



2020 GOLD LEVEL Cost	Sharing for	Individual	Plans in th	e Montan	a Federa	l Marketplace	е								
	DEDUCTIBLE	MAX OOP Out-of-Pocket	PROVIDER VISITS			HOSPITAL	SURGERY	LAB WORK /	ER SERVICES	MENTAL HEALTH	PRESCRIPTION DRUG COVERAGE 3 O-day retail order (Cost: differ for 90-day mail order)				
HEALTH PLAN :: In Network	Ind/Family	Ind/Family	PRIMARY CARE Office Visit	SPECIALIST Office Visit	PREVENTIVE CARE*	HOSTITAL	Outpatient	IMAGING	ENSERVICES	SERVICES Office Visit	Generic Tier 1	Preferred Brand Tier 2	Non-Preferred Brand Tier 3	Specialty Tier 4/SP	
GOLD															
BlueCross BlueShield															
			2 \$10 copay visits*	30% co-					\$15 copay/visit*		\$5 copay*	\$50 copay*	\$100 copay*	\$250 copay*	
Blue Preferred Gold PPO 204	\$750/\$1,500	\$8,150/\$16,300	then 30% co- insurance after deductible met	insurance* after deductible met	\$0	\$850 deductible/visit** + 30% co-insurance	30% co-insurance after deductible met	r 30% co-insurance after deductible met	for Urgent Care \$1,000 deductible/visit** + 30% co-insurance	30% co-insurance* after deductible met	30-day retail order (Costs differ for 90-day mail order) Generic Tier 1 Preferred Brand Tier 2 Non-Preferred Brand Tier 3 \$55 copay* \$50 copay* \$100 copay* \$10 copay* non-preferred preferred \$70 copay* non-preferred	\$250 copay* non- preferred			
		\$8,150/\$16,300	20% co-insurance		\$0	\$850 deductible/visit** + 40% co-insurance	\$600 deductible/visit** + 40% co-insurance	40% co-insurance*	40% co-insurance/visit for Urgent Care \$1,000 deductible/visit + 40% co-insurance		10% co-insurance	30% co-insurance	35% co-insurance	45% co-insurance	
Blue Focus Gold POS 207	\$300/\$600			40% co- insurance*						20% co-insurance*	20% co-insurance non- preferred			45% co-insurance no preferred	
Montana Health Co-op							•	•	•						
Connected Care Gold	\$750/\$15,000	\$5,750/\$11,500	\$35 copay per visit	\$40 copay per visit	\$0		30% co-insuranc	ce After Deductible		\$35 copay per visit				45% co-insurance prescription	
Co-op Plus Gold	\$750/\$15,000	\$5,750/\$11,500	Tier 1: \$5 copay per visit Tier 2: 30% co- insurance After Deductible	\$40 / Visit	\$0	30% co-insurance After Deducti			Tier 1: \$5 v After Deductible Tier 2: insurar Dedu		· ·			45% co-insurance pe prescription	
PacificSource															
Navigator Gold 1500	\$1,500/\$3,000	\$5,000/\$10,000	After deduc	tible 10%	No deductible, \$0			No deductible, \$15	No deductible, \$50	No deductible, \$75	No deductible, \$250				
Voyager Gold 1500	\$1,500/\$3,000	\$5,000/\$10,000	After deduc	tible 10%	No deductible, \$0			After deductible 10%			No deductible, \$15	No deductible, \$50	No deductible, \$75	No deductible, \$25	
OLD															

GLOSSARY of TERMS Co-insurance: 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.

^{*} 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.

[^] Navigator product is available in Carbon, Flathead, Lake, Lewis & Clark, Missoula, Musselshell, Park, Stillwater, Sweet Grass and Yellowstone counties.





