs – Tier 1: Generic	You pay 35% after deductible		You pay $0 after deductible		You pay 25% per drug		You pay 20% per drug	
Prescription Drugs – Tier 2: Preferred Brand	You pay 40% after deductible		You pay $0 after deductible		You pay 30% per drug		You pay 25% per drug	
Prescription Drugs – Tier 3: Non-preferred	You pay 60% after deductible		You pay $0 after deductible		You pay 50% per drug		You pay 45% per drug	
Prescription Drugs – Tier 4: Specialty	You pay 60% after deductible		You pay $0 after deductible		You pay 50% per drug		You pay 45% per drug	
Prescription Drugs – Tier 5: Non-preferred Specialty	You pay 60% after deductible		You pay $0 after deductible		You pay 50% per drug		You pay 45% per drug	
Preventive Care Services, Immunizations	You pay nothing for preventive services in-network –deductible does not apply	You pay 70% after deductible	You pay nothing for preventive services in-network –deductible does not apply	You pay 0% after deductible	You pay nothing for preventive services in-network –deductible does not apply	You pay 60% after deductible	You pay nothing for preventive services in-network –deductible does not apply	You pay 50% after deductible
Chiropractic Care (Covered up to 20 visits per year)	You pay 50% after deductible		You pay $0 after deductible		$65 copay after deductible		$40 copay per visit	
Physical, Occupational & Speech Therapy								
Diagnostic X-Ray & Lab Services	You pay 50% after deductible		You pay 0% after deductible		You pay 40% after deductible		You pay 30% after deductible	
Inpatient Hospital Services								
Maternity								
Physician, Surgical & Medical Services								

