MONTANAHEALTH INSURANCEANSWERS

Office of the Montana State Auditor CSI Commissioner of Securities & Insurance

2017 GOLD LEVEL Cost Sharing for Individual Plans in the Montana Federal Marketplace

HEALTH PLAN :: In Network	DEDUCTIBLE Ind/Family	MAX OOP Out-of-Pocket Ind/Family	PROVIDER VISITS			HOSPITAL	SURGERY Outpatient	LAB WORK/ IMAGING	ER SERVICES	MENTAL HEALTH SERVICES Office Visit	PRESCRIPTION DRUG COVERAGE 30-day retail order *(Costs differ for 90-day mail order)*			
			PRIMARY CARE	SPECIALIST	PREVENTIVE CARE*						Generic Tier 1	Preferred Brand Tier 2	Non-Preferred Brand Tier 3	Specialty Tier 4/SP
GOLD														
BlueCross BlueShield														
Blue Focus+ Gold POS 101	$500/$1,000	$5,250/$10,500	$20 copay*	$40 copay*	$0	$300 deductible** *per occurrence;* 30% coinsurance after deductible	$200 deductible** *per occurrence*; 30% coinsurance after deductible	30% coinsurance after deductible	$500 deductible** *per occurrence*; 30% coinsurance after deductible	$20 copay*	$0	$50 copay*	$100 copay*	$250 copay*
											$10* non-preferred			
Blue Preferred Gold PPO 104	$1,400/$2,800	$3,350/$6,700	No copay; 20% coinsurance after deductible *(3 $0 PCP visits*)*		$0	$300 deductible** *per occurrence*; 20% coinsurance after deductible	$200 deductible** *per occurrence*; 20% coinsurance after deductible	20% coinsurance after deductible	$750 deductible** 20% coinsurance after deductible	$0	$0	$50 copay*	$100 copay*	$250 copay*
											$10* non-preferred			
BCBS Premier 101 Multi-state Plan	$1,650/$3,300	$3,350/$6,700	No copay; 20% coinsurance after deductible *(3 $0 PCP visits*)*		$0	$300 deductible** *per occurrence* 20% coinsurance after deductible	$200 deductible** *per occurrence*; 20% coinsurance after deductible	20% coinsurance after deductible	$750 deductible** 20% coinsurance after deductible	$0	$0	$50 copay*	$100 copay*	$250 copay*
											$10* non-preferred			
Montana Health Coop														
Access Care	$800/$1,600	$4,750/$9,500	$40 copay*		$0	No copay; 30% coinsurance after deductible				$40 copay*	$10 copay*	$30 copay*	$60 copay*	$75 copay*
Connected Care	$750/$1,500	$5,750/$11,500	$25 copay*	$40 copay*	$0	No copay; 30% coinsurance after deductible			$200 deductible** per visit; 30% coinsurance after deductible	$25 copay*	20% coinsurance*	25% coinsurance*	45% coinsurance*	coinsurance*
PacificSource														
PSN Gold 1500	$1,500/$3,000	$3,000/$6,000	20% coinsurance after deductible		$0	20% coinsurance after deductible					$10 copay*	$50 copay*	$75 copay*	$250 copay*
SmartHealth^ Balance Gold 1500	$1,500/$3,000	$3,000/$6,000	20% coinsurance after deductible		$0	20% coinsurance after deductible					$10 copay*	$50 copay*	$75 copay*	$250 copay*

* Deductible and other cost-sharing do not apply to these services, mandated preventive care services, or prescription drugs, as noted.

** These deductibles are in addition to the plan deductible and any coinsurance.

+ Blue Focus network is available in Carbon, Lake, Missoula, Musselshell, Stillwater, Sweet Grass and Yellowstone counties.

^ SmartHealth network is available in Carbon, Missoula, Musselshell, Park, Stillwater, Sweet Grass and Yellowstone counties.

GLOSSARY of TERMS

Coinsurance: *Patient share of the costs of covered health care services, calculated as a percent of the allowed amount.*

Co-pay: *A fixed dollar amount paid for a covered health care service, usually at the time of service.*

Deductible: *Amount paid by patient before insurer begins to pay. (Unless otherwise noted.)*

OOP Maximum: *The most you could pay during a coverage period for your share of the cost of covered services.*