2020 SILVER LEVEL Cos	t Sharing	for Individ	lual Plans i	n the Mor	ntana Fe	deral Market	place									
	DEDUCTIBLE	MAX OOP	PROVIDER VISITS				SURGERY	LAB WORK/	ER SERVICES	MENTAL HEALTH	PRESCRIPTION DRUG COVERAGE 30-day retail order (Costs differ for 90-day mail order)					
HEALTH PLAN:: In-Network	Ind/Family	Out-of-pocket Ind/Family	PRIMARY CARE Office Visit	SPECIALIST Office Visit	PREVENTIVE CARE*	HOSPITAL	Outpatient	IMAGING	ER SERVICES	SERVICES Office Visit	Generic Tier 1	Preferred Brand Tier 2	Non-Preferred Brand Tier 3	Specialty Tier 4/SP		
SILVER																
BlueCross BlueShield			•							•		_				
			409/ so incurance	FOW on incurance		\$850	\$600		50% co-insurance/visit fo	40% co-insurance	20% co-insurance after deductible met	30% co-insurance after deductible met	35% co-insurance after deductible met	45% co-insurance after deductible met		
Blue Preferred Silver PPO 203	\$650/\$1,300	\$8,150/\$16,300		e 50% co-insurance after deductible met	\$0	deductible/visit* + 50% co-insurance after deductible met	deductible/visit** + 50% co-insurance after deductible met	50% co-insurance after deductible met	Urgent Care* \$1,000 deductible/visit** 50% co-insurance after deductible met	after deductible met	25% co-insurance after deductible met non- preferred	35% co-insurance after deductible met non- preferred	40% co-insurance after deductible met non-preferred	45% co-insurance after deductible met non- preferred		
								•			\$10 copay*	\$50 copay*	\$100 copay*	\$250 copay*		
Blue Preferred Silver PPO 308	\$8,150/\$16,300	\$8,150/\$16,300	\$0 after dec	luctible met	\$0		\$0 after deductible met					\$100 copay* non- preferred	\$150 copay* non- preferred	\$250 copay* non- preferred		
						4			\$40 copay/visit for Urgent Care* \$1,000 deductible/visit** 50% co-insurance after deductible met		\$5 copay*	\$50 copay*	\$100 copay*	\$250 copay*		
Blue Focus Silver POS 206	\$4,000/\$8,000	\$8,150/\$16,300	2 \$25 copay then 50% co-insurance after deductible met	50% co-insurance after deductible met	\$0	\$850 deductible/visit* + 50% co-insurance after deductible met	50% co-insurance after deductible met	50% co-insurance after deductible met		50% co-insurance after deductible met	\$10 copay* non- preferred	\$70 copay non- preferred	\$120 copay* non- preferred	\$250 copay* non- preferred		
Montana Health Co-op			L				•			ı						
Connected Care Silver	\$4,000/\$8,000	\$8,150/\$16,300	First 10 visits \$40 copay per visits, Then \$40 copay per visit After Deductible	\$65 copay per visit After Deductible	\$0		40% co-insura	nce After Deductible		First 10 visits \$40 copay per visits, Then \$40 copay per visit After Deductible	20% co-insurnace per prescription	30% co-insurance per prescription	40% co-insurance per prescription	50% co-insurance per prescription		
Connected Care Silver Option 2	\$5,700/\$11,400	\$8,150/\$16,300	First 10 visits \$40 copay per visits, Then \$40 copay per visit After Deductible	\$65 copay per visit After Deductible	\$0		40% co-insura	nce After Deductible		First 10 visits \$40 copay per visits, Then \$40 copay per visit After Deductible	25% co-insurance per prescription	40% co-insurance per prescription	50% co-insurance per prescription	60% co-insurance per prescription		
Co-op Plus Silver	\$4,000/\$8,000	\$8,150/\$16,300	Tier 1: \$10 copay per visit Tier 2: 40% co- insurance After Deductible	\$65 copay per visit After Deductible	\$0		Tier 1: \$10 copa per visit 40% co-insurance After Deductible Tier 2: 40% co- insruance After Deductible				20% co-insurnace per prescription	30% co-insurance per prescription	40% co-insurance per prescription	50% co-insurance per prescription		
PacificSource						1										
Voyager Silver HSA 3500	\$3,500/\$7,000	\$6,750/\$13,500	After dedu	ctible 25%	\$0, No deductible			After deductible 25%	6		After dedu	uctible 25%				
Navigator Silver HSA 3500	\$3,500/\$7,000	\$6,750/\$13,500	After dedu	ctible 25%	\$0, No deductible			After deductible 25%	<u> </u>		After deductible 25%					
Voyager Silver 5000	\$5,000/\$10,000	\$8,150/\$16,300	No deductible \$35	No deductible \$70	\$0, No deductible		After de	eductible 30%		No deductible \$35	After deductible 30%					
Navigator Silver 5000	\$5,000/\$10,000	\$8,150/\$16,300	No deductible \$35	No deductible \$70	\$0, No deductible		After de	eductible 30%		No deductible \$35		After dedu	uctible 30%			
SILVER										•						