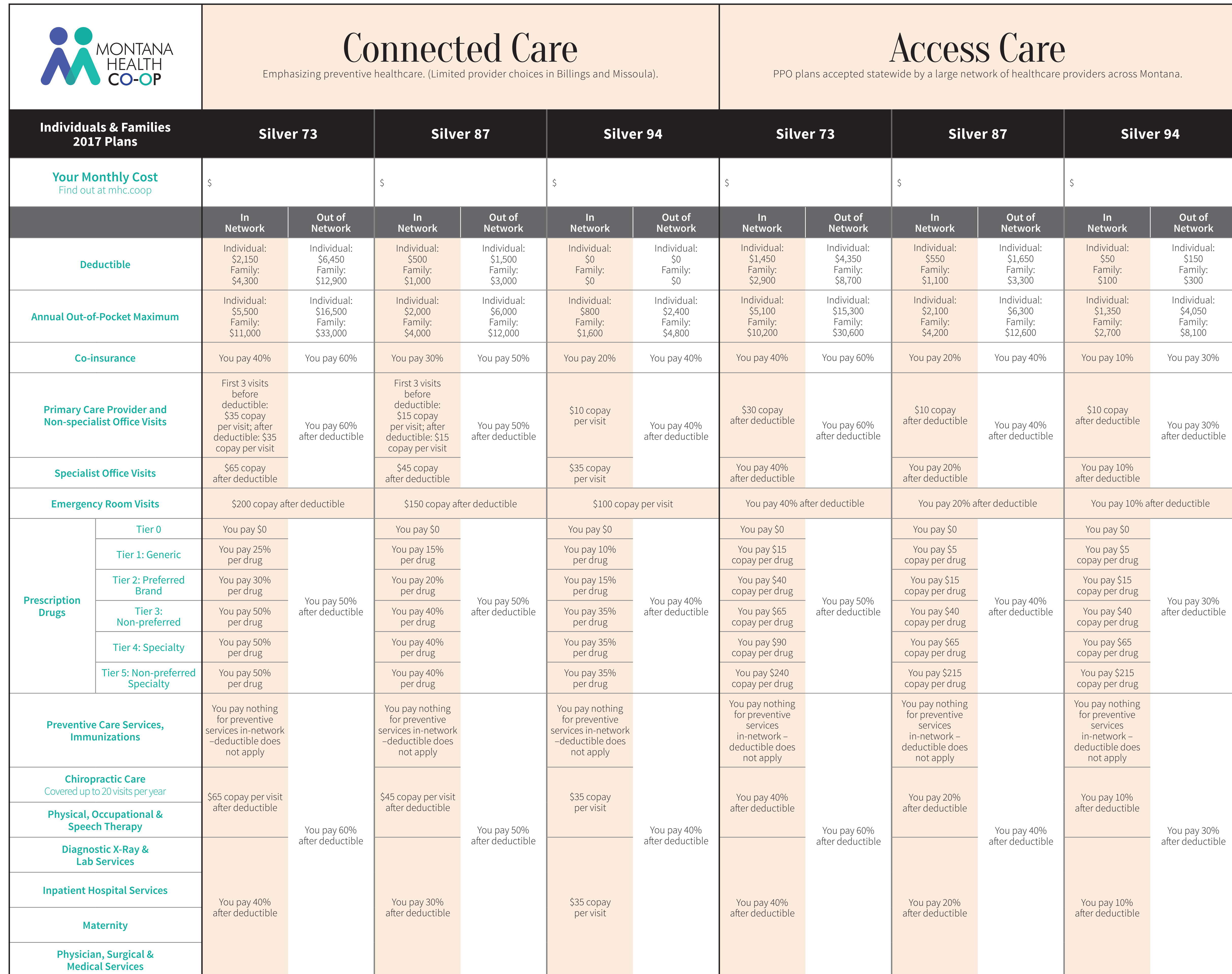
Access Care

PPO plans accepted statewide by a large network of healthcare providers across Montana.

Individuals & Families 2017 Plans	Bronze		Bronze Plus *HSA-compatible		Silver		Gold		Catastrophic	
Your Monthly Cost Find out at mhc.coop	$		$		$		$		$	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible	Individual: $5,250 Family: $10,500	Individual: $15,750 Family: $31,500	Individual: $5,750 Family: $11,500	Individual: $17,250 Family: $34,500	Individual: $2,250 Family: $4,500	Individual: $6,750 Family: $13,500	Individual: $800 Family: $1,600	Individual: $2,400 Family: $4,800	Individual: $7,150 Family: $14,300	Individual: $21,450 Family: $42,900
Annual Out-of-Pocket Maximum	Individual: $7,150 Family: $14,300	Individual: $21,450 Family: $42,900	Individual: $6,550 Family: $13,100	Individual: $19,650 Family: $39,300	Individual: $6,850 Family: $13,700	Individual: $20,550 Family: $41,100	Individual: $4,750 Family: $9,500	Individual: $14,250 Family: $28,500	Individual: $7,150 Family: $14,300	Individual: $21,450 Family: $42,900
Co-insurance	You pay 60%	You pay 70%	You pay 60%	You pay 70%	You pay 40%	You pay 60%	You pay 30%	You pay 50%	You pay 0%	
Primary Care Provider & Non-specialist Office Visits	You pay 60% after deductible	You pay 70% after deductible	You pay 60% after deductible	You pay 70% after deductible	$35 copay after deductible	You pay 60% after deductible	$40 copay per visit	You pay 50% after deductible	First 3 visits before deductible: $0; after deductible: $0	You pay 0% after deductible
Specialist Office Visits					You pay 40% after deductible		$40 copay per visit		0% co-insurance after deductible	
Emergency Room Visits	You pay 60% after deductible		You pay 60% after deductible		You pay 40% after deductible		You pay 30% after deductible		You pay 0% after deductible	
Prescription Drugs – Tier 0	You pay $0	You pay 50% after deductible	You pay $0	You pay 50% after deductible	You pay $0	You pay 50% after deductible	You pay $0	You pay 50% after deductible	You pay $0	You pay 0% after deductible
