



Connected Care Emphasizing preventive healthcare.

CO-OP Plus
(Limited provider choices for Tier 1 Network)

HEALTH CO-	OP								critive ricute												
Individuals & Families 2020 Plans		Bro	nze	Bronze Plus *HSA-compatible		Expanded Bronze		Silver Option 2		Silver		Gold		Catastrophic		Bronze		Silver		Gold	
Your Monthl Find out at m		\$		\$		\$		\$		\$		\$		\$		\$		\$	\$		
		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 In Network Network Tier 1 Tier 2	Out of Network	In In Network Network Tier 1 Tier 2	Out of Network	In In Network Tier 1 Tier 2	Out of Network
Deductik	ole	Individual: \$7,200 Family: \$14,400	Individual: \$21,600 Family: \$43,200	Individual: \$6,900 Family: \$13,800	Individual: \$21,600 Family: \$43,200	Individual: \$5,500 Family: \$11,000	Individual: \$16,500 Family: \$33,000	Individual: \$5,700 Family: \$11,400	Individual: \$17,100 Family: \$34,200	Individual: \$4,000 Family: \$8,000	Individual: \$12,000 Family: \$24,000	Individual: \$750 Family: \$1,500	Individual: \$2,250 Family: \$4,500	Individual: \$8,150 Family: \$16,300	Individual: \$24,450 Family: \$48,900	Individual: \$7,200 Family: \$14,400	Individual: \$21,600 Family: \$43,200	Individual: \$4,000 Family: \$8,000	Individual: \$12,000 Family: \$24,000	Individual: \$750 Family: \$1,500	Individual: \$2,250 Family: \$4,500
Annual Out-of- Pocket Maximum		Individual: \$8,150 Family: \$16,300	Individual: \$23,700 Family: \$47,400	Individual: \$6,900 Family: \$13,800	Individual: \$23,700 Family: \$47,400	Individual: \$8,150 Family: \$16,300	Individual: \$24,450 Family: \$48,900	Individual: \$8,150 Family: \$16,300	Individual: \$24,450 Family: \$48,900	Individual: \$8,150 Family: \$16,300	Individual: \$24,450 Family: \$48,900	Individual: \$5,750 Family: \$11,500	Individual: \$17,250 Family: \$34,500	Individual: \$8,150 Family: \$16,300	Individual: \$24,450 Family: \$48,900	Individual: \$8,150 Family: \$16,300	Individual: \$23,700 Family: \$47,400	Individual: \$8,150 Family: \$16,300	Individual: \$24,450 Family: \$48,900	Individual: \$5,750 Family: \$11,500	Individual: \$17,250 Family: \$34,500
Coinsurance		You pay 60%	You pay 70%	You pay 0% after deductible	You pay 0% after deductible	You pay 50%	You pay 70%	You pay 40%	You pay 60%	You pay 40%	You pay 60%	You pay 30%	You pay 50%	You p	ay 0%	You pay 60%	You pay 70%	You pay 40%	You pay 60%	You pay 30%	You pay 50%
Primary Care Provider & Non-specialist Office Visits		\$60 copay per visit after deductible	You pay 70% after deductible	You pay 0% after deductible	You pay 0% after deductible	\$50 copay per visit	You pay 70% after deductible	1st 10 visits \$40 copay per visit then \$40 copay per visit after deductible	You pay 60% after deductible	1st 10 visits \$40 copay per visit then \$40 copay per visit after deductible	You pay 60% after deductible	\$35 copay per visit	You pay 50% after deductible	1st 3 visits \$0 copay per visit then \$0 copay per visit after deductible	You pay 0% after deductible	\$10 copay per visit You pay 60% after deductible	You pay 70% after deductible	\$10 copay per visit You pay 40% after deductible	You pay 60% after deductible	\$5 copay per visit You pay 30% after deductible	You pay 50% after deductible
Specialist Office Visits		You pay 60% after deductible	0% after eductible			\$60 copay per visit		\$65 copay per visit after deductible		\$65 copay per visit after deductible		\$40 copay per visit		You pay 0% after deductible		You pay 60% after deductible		\$65 copay per visit after deductible \$65 copay per visit after deductible		\$40 copay per visit	