^{*} 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.

[^] Navigator product is available in Carbon, Flathead, Lake, Lewis & Clark, Missoula, Musselshell, Park, Stillwater, Sweet Grass and Yellowstone counties.





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Annie Port Part				-	PROVIDER VISITS		HOSPITAL			ER SERVICES	HEALTH		30-day rei (Costs differ for 90	ail order I-day mail order)	ı	
## Preferred Bronzs PTO 201 \$1,210/51,200 \$1,210/51,200 \$1,210/51,200 \$2,210/		may anny	Ind/Family					Outputient	IIVIAGIIVG				Preferred Brand Tier 2		Specialty Tier 4/SP	
Make Peterse Bronze PFO 201 13, 2055, 1/20 25, 100 13, 100				Office visit	Office Visit	CARE										
Make Preferred Bronce PPO 201 \$2,120/54,700 \$2,120/54,00																
### Preferred fromas PPO 201 \$2,280,053,700 \$5,150,054,000 \$2,150,054,000 \$2,150,054,000 \$2,150,054,000 \$3,150,054,000 \$3,150,054,000 \$4,150	ueCross BlueShield								l			0% co-insurance		35% co-insurance	45% co-insur:	
1							6050			\$40 copay/visit for	F00/	after deductible		after deductible	after deduct	
## defection of the control of the c	Dive Deefersed Deeper DDO 201	£2.050/£5.700	¢0.450/¢46.200	2 \$25 visits* then	50% co-insurance	ćo.						met	arter deddetible met	met	met	
Make Preferred Broate PO 202 3,100/56,00 56,750/513,00	blue Preferreu brotize PPO 201	\$2,850/\$5,700	\$8,150/\$16,500	after ded	uctible met	\$0									45% co-insur	
Section Sect							arter deductible met			deductible met	met				met non-pref	
Section Sect												20% co-incurance	·	35% co-insurance	45% co-insur	
Mile Preferred Bronze PD 202 \$3,100/56,200 \$4,750/513,000 \$0,150/516,100 \$0,150/516,000 \$0,150							\$850				30%	after deductible		after deductible	after deduct	
describe met descr	Blue Preferred Bronze PPO 202	\$3.100/\$6.200	\$6.750/\$13.500			\$0	deductible/visit* +			\$1,000 deductible per	coinsurance			assistant de la composición del composición de la composición de la composición de la composición de la composición del composición de la		
Section Sect	HEALTH PLAN :: IN NETWORK BRONZE BlueCross BlueShield Blue Preferred Bronze PPO 201 Blue Preferred Bronze PPO 301 Blue Preferred Bronze PPO 301 Blue Focus Bronze POS 205 Montana Health Co-op Connected Care Bronze Plus Connected Care Expanded Bronze Co-op Plus Bronze PacificSource Voyager Bronze HSA 6750 Navigator Bronze PSO 300	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	deduct	ible met	, ,									45% co-insura after deduct	
Section Sect										deductible met					met non-pref	
Section Sect									•							
Section Sect	Blue Preferred Bronze PPO 301	\$8,150/\$16,300	\$8,150/\$16,300	\$0 after de	ductible met	\$0		\$0 at	fter deductible me	t			\$0 after deductible met			
Section Sect																
Ses of deductible/wire* some contained for deductible met after deductib									50% co-				20% co-insurance		45% co-insur	
Super Focus Bronze POS 205 \$4,400/58,800 \$8,150/516,300 \$2,40 water the deductible met after deductible								\$600 deductible/visit*					after deductible met			
after deductible met after deductible met after deductible met after deductible met non-preferred after deductible met non-preferred met n	Blue Focus Bronze POS 205	\$4,400/\$8,800	\$8,150/\$16,300			\$0		+ 50% co-insurance	insurance after	deductible per visit** +		10% co-insurance	30% co-insurance	40% co-insurance	45% co-insura	