Prescription Drugs – Tier 1: Generic	You pay $25 after deductible		You pay $25 after deductible		You pay $15 copay per drug		You pay $10 copay per drug		You pay $0 after deductible	
Prescription Drugs – Tier 2: Preferred Brand	You pay $125 after deductible		You pay $125 after deductible		You pay $40 copay per drug		You pay $30 copay per drug		You pay $0 after deductible	
Prescription Drugs – Tier 3: Non-preferred	You pay $160 after deductible		You pay $160 after deductible		You pay $65 copay per drug		You pay $60 copay per drug		You pay $0 after deductible	
Prescription Drugs – Tier 4: Specialty	You pay $185 after deductible		You pay $185 after deductible		You pay $100 copay per drug		You pay $75 copay per drug		You pay $0 after deductible	
Prescription Drugs – Tier 5: Non-preferred Specialty	You pay $335 after deductible		You pay $335 after deductible		You pay $250 copay per drug		You pay $225 copay per drug		You pay $0 after deductible	
Preventive Care Services, Immunizations	You pay nothing for preventive services in-network –deductible does not apply	You pay 70% after deductible	You pay nothing for preventive services in-network –deductible does not apply	You pay 70% after deductible	You pay nothing for preventive services in-network –deductible does not apply	You pay 60% after deductible	You pay nothing for preventive services in-network –deductible does not apply	You pay 50% after deductible	You pay nothing for preventive services in-network –deductible does not apply	You pay 0% after deductible
Chiropractic Care (Covered up to 20 visits per year)	You pay 60% after deductible		You pay 60% after deductible		You pay 40% after deductible		$40 copay per visit		You pay 0% after deductible	
Physical, Occupational & Speech Therapy										
Diagnostic X-Ray & Lab Services	You pay 60% after deductible		You pay 60% after deductible		You pay 40% after deductible		You pay 30% after deductible		You pay 0% after deductible	
Inpatient Hospital Services										
Maternity										
Physician, Surgical & Medical Services										