Emergency Room Visits		60% after	deductible	0% after deductible		50% after deductible		40% after deductible		40% after deductible		30% after deductible		0% after deductible		60% after deductible		40% after deductible		30% after deduct	ible
Eye Exa		*-		4			reimbursemei		r adult vision e	exam, any opto	ometrist I						Annual reimbu	rsement up to \$60 for adult	vision exam, a		
	Tier 0 Tier 1: Generic	\$0 You pay 10% after deductible		\$0 You pay 0% after deductible	You pay 0% after deductible ay er	\$15 copay per drug after deductible \$125 copay per drug after deductible \$160 copay per drug after deductible	You pay 50% after deductible	\$0 You pay 25% per drug		You pay 20% per drug	You pay 50% after deductible	You pay 10% per drug	You pay \$0 after	You pay \$0 after deductible		\$0 You pay 10% per drug after deductible		\$0 You pay 20% per drug		\$0 You pay 10% per drug	You pay 50% after deductible
Prescription Drugs	Tier 2: Preferred Brand	You pay 40% after deductible	You pay 50% after deductible	You pay 0% after deductible				You pay 40% per drug	You pay 50% after deductible	You pay 30% per drug You pay 40% per drug You pay 50% per drug		You pay 25% per drug	You pay 50% after deductible	You pay \$0 after deductible	You pay 0% after deductible	You pay 40% per drug after deductible	You pay 50% after deductible	You pay 30% per drug	You pay 50% after deductible	You pay 25% per drug	
	Tier 3: Non- preferred	You pay 50% after deductible	deductible	You pay 0% after deductible				You pay 50% per drug				You pay 35% per drug	deductible	You pay \$0 after deductible	deductible	You pay 50% per drug after deductible		You pay 40% per drug	deddelible	You pay 35% per drug	
	Tier 4: Specialty	You pay 60% after deductible		You pay 0% after deductible		\$185 copay per drug after deductible		You pay 60% per drug				You pay 45% per drug		You pay \$0 after deductible		You pay 60% per drug 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 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 Covere year	d up to 20 visits per	You pay 60% after deductible	You pay 70% after	You pay \$0 after deductible	You pay 0% after	\$60 copay per visit	You pay 70% after	\$65 copay per visit after deductible	You pay 60% after	\$65 copay per visit after deductible	You pay 60% after	\$40 copay per visit	You pay 50% after	You pay 0% after deductible	You pay 0% after	You pay 60% after deductible	You pay 70% after	\$65 copay after deductible	You pay 60% after	\$40 copay per visit	You pay 50% after
Physical, Occupational & Speech Therapy		Vou pay	deductible	You pay 0% after deductible	deductible :	\$60 copay per visit	deductible	\$65 copay per visit after deductible	deductible	\$65 copay per visit after deductible	deductible	\$40 copay per visit	deductible	You pay 0% after deductible	deductible	You pay 60% after deductible	deductible	\$65 copay after deductible	deductible	\$40 copay per visit	deductible
Diagnostic X-Ray & Lab Services Inpatient Hospital Services Maternity Physician, Surgical & Medical Services		You pay 60% after deductible				You pay 50% after deductible		You pay 40% after deductible		You pay 40% after deductible		You pay 30% after deductible						You pay 40% after deductible		You pay 30% after deductible	



