MONTANA HEALTH CO-OP

Connected Care

Our most affordable plans. Emphasizing preventive healthcare and accepted by doctors and hospitals across Montana. (Limited provider choices in Billings and Missoula.)

Access Care

PPO plans accepted by doctors and hospitals across Montana.

Small Business 2015 Plans	Bronze		Bronze Plus *HSA-compatible		Silver		Silver Plus		Gold		Gold Plus		Platinum		Bronze		Bronze Plus *HSA-compatible		Silver		Gold	
	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	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: $3,950 Family: $7,900	Individual: $7,900 Family: $12,000	Individual: $3,950 Family: $7,900	Individual: $7,900 Family: $15,800	Individual: $1,750 Family: $3,500	Individual: $3,500 Family: $7,000	Individual: $3,650 Family: $7,300	Individual: $7,300 Family: $14,600	Individual: $700 Family: $1,400	Individual: $1,400 Family: $2,800	Individual: $2,100 Family: $4,200	Individual: $4,200 Family: $8,400	Individual: $350 Family: $700	Individual: $700 Family: $1,400	Individual: $3,950 Family: $7,900	Individual: $7,900 Family: $12,000	Individual: $3,950 Family: $7,900	Individual: $7,900 Family: $15,800	Individual: $1,750 Family: $3,500	Individual: $3,500 Family: $7,000	Individual: $750 Family: $1,500	Individual: $1,500 Family: $3,000
Annual Out-of-Pocket Maximum	Individual: $6,350 Family: $12,700	Individual: $12,000 Family: $15,000	Individual: $6,350 Family: $12,700	Individual: $12,700 Family: $25,400	Individual: $6,350 Family: $12,700	Individual: $12,000 Family: $15,000	Individual: $3,650 Family: $7,300	Individual: $7,300 Family: $14,600	Individual: $4,500 Family: $9,000	Individual: $7,500 Family: $15,000	Individual: $2,100 Family: $4,200	Individual: $4,200 Family: $8,400	Individual: $1,200 Family: $2,400	Individual: $2,400 Family: $4,800	Individual: $6,350 Family: $12,700	Individual: $12,000 Family: $15,000	Individual: $6,350 Family: $12,700	Individual: $12,700 Family: $25,400	Individual: $6,350 Family: $12,700	Individual: $12,000 Family: $15,000	Individual: $4,500 Family: $9,000	Individual: $7,500 Family: $15,000
Co-insurance	You pay 50%	You pay 70%	You pay 50%	You pay 70%	You pay 40%	You pay 60%	You pay 0% after deductible		You pay 30%	You pay 50%	You pay 0%		You pay 10%	You pay 30%	You pay 50%	You pay 70%	You pay 50%	You pay 70%	You pay 40%	You pay 60%	You pay 30%	You pay 50%
Provider Network	Connected Care Network: Emphasizing preventive healthcare and accepted by doctors and hospitals across Montana. (Limited provider choices in Billings and Missoula.)														Access Care Network: Accepted by doctors and hospitals across Montana.							
Office Visits	Non-specialist: $35 copay, Specialist: 50% after deductible	You pay 70% after deductible	You pay 50% after deductible	You pay 70% after deductible	Non-specialist: $35 copay, Specialist: $60 copay after deductible	You pay 60% after deductible	You pay 0% after deductible		Non-specialist: $25 copay, Specialist: $40 copay	You pay 50% after deductible	You pay 0% after deductible		Non-specialist: $20 copay, Specialist: $40 copay	You pay 30% after deductible	You pay 50% after deductible	You pay 70% after deductible	You pay 50% after deductible	You pay 70% after deductible	Non-specialist: $35 copay, Specialist: you pay 40% after deductible	You pay 60% after deductible	Non-specialist: $25 copay, Specialist: $40 copay	You pay 50% after deductible
Emergency Room Visits	You pay 50% after deductible		You pay 50% after deductible		$200 copay after deductible		You pay 0% after deductible		$200 copay per visit		You pay 0% after deductible		You pay 10% after deductible		You pay 50% after deductible		You pay 50% after deductible		You pay 40% after deductible		You pay 30% after deductible	
Prescription Drugs In-network benefits shown	You pay: Generic: $15 after deductible Preferred Brand: $115 after deductible Non-preferred: $150 after deductible Specialty: $175 after deductible		You pay: Generic: $15 after deductible Preferred Brand: $115 after deductible Non-preferred: $150 after deductible Specialty: $175 after deductible		You pay: Generic: $15 copay per drug Preferred Brand: $40 copay per drug Non-preferred: $65 copay per drug Specialty: $90 copay per drug		You pay 0% after deductible		You pay: Generic: $10 copay per drug Preferred Brand: $30 copay per drug Non-preferred: $55 copay per drug Specialty: $80 copay per drug		You pay 0% after deductible		You pay: Generic: $5 copay per drug Preferred Brand: $20 copay per drug Non-preferred: $45 copay per drug Specialty: $70 copay per drug		You pay: Generic: $15 after deductible Preferred Brand: $115 after deductible Non-preferred: $150 after deductible Specialty: $175 after deductible		You pay: Generic: $15 after deductible Preferred Brand: $115 after deductible Non-preferred: $150 after deductible Specialty: $175 after deductible		You pay: Generic: $15 copay per drug Preferred Brand: $40 copay per drug Non-preferred: $65 copay per drug Specialty: $100 copay per drug		You pay: Generic: $10 copay per drug Preferred Brand: $30 copay per drug Non-preferred: $60 copay per drug Specialty: $75 copay per drug	
Preventive Care Services, Immunizations	You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply		You pay nothing for preventive services in-network –deductible does not apply	
Chiropractic Care Covered up to 20 visits per year	You pay 50% after deductible		You pay 50% after deductible		You pay $60 copay after deductible		You pay 0% after deductible		You pay $40 copay per visit		You pay 0% after deductible		You pay $40 copay per visit		You pay 50% after deductible		You pay 50% after deductible		You pay 40% after deductible		You pay $40 copay per visit	
Diagnostic X-Ray & Lab Services	You pay 50% after deductible	You pay 70% after deductible	You pay 50% after deductible	You pay 70% after deductible	You pay 40% after deductible	You pay 60% after deductible	You pay 0% after deductible	You pay 0% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible	You pay 10% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 70% after deductible	You pay 50% after deductible	You pay 70% after deductible	You pay 40% after deductible	You pay 60% after deductible	You pay 30% after deductible	You pay 50% after deductible
Inpatient Hospital Services																						
Maternity																						
Physician, Surgical & Medical Services																						
Diabetes Education Services																						
Outpatient Rehabilitation Services																						
Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST) Covered up to 20 visits per year																						