COST SHARE REDUCTION PLANS

If your income is within certain levels, you may be eligible for an even better benefit package. These better benefit options are only included in the Silver level. You can get an estimate of your eligibility for one of these plans by visiting www.healthcare.gov. The site will guide you through the application process to obtain formal approval of your tax credit and eligibility for these additional benefits.



MONTANA HEALTH CO-OP	Connected Care Emphasizing preventive healthcare. (Limited provider choices in Billings and Missoula).						Access Care PPO plans accepted statewide by a large network of healthcare providers across Montana.					
Individuals & Families 2017 Plans	**Silver 73**		**Silver 87**		**Silver 94**		**Silver 73**		**Silver 87**		**Silver 94**	
Your Monthly Cost Find out at mhc.coop	$		$		$		$		$		$	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible	Individual: $2,150 Family: $4,300	Individual: $6,450 Family: $12,900	Individual: $500 Family: $1,000	Individual: $1,500 Family: $3,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1,450 Family: $2,900	Individual: $4,350 Family: $8,700	Individual: $550 Family: $1,100	Individual: $1,650 Family: $3,300	Individual: $50 Family: $100	Individual: $150 Family: $300
Annual Out-of-Pocket Maximum	Individual: $5,500 Family: $11,000	Individual: $16,500 Family: $33,000	Individual: $2,000 Family: $4,000	Individual: $6,000 Family: $12,000	Individual: $800 Family: $1,600	Individual: $2,400 Family: $4,800	Individual: $5,100 Family: $10,200	Individual: $15,300 Family: $30,600	Individual: $2,100 Family: $4,200	Individual: $6,300 Family: $12,600	Individual: $1,350 Family: $2,700	Individual: $4,050 Family: $8,100
Co-insurance	You pay 40%	You pay 60%	You pay 30%	You pay 50%	You pay 20%	You pay 40%	You pay 40%	You pay 60%	You pay 20%	You pay 40%	You pay 10%	You pay 30%
Primary Care Provider and Non-specialist Office Visits	First 3 visits before deductible: $35 copay per visit; after deductible: $35 copay per visit	You pay 60% after deductible	First 3 visits before deductible: $15 copay per visit; after deductible: $15 copay per visit	You pay 50% after deductible	$10 copay per visit	You pay 40% after deductible	$30 copay after deductible	You pay 60% after deductible	$10 copay after deductible	You pay 40% after deductible	$10 copay after deductible	You pay 30% after deductible
Specialist Office Visits	$65 copay after deductible		$45 copay after deductible		$35 copay per visit		You pay 40% after deductible		You pay 20% after deductible		You pay 10% after deductible	
Emergency Room Visits	$200 copay after deductible		$150 copay after deductible		$100 copay per visit		You pay 40% after deductible		You pay 20% after deductible		You pay 10% after deductible	
Prescription Drugs – Tier 0	You pay $0	You pay 50% after deductible	You pay $0	You pay 50% after deductible	You pay $0	You pay 40% after deductible	You pay $0	You pay 50% after deductible	You pay $0	You pay 40% after deductible	You pay $0	You pay 30% after deductible
Tier 1: Generic	You pay 25% per drug		You pay 15% per drug		You pay 10% per drug		You pay $15 copay per drug		You pay $5 copay per drug		You pay $5 copay per drug	
Tier 2: Preferred Brand	You pay 30% per drug		You pay 20% per drug		You pay 15% per drug		You pay $40 copay per drug		You pay $15 copay per drug		You pay $15 copay per drug	
Tier 3: Non-preferred	You pay 50% per drug		You pay 40% per drug		You pay 35% per drug		You pay $65 copay per drug		You pay $40 copay per drug		You pay $40 copay per drug	
Tier 4: Specialty	You pay 50% per drug		You pay 40% per drug		You pay 35% per drug		You pay $90 copay per drug		You pay $65 copay per drug		You pay $65 copay per drug	
Tier 5: Non-preferred Specialty	You pay 50% per drug		You pay 40% per drug		You pay 35% per drug		You pay $240 copay per drug		You pay $215 copay per drug		You pay $215 copay per drug	
Preventive Care Services, Immunizations	You pay nothing for preventive services in-network –deductible does not apply	You pay 60% after deductible	You pay nothing for preventive services in-network –deductible does not apply	You pay 50% after deductible	You pay nothing for preventive services in-network –deductible does not apply	You pay 40% after deductible	You pay nothing for preventive services in-network – deductible does not apply	You pay 60% after deductible	You pay nothing for preventive services in-network – deductible does not apply	You pay 40% after deductible	You pay nothing for preventive services in-network – deductible does not apply	You pay 30% after deductible
Chiropractic Care Covered up to 20 visits per year	$65 copay per visit after deductible		$45 copay per visit after deductible		$35 copay per visit		You pay 40% after deductible		You pay 20% after deductible		You pay 10% after deductible	
Physical, Occupational & Speech Therapy												
Diagnostic X-Ray & Lab Services	You pay 40% after deductible		You pay 30% after deductible		$35 copay per visit		You pay 40% after deductible		You pay 20% after deductible		You pay 10% after deductible	
Inpatient Hospital Services												
Maternity												
Physician, Surgical & Medical Services												

Glossary of Terms

Co-insurance:
Your share of the costs of a covered service, calculated as a percentage of the allowed amount for that service (for example, 20%). You pay co-insurance plus any deductible you owe.

Copayment:
A fixed dollar amount you pay for a covered service, usually at the time of service.

Deductible:
The amount you owe for covered healthcare services before your plan begins to pay.

HSA-compatible:
Denotes a qualified High Deductible Health Plan that can be paired with a Health Savings Account.

In-network provider:
Doctors, hospitals and other healthcare professionals who are under contract to provide services through your plan. They typically cost you less.

Out-of-network provider:
Healthcare providers who are NOT under contract to provide services through your plan. They typically cost you much more.

Out-of-pocket maximum:
The most you pay during a policy period. After you have hit this maximum, your plan pays 100% of covered health services.

Premium:
The amount you pay monthly for your health insurance plan.

To Learn More:
855-447-2900
information@mhc.coop
www.mhc.coop

Exclusions and Limitations

All benefits provided under this Policy are subject to the exclusions and below. No benefits will be paid under this Policy that are incurred by or results from any of the following.

1. Sanitarium care, custodial care, rest cures, custodial care or convalescent care to help the Covered Person with daily living tasks. Such tasks include, but limited to, the following:

   (a) walking; (b) getting in and out of bed; (c) bathing; (d) dressing; (e) feeding; (f) using the toilet; (g) preparing special diets; or (h) supervision of medication which is usually self-administered and does not require the continuous attention of medical personnel.

2. An Illness or Injury arising out of or in the course of doing any job or work for wage or profit, or Illness covered by any Workers' Compensation Law or Act, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This exclusion applies to all services and supplies provided to treat such Illness or Injury even though: (a) coverage under the government legislation provides benefits for only a portion of the services incurred; (b) the employer has failed to obtain such coverage required by law; (c) the Covered Person waives the Covered Person's rights to such coverage or benefits; (d) the Covered Person fails to file a claim within the filing period allowed by law for such benefits; (e) the Covered Person fails to comply with any other provision of the law to obtain coverage or benefits; and (f) the Covered Person was permitted to elect not to be covered by the Worker's Compensation Act but failed to properly make such election effective.

   This exclusion will not apply if the Covered Person is permitted by statute not be covered and the Covered Person elects not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws.

This exclusion will not apply if the Covered Person's employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws or employer's liability acts of any state, country, or the United States.

1. Services, supplies, drugs and devices which the Covered Person is entitled to receive or does receive TRICARE, the Veteran's Administration (VA), and Indian Health Services but not Medicaid. This exclusion is not intended to exclude Covered Medical Expenses from coverage if the Covered Person is a resident of a Montana State institution when benefits are provided.

   Note: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Covered Person. When such a circumstance occurs, the Covered Person will receive an explanation of benefits.

2. War, or act of war, whether declared or not, rebellion, armed invasion, or insurrection;
3. Service in the Armed Forces or any auxiliary units of the Armed Forces;
4. Any loss for which a contributing cause was commission by the Covered Person of a felony, or attempt to commit a felony. This exclusion does not apply if the loss is related to being a victim of domestic violence.
5. Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline
6. Dental care and treatment except for such care or treatment due to accidental Injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;
7. Vision services, including, but not limited to, (a) eye examinations for the prescription or fitting of eyeglasses or contact lenses; (b) purchase of eyeglasses and contact lenses; (c) Lasik surgery; or (d) radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism). This exclusion does not apply to the Pediatric Vision Care benefit provided under this Policy;
8. Hearing aids and examinations for the prescription or fitting of hearing aids;
9. Cosmetic Surgery, unless (a) it is Medically Necessary; or (b) it is reconstructive surgery.

   Such reconstructive surgery must be: (a) incidental to or following surgery resulting from trauma, infection or other diseases of the involved part; and (b) because of congenital disease or anomaly of a covered Dependent Child which has resulted in a functional defect;

10. Foot care, including but limited to: (a) routine foot care; (b) treatment or removal of corns and callosities; (c) hypertrophy, hyperplasia of the skin or subcutaneous tissues; (d) cutting or trimming toenails; (e) any Treatment of congenital flat foot; (f) injections and nonsurgical Treatment of acquired flat foot, fallen arches, or chronic foot strain; (g) any Treatment of flat foot purely for the purpose of altering the foot's contour where no medicine or functional impairment exists; (h) orthotic appliances; (i) impression casting for orthotic appliances; (j) padding and strapping; or (k) fabrication;
11. Foot orthotic appliance provided for the treatment of any medical condition;
12. Treatment provided in a government hospital, except Montana residents who are confined in state medical institutions; benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employers' liability or occupational disease law;
13. Services rendered and separately billed by employees of hospitals, laboratories or other institutions;
14. Services performed by You or a member of Your Immediate Family;
15. Services for which there is no legal obligation for the Covered Person to pay or for which no charge would be made if insurance did not exist, unless such charge is regularly and customarily made in similar amount by the provider of such to other non-indigent patients, or unless, in either case, We are required by law to pay to the Government of the United States;
16. Nonsurgical Treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction, anterior or internal dislocation, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances;
17. Unless otherwise included under this Policy as a Covered Benefit, dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;
18. Unless otherwise included under this Policy as a Covered Benefit, Vision care, except for medical treatment of the eyes by an ophthalmologist. Coverage is not provided for lenses, frames or contact lenses or any vision supplies;
19. Chiropractic maintenance therapy.
20. Private duty nursing;
21. Services, supplies, drugs and devices related to in vitro fertilization;
22. Reversal of an elective sterilization;
23. Outpatient prescription drugs for which benefits are provided under the Prescription Drug Benefit in this Policy;
24. Transplants of a non-human organ or artificial organ transplant;
25. Any services, supplies, drugs and devices which are: (a) an investigational/Experimental Service; (b) not accepted medical practice; and (c) not a Covered Medical Expense. We may consult with Physicians or national medical specialty organizations for advice determining whether the service or supply is accepted-medical practices;
26. For travel by the Covered Person or a provider;
27. Orthodontics;
28. Services, supplies and devices relating to: (a) Holistic Medicine; (b) Holistic Healing; (c) Reiki; (d) Medical Herbalism; (e) Natural Healing; (f) acupuncture; (g) acupressure; (h) homeopathic treatments; (i) Rolfing; and other forms of Complementary and Alternative Medical treatments or therapy;
29. Services, supplies and devices relating to any of the following treatments or related procedures: (a) marriage counseling; (b) religious counseling; (c) self-help programs; or (d) stress management;
30. Vitamins. NOTE: Certain vitamins may be covered for specific conditions in accordance with published Medical Policy;
31. Food supplements and/or medical foods, except when used for Inborn Errors of Metabolism or Enteral Nutrition services as defined in the Medial Policy;
32. Services, supplies, drugs and devices for weight reduction or weight control, whether rendered for weight control or any other condition. This Exclusion does not include intensive behavioral dietary counseling for adult patients when services are provided by a Physician, Physician Assistant or Advanced Nurse Practitioner;
33. Education services, unless otherwise specified as a Covered Benefit, or tutoring services;
34. Any services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature;
35. Computerized items including, but not limited to, the following: (a) durable medical equipment; (b) prosthetic limbs; and (c) communication devices. Payment for deluxe prosthetics and computerized limbs will be based on the Allowable Fee for a standard prosthesis;
36. Applied Behavior Analysis (ABA) services, except as specifically included in this Policy under the Autism Spectrum Disorders;
37. Services, supplies, drugs and devices which are not listed as a Covered Benefit as provided in this Policy; or
38. All services, supplies, drugs and devices provided to treat any Illness or Injury arising out of employment as an athlete by or on a team or sports club engaged in any contact sport that includes significant physical contact between the athletes involved, including, but not limited to, the following: (a) football; (b) hockey; (c) roller derby; (d) rugby; (e) lacrosse; (f) wrestling and boxing; and (g) where the Covered Person's employer is not required by law to obtain coverage for Illness or Injury under state or federal workers' compensation, occupational disease or similar laws.
39. For any of the following: (a) For appliances, splints, or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service in this Policy; (b) for orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw; (c) for implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies; (d) for alveolectomy or alveoloplasty when related to tooth extraction.

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