

Plan Details

Selected Plans

Plus Gold HDHP	
Summary	<p>Offering a wide network of providers and a comprehensive array of benefits, Plus at the gold level requires low out-of-pocket expenses, providing highly inclusive health care coverage for Montanans.</p> <p>Outline of Coverage Coverage Summary</p>
Metal Level	GOLD
Plan Highlights	
Plan Type	PPO
HSA Compatible	Yes
Deductible : Family	\$3,500 individual/\$7,000 family
Out-of-Pocket Limit : Family	\$3,500 individual/\$7,000 family
Coinsurance	0% coinsurance
Annual Vision Exam	Up to \$60 reimbursement for exam
Travel Benefit	Yes
Centers of Excellence	Yes
Preventive Services	\$0 copay
Primary Care Visit	0% coinsurance
Chiropractic Services	0% coinsurance
Urgent Care	0% coinsurance

Value Based Insurance Design	N/A
Tier 1 - Preferred Generic Drugs	0% coinsurance
Plus Gold HDHP	
Medical Deductible : Family	\$3,500 individual/\$7,000 family
Out-of-Pocket Maximum : Family	\$3,500 individual/\$7,000 family
<p>The amounts or percentages displayed represent the amounts that a member pays. Generally copayments are indicated as dollar amounts and are paid before the deductible amount. Coinsurance is indicated as percentages. Generally the deductible is paid by the member first, then the coinsurance amount is paid until the member reaches the out of pocket maximum. All amounts below are for in-network services unless indicated differently.</p>	
Provider's Office or Clinic Visit	
Preventive & Screening Services	\$0 copay
Primary Care Office Visits	0% coinsurance
Primary Care Network	Provider Network
Specialist Office Visit	0% coinsurance
Other Services	
Chiropractic Services	0% coinsurance
Urgent Care	0% coinsurance
Emergency Services	0% coinsurance
Hospital Inpatient /Outpatient	0% coinsurance
Chemical Dependency Inpatient	0% coinsurance

Chemical Dependency Outpatient	0% coinsurance
Mental Health Inpatient	0% coinsurance
Mental Health Outpatient	0% coinsurance
Adult Dental	0% coinsurance
Telemedicine	Yes
Doctor on Demand	Yes
Value Based Insurance Design	N/A
Maternity	
Maternity	0% coinsurance
Pediatric Dental/Vision	
Dental	Not covered; you must purchase a separate dental plan
Vision (children 18 & under)	\$0 copay
Disclaimer: Plans do not provide benefits for pediatric dental services. Pediatric dental benefits must be purchased from another source that offers such benefits.	
Prescription Drugs	
Formulary	Formulary
31 day supply purchased from a pharmacy	
Tier 1 - Preferred Generic Drugs	0% coinsurance
Tier 2 - Preferred Brand Drugs	0% coinsurance
Tier 3 - Non Preferred Brand /Generic Drugs	0% coinsurance

Tier 4 - Specialty	0% coinsurance
31 day supply purchased from a pharmacy	
Tier 1 - Preferred Generic Drugs	0% coinsurance
Tier 2 - Preferred Brand Drugs	0% coinsurance
Tier 3 - Non Preferred Brand /Generic Drugs	0% coinsurance
Out of Network Coverage	
Deductible : Family	\$9,000 individual/\$18,000 family

Balance Billing 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 for the difference. This is called balance billing and the balance bill amount does not apply toward deductible or out of pocket maximum. For example, you go to an out of network no choice provider, they charge \$1,000 for the service, our allowed amount is \$500, we process the \$500 toward your in network benefit, the provider may balance bill you the additional \$500.

No Choice Provider There are circumstances where you may find yourself seen by a no choice provider. A no choice provider is a provider you do not have a say in going to or you may not know they are out of network. Example: 1. You are traveling and get in a car accident and go to the nearest Emergency Room which is not in network. 2. You go to an in network hospital for surgery and your anesthesiologist is not in network. In these cases we process these claims toward your in network benefit and pay our allowed amount. Unfortunately, the provider may balance bill you the difference between billed charges and allowed amount.

Coinsurance	0% coinsurance
Out-of-Pocket Limit : Family	\$9,000 individual/\$18,000 family
Cost Share Methodology	0% coinsurance

The amounts quoted are the lowest rates available for the health plans listed and are subject to change based on the optional benefits you selected, if any, and other relevant factors. It may be the sum of estimated premiums and other recurring charges, if the insurance company has such charges. Insurance companies reserve the right to change the terms of a policy upon proper notification. Please note that definitions of certain terms may vary across insurance companies.

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