MOUNTAIN HEALTH CO-OP

Call us Mon-Fri 9 AM - 5 PM
855-447-2900

Plan Details

Selected Plans

	Plus Silver
Summary	*Offering a wide network of providers and a comprehensive array of benefits, Plus at the silver level provides solid health care coverage for Montanans.* Outline of Coverage Coverage Summary
Metal Level	SILVER
Plan Highlights	
Plan Type	PPO
HSA Compatible	No
Deductible *: Family*	$6,000 individual/$12,000 family
Out-of-Pocket Limit *: Family*	$9,000 individual/$18,000 family
Coinsurance	40% coinsurance
Annual Vision Exam	Up to $60 reimbursement for exam
Travel Benefit	Yes
Centers of Excellence	Yes
Preventive Services	$0 copay
Primary Care Visit	Tier 1: $10 copay, deductible does not apply; Tier 2: $50 copay, deductible does not apply
Chiropractic Services	$75 copay, deductible does not apply
Urgent Care	$110 copay, deductible does not apply

Value Based Insurance Design	This benefit enhances your pharmacy benefit by adding more medications at No Cost. Certain medications that treat the following conditions cardiovascular (hypertension, high cholesterol, heart failure, etc..) diabetes, asthma, COPD, depression and osteoporosis will be included. Please check your drug formulary.
Tier 1 - Preferred Generic Drugs	$10 copay deductible does not apply
	Plus Silver
Medical Deductible *: Family*	$6,000 individual/$12,000 family
Out-of-Pocket Maximum *: Family*	$9,000 individual/$18,000 family
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.	
Maternity	
Maternity	40% 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	$10 copay deductible does not apply
Tier 2 - Preferred Brand Drugs	$60 copay deductible does not apply

Tier 3 - Non Preferred Brand /Generic Drugs	$150 copay deductible does not apply
Tier 4 - Specialty	$200 copay deductible does not apply
31 day supply purchased from a pharmacy	
Tier 1 - Preferred Generic Drugs	$20 copay deductible does not apply
Tier 2 - Preferred Brand Drugs	$120 copay deductible does not apply
Tier 3 - Non Preferred Brand /Generic Drugs	$300 copay deductible does not apply
Out of Network Coverage	
Deductible *: Family*	$15,600 individual/$31,200 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	60% coinsurance
Out-of-Pocket Limit *: Family*	$24,450 individual/$48,900 family
Cost Share Methodology	60% 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.

Compliance and Privacy