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CO-OP Plus (Limited provider choices for Tier 1 Network)

Individuals & Families 2020 Plans		Silver 73		Silver 87		Silver 94		Silver Option 2 73		Silver Option 2 87		Silver Option 2 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	In Network Tier 1	In Network Tier 2	Out of Network	In Network Tier 1	In Network Tier 2	Out of Network	In Network Tier 1	In Network Tier 2	Out of Network	
Deductible		Individual: \$3,500 Family: \$7,000	Individual: \$9,900 Family: \$19,800	Individual: \$500 Family: \$1,000	Individual: \$1,500 Family: \$3,000	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$4,500 Family: \$9,000	Individual: \$13,500 Family: \$27,000	Individual: \$300 Family: \$600	Individual: \$900 Family: \$1,800	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	\$3,	idual: 300 nily: 600	Individual: \$9,900 Family: \$19,800	\$5 Fam	Individual: Indiv \$500 \$1 Family: Fa \$1,000 \$3		Individual: \$0 Family: \$0		Individual: \$0 Family: \$0	
Annual Out-of-Pocket Maximum		Individual: \$6,500 Family: \$13,000	Individual: \$19,800 Family: \$39,600	Individual: \$2,200 Family: \$4,400	Individual: \$6,600 Family: \$13,200	Individual: \$800 Family: \$1,600	Individual: \$2,400 Family: \$4,800	Individual: \$6,500 Family: \$13,000	Individual: \$19,800 Family: \$39,600	Individual: \$2,450 Family: \$4,900	Individual: \$7,350 Family: \$14,700	Individual: \$1,000 Family: \$2,000	Individual: \$3,000 Family: \$6,000	\$6, Fan	idual: 500 nily: ,000	Individual: \$19,800 Family: \$39,600	00 \$2,200 y: Family:		Individual: \$6,600 Family: \$13,200	Individual: \$800 Family: \$1,600		Individual: \$2,400 Family: \$4,800	
Coinsurance		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 30%	You pay 50%	You pay 20%	You pay 40%			You pay 60%	You pay 30%		You pay 50%	You pay 20%		You pay 40%	
Primary Care Provider & Non-specialist Office Visits		1st 10 visits \$40 copay per visit then \$40 copay per visit after deductible	You pay 60% after deductible	1st 10 visits \$15 copay per visit then \$15 copay per visit after deductible	You pay 50% after deductible	\$10 copay per visit	You pay 40%	1st 10 visits \$40 copay per visit then \$40 copay per visit after deductible	You pay 60% after deductible	1st 10 visits \$30 copay per visit then \$30 copay per visit after deductible	You pay 50% after deductible	\$20 copay per visit	You pay 40%	\$5 copay per visit	30% after deductible	You pay 60% after deductible	\$5 copay per visit	30% after deductible	You pay 50% after deductible	\$5 copay per visit	You pay 20%	You pay 40%	
Specialist Office Visits		\$65 copay per visit after deductible	\$45 copay per visit after deductible		\$35 copay per visit		\$65 copay per visit after deductible		\$40 copay per visit		\$25 copay per visit			\$50 copay per visit after deductible		\$45 copay per visit after deductible			\$35 copa	\$35 copay per visit			
Emergency Room Visits			ay 40% eductible	You pa after de	ay 30% ductible	You pay 20%		You pay 40% after deductible		You pay 30% after deductible		You pa	You pay 20%		You pay 30% after ded		ctible You pay 30%		luctible	You pay 20%			
Eye Exam						al reimbursement up to \$60 f		for adult vision exam, any opto								Annual reimb			p to \$60 for adult vision exam, ar				
	Tier 0 Tier 1: Generic	You pay \$0 You pay 10% per drug	You pay 50% after deductible	You pay \$0 You pay 10% per drug		You pay \$0 You pay 10% per drug		You pay 40% per drug		You pay \$0 You pay 10% per drug	_	You pay \$0 You pay 10% per drug			oay \$0 % per drug		You p You pay 10 ^o				oay \$0 0% per drug		
Prescription Drugs	Tier 2: Preferred Brand	You pay 30% per drug		You pay 25% per drug	You pay 50% after deductible	You pay 20% per drug	You pay		50% after	You pay 25% per You pay drug 50% after	50% after	You pay 20% per drug	You pay 40%	You pay 30% per drug		You pay 50% after	You pay 25 ^o	% per drug	You pay 50% after deductible	You pay 20	0% per drug	You pay 40%	
	Tier 3: Non-preferred	You pay 40% per drug		You pay 30% per drug		You pay 25% per drug			deductible	You pay 30% per drug	deductible	You pay 25% per drug		You pay 40% per drug You pay 50% per drug		deductible	You pay 30% per drug		deductible	You pay 25	5% per drug		
	Tier 4: Specialty	You pay 50% per drug		You pay 40% per drug		You pay 30% per drug		You pay 50% per drug		You pay 40% per drug		You pay 30% per drug					You pay 40% per drug			You pay 30)% 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		You pay nothing for preventive services in-network, deductible does not apply	nothing for preventive services in-network, deductible does not apply \$65 copay per visit after deductible 60% after	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 \$65 copay per visit after deductible			0% after 0			preventiv in-network	nothing for ve services s, deductible ot apply		
Chiropractic Care Covered up to 20 visits per year		\$65 copay per visit after deductible	\$45 copay per visit You pay after You		You pay 50% after	\$35 copay per visit	You pay	per visit after		\$40 copay per visit	You pay 50% after	\$25 copay per visit	You pay 40%			You pay 60% after			You pay 0% after	\$35 copa	\$35 copay per visit		
Physical, Occupational & Speech Therapy		\$65 copay per visit after deductible	deductible	\$45 copay per visit after deductible	deductible	\$35 copay per visit	4070	\$65 copay per visit after deductible	deductible	\$40 copay per visit	deductible	\$25 copay per visit		\$65 copay p dedu	per visit after ctible	deductible	\$45 copay p dedu	er visit after ctible	deductible	\$35 copa	ay per visit	40%	
Diagnostic X-Ray & Lab Services Inpatient Hospital Services Maternity		You pay 40% after deductible		You pay 30% after deductible		You pay 20%		You pay 40% after deductible		You pay 30% after deductible		You pay 20%		You pay 40% after deductible			You pay 30% after deductible			You p	ay 20%		
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.

In-network provider:

Doctors, hospitals and other healthcare professionals who are under contract to provide services through your plan. They typically cost you less. You pay co-insurance plus any deductible you owe.

Out-of-network provider:

Healthcare providers who are NOT under contract to provide services through your plan. They typically cost you much more.

Deductible:

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

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.

HSA-compatible:

Denotes a qualified High Deductible Health Plan that can be paired with a Health Savings Account.

Premium:

The amount you pay monthly for your health insurance plan.



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