MONTANA HEALTH INSURANCE ANSWERS

Office of the Montana State Auditor CSI Commissioner of Securities & Insurance

2017 SILVER LEVEL Cost Sharing for Individual Plans in the Montana Federal Marketplace

HEALTH PLAN:: In-Network	DEDUCTIBLE Ind/Family	MAX OOP Out-of-pocket Ind/Family	PROVIDER VISITS: Primary Care	PROVIDER VISITS: Specialist	PROVIDER VISITS: Preventive Care*	HOSPITAL	SURGERY Outpatient	LAB WORK/ IMAGING	ER SERVICES	MENTAL HEALTH SERVICES Office Visit	PRESCRIPTION DRUG COVERAGE 30-day retail order (Costs differ for 90-day mail order): Generic Tier 1	Preferred Brand Tier 2	Non-Preferred Brand Tier 3	Specialty Tier 4/SP
SILVER														
BlueCross BlueShield														
Blue Preferred Silver PPO 101	$3,000/$6,000	$6,600/$13,200	No copay; 20% coinsurance after deductible *(3 $0 PCP visits*)*		$0	$400 deductible** *per occurrence;* 20% coinsurance after deductible	$300 deductible** *per occurrence;* 20% coinsurance after deductible	20% coinsurance after deductible	$600 deductible** *per occurrence;* 20% coinsurance after deductible	$0	$0 $10* non-preferred	$50 copay*	$100 copay*	$250 copay*
Blue Preferred Silver PPO 105	$3,000/$6,000	$4,500/$9,000	20% coinsurance after deductible		$0	20% coinsurance after deductible					$0 after deductible 10% non-preferred	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Blue Focus+ Silver POS 102	$2,500/$5,000	$7,150/$14,300	$40 copay*	$60 copay*	$0	$500 deductible** *per occurrence,* 30% coinsurance after deductible	$300 deductible** *per occurrence;*30% coinsurance after deductible	30% coinsurance after deductible	$600 deductible** *per occurrence;* 30% coinsurance after deductible	$40 copay*	0% coinsurance $10* non-preferred	$50 copay*	$100 copay*	$250 copay*
Blue Focus+ Silver POS 103	$3,850/$7,700	$6,850/$13,700	$15 copay*	$60 copay*	$0	$250 deductible** *per occurrence;* 20% coinsurance after deductible	$200 deductible** *per occurrence;* 20% coinsurance after deductible	20% coinsurance after deductible	$500 deductible** *per occurrence;* 20% coinsurance after deductible	$15 copay*	$0 $10* non-preferred	$50 copay*	$100 copay*	$250 copay*
BCBS Solution 102 Multi State Plan	$3,350/$6,700	$5,600/$11,200	No copay; 20% coinsurance after deductible *(2 $0 PCP visits*)*		$0	$400 deductible** *per occurrence;* 20% coinsurance after deductible	$300 deductible** *per occurrence;* 20% coinsurance after deductible	20% coinsurance after deductible	$750 deductible** *per occurrence;* 20% coinsurance after deductible	$0	$0 $10* non-preferred	$50 copay*	$100 copay*	$250 copay*
Montana Health Coop														
Access Care	$2,250/$4,500	$6,850/$13,700	$35 copay after deductible	No copay; 40% coinsurance after deductible	$0	No copay; 40% coinsurance after deductible				$35 copay after deductible	$15 copay*	$40 copay*	$65 copay*	$100 copay*
Connected Care	$2,150/$4,300	$7,150/$14,300	$35 for first 3 visits, before deductible; then $35 copay on visits after deductible	$65 copay after deductible	$0	No copay; 40% coinsurance after deductible			$200 copay per visit, after deductible	$35 for first 3 visits, before deductible; then $35 copay on visits after deductible	25% coinsurance*	30% coinsurance*	50% coinsurance*	50% coinsurance*
PacificSource														
PSN Silver (HSA) 3000	$3,000/$6,000	$5,000/$10,000	25% coinsurance after deductible		$0	25% coinsurance after deductible					25% coinsurance after deductible			
SmartHealth^ Silver (HSA) 3000	$3,000/$6,000	$5,000/$10,000	25% coinsurance after deductible		$0	25% coinsurance after deductible					25% coinsurance after deductible			

* Deductible and other cost-sharing do not apply to these services, mandated preventive care services, or prescription drugs, as noted.

** These deductibles are in addition to the plan deductible and any coinsurance.

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MONTANA HEALTH INSURANCE ANSWERS

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2017 BRONZE LEVEL Cost Sharing for Individual Plans in the Montana Federal Marketplace

HEALTH PLAN :: IN NETWORK	DEDUCTIBLE Ind/Family	MAX OOP Out-of-pocket Ind/Family	PROVIDER VISITS			HOSPITAL	SURGERY Outpatient	LAB WORK/ IMAGING	ER SERVICES	MENTAL HEALTH SERVICES Office Visit	PRESCRIPTION DRUG COVERAGE 30-day retail order *(Costs differ for 90-day mail order)*			
			PRIMARY CARE	SPECIALIST	PREVENTIVE CARE*						Generic Tier 1	Preferred Brand Tier 2	Non-Preferred Brand Tier 3	Specialty Tier 4/SP
BRONZE														
BlueCross BlueShield														
Blue Preferred Bronze PPO 006	$6,500/$13,000	$6,500/$13,000	No copay; 0% after deductible		$0	No copay; 0% after deductible					No copay; $0 after deductible			
Blue Preferred Bronze PPO 102	$5,000/$10,000	$6,550/$13,100	No copay; 40% coinsurance after deductible		$0	40% coinsurance after deductible					30% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible
Blue Preferred Bronze PPO 103	$6,350/$12,700	$7,150/$14,300	No copay; 30% coinsurance after deductible		$0	30% coinsurance after deductible					$0 copay $10* copay non-preferred	$50 copay*	$100 copay*	$250 copay*
Blue Focus+ POS 104	$6,000/$12,000	$7,150/$14,300	No copay; 20% coinsurance after deductible *(1 $0 PCP visit*)*		$0	$750 deductible** *per occurrence;* 20% coinsurance	$ 400 deductible** *per occurrence*; 20% coinsurance after deductible	$80 deductible** labs; $700 deductible** imaging *per occurrence*; 20% coinsurance after deductible	$1000 deductible** *per occurrence*; 20% coinsurance after deductible	$0	$0 after deductible 20% coinsurance non-preferred	30% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
BCBS Basic 103 Multi State Plan	$6,100/$12,200	$7,150/$14,300	No copay; 30% coinsurance after deductible *(1 $0 PCP visit*)*		$0	$750 deductible** *per occurrence*; 30% coinsurance after deductible	$400 deductible** *per occurrence;* 30% coinsurance after deductible	$500 deductible** imaging; 30% coinsurance after deductible	$1000 deductible**; 30% coinsurance after deductible	$0	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Montana Health Coop														
Access Care	$5,250/$10,500	$7,150/$14,300	60% coinsurance after deductible		$0	No copay; 60% coinsurance after deductible					$25 copay	$125 copay	$160 copay	$185 copay
Access Care PLUS	$5,750/$11,500	$6,550/$13,100	60% coinsurance after deductible		$0	No copay; 60% coinsurance after deductible					$25 copay	$125 copay	$160 copay	$185 copay
Connected Care	$5,550/$11,100	$7,150/$14,300	$40 for first 3 visits, before deductible; then $40 copay on visits after deductible	50% coinsurance after deductible	$0	50% coinsurance after deductible				$40 for first 3 visits, before deductible; then $40 copay on visits after deductible	35% coinsurance	40% coinsurance	60% coinsurance	60% coinsurance
Connected Care PLUS	$6,550/$13,100	$6,550/$19,650	0% after deductible		$0	0% after deductible					0% after deductible			
											*(All above MHC drug plan cost-sharing is **after** deductible)*			
PacificSource														
PSN Bronze (HSA) 6550	$6,550/$13,100	$6,550/$13,100	No charge after deductible		$0	No charge after deductible					No charge after deductible			
SmartHealth^ Bronze (HSA)6550	$6,550/$13,100	$6,550/$13,100	No charge after deductible		$0	No charge after deductible					No charge after deductible			

* Deductible and other cost-sharing do not apply to these services, mandated preventive care services, or prescription drugs, as noted.

** These deductibles are in addition to the plan deductible and any coinsurance.

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MONTANA HEALTH INSURANCE ANSWERS

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2017 CATASTROPHIC* LEVEL Cost Sharing for Plans in the Montana Federal Marketplace

HEALTH PLAN :: In Network	DEDUCTIBLE Ind/Family	MAX OOP Out-of-Pocket Ind/Family	PROVIDER VISITS			HOSPITAL	SURGERY Outpatient	LAB WORK/ IMAGING	ER SERVICES	MENTAL HEALTH SERVICES Office Visit	PRESCRIPTION DRUG COVERAGE 30-day retail order *(Costs differ for 90-day mail order)*			
			PRIMARY CARE	SPECIALIST	PREVENTIVE CARE						Generic Tier 1	Preferred Tier 2	Non-Preferred Tier 3	Specialty Tier 4/SP
CATASTROPHIC														
BlueCross BlueShield														
Blue Preferred Security PPO 100	$7,150/$14,300	$7,150/$14,300	3 $50 copay visits*; then $0 after deductible	$0 after deductible	$0	No copay; $0 after deductible					No copay; $0 after deductible			
Montana Health Coop														
Access Care	$7,150/$14,300	$7,150/$14,300	3 $0 visits** before deductible	0% after deductible	$0	0% after deductible				3 $0 visits** before deductible	0% after deductible			

* A **catastrophic health plan** meets all of the requirements applicable to other Qualified Health Plans (QHPs) but does not cover any benefits other than **3 primary care visits** per year before the plan's deductible is met. The premium amount you pay each month for healthcare is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. To qualify for a catastrophic plan, you must be under 30 years old OR get a "hardship exemption" because the Marketplace determined that you're unable to afford health coverage.

** First 3 visits combined between chemical dependency, mental health and primary care office visits.

Please Note: This chart is a summary and for comparison only. For more detail about specific coverage and associated costs/charges, you must refer to the individual health plan documents available online at each insurer's website:

www.bcbsmt.com
www.mhc.coop
www.PacificSource.com