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.

Exclusions and Limitations: Sanitarium care, custodial care, rest cures, custodial care or convalescent care to help the Covered Person with daily living tasks. Such tasks include, but are not 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. 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. 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. War, or act of war, whether declared or not, rebellion, armed invasion, or insurrection; Service in the Armed Forces or any auxiliary units of the Armed Forces; Any loss for which a contributing cause was commissioned 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. Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; 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; 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; 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; Hearing aids and examinations for the prescription or fitting of hearing aids; 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; Foot care, including but not limited to: (a) routine foot care; (b) treatment or removal of corns and callosities; (c) hypertrophy, hyperplasia of the skin or subcutaneous tissues; 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; Foot orthotic appliance provided for the treatment of any medical condition; The Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of Physician; 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; Benefits to the extent provided for any loss or portion of such loss for which mandatory automobile no-fault benefits are recovered or recoverable; Services rendered and separately billed by employees of hospitals, laboratories or other institutions; Services performed by You or a member of Your Immediate Family; 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; 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; 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; 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; Chiropractic maintenance therapy; private duty nursing; Services, supplies, drugs and devices related to in vitro fertilization; Reversal of an elective sterilization; Outpatient prescription drugs for which benefits are provided under the Prescription Drug Benefit in this Policy; Transplants of a non-human organ or artificial organ transplant; Any services, supplies, drugs and devices which are: (a) an investigational/Experimental Service or Clinical Trial; (b) not accepted medical practice; and (c) not a Covered Medical Expense; For travel by the Covered Person or a provider; Orthodontics; 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; 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; Vitamins. NOTE: Certain vitamins may be covered for specific conditions in accordance with published Medical Policy; Food supplements and/or medical foods, except when used for Inborn Errors of Metabolism or Enteral Nutrition services as defined in the Medical Policy; 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; Education services, unless otherwise specified as a Covered Benefit, or tutoring services; Any services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature; Computerized items including, but not limited to, the following: (a) durable medical equipment; (b) prosthetic limbs; and (c) communication devices; Applied Behavior Analysis (ABA) services, except as specifically included in this Policy under the Autism Spectrum Disorders; Services, supplies, drugs and devices which are not listed as a Covered Benefit as provided in this Policy; or 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; Charges for any procedures, services, supplies, care or treatment, including gender-reassignment drug therapies in a pre-surgery situation, related to a sex reassignment, including transgender reassignment surgery. Please refer to the complete policy located on www.mhc.coop.