Interest Corp Plus Bronze 57,200/\$14,400 58,150/\$16,300 58,								after deductible met	deductible met			after deductible	after deductible met	after deductible	after deduct	
Someted Care Bronze Sr,200/\$14,400 S8,150/\$16,300 S8,150/\$1												met non-preferred	non-preferred	met non-preferred	met non-prefe	
Somected Care Bronze \$7,200/\$14,400 \$8,150/\$16,300 vist After Deductible After Deductible After Deductible After Deductible No Charge After Deductible S50 copay per visit No Charge After Deductible No Charge After Deductible No Charge After Deductible S15 Copay per prescription After Deductible No Charge After Deductible No Charge After Deductible S15 Copay per visit Ter 1: \$10 copay per visit Ter 2: \$0% co-insurance After Deductible No Co-insurance After Deductible No Charge After Deductible S15 Copay per visit Ter 2: \$10 copay per vi	ontana Health Co-op	T		<u> </u>		İ	l						ı			
Somected Care Bronze \$7,200/\$14,400 \$8,150/\$16,300 vist After Deductible After Deductible After Deductible After Deductible No Charge After Deductible S50 copay per visit No Charge After Deductible No Charge After Deductible No Charge After Deductible S15 Copay per prescription After Deductible No Charge After Deductible No Charge After Deductible S15 Copay per visit Ter 1: \$10 copay per visit Ter 2: \$0% co-insurance After Deductible No Co-insurance After Deductible No Charge After Deductible S15 Copay per visit Ter 2: \$10 copay per vi				\$60 copay per							\$60 consy per	10% co-incurance	40% co-insurance per	50% co-insurance	60% co-insur	
Deductible Score Plus Score Plus Score Plus Bronze Score P	Connected Care Bronze	\$7,200/\$14,400	\$8,150/\$16,300	visit After	60% co-insurance	\$0		60% co-insurance	After Deductible		visit After	per prescription	prescription After	per prescription	per prescrip	
Connected Care Expanded Bronze S5,500/S11,000 S8,150/S16,300 S6,750/S13,500 After deductible O% No deductible S0 After deductible O% S0 S0,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 After deductible O% No deductible S0 No deductible S0 No deductible S0 No deductible O% S0 S0,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 After deductible O% No deductible S0 No deductible S0 No deductible S0 No deductible O% No deductible S0 No deductible O% No deductible O% No deductible S0				Deductible	Arter beductible						Deductible	After Deductible	Deductible	After Deductible	After Deduct	
Connected Care Expanded Bronze S5,500/S11,000 S8,150/S16,300 S6,750/S13,500 After deductible O% No deductible S0 After deductible O% S0 S0,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 After deductible O% No deductible S0 No deductible S0 No deductible S0 No deductible O% S0 S0,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 S6,750/S13,500 After deductible O% No deductible S0 No deductible S0 No deductible S0 No deductible O% No deductible S0 No deductible O% No deductible O% No deductible S0	Connected Care Bronze Plus	¢6 000/¢13 900	¢6 000/¢12 900	No Charge Af	ter Deductible	én.		No Ch:	arge After Deductil	nle.			No Charge Aft	ar Daductible		
Source Expanded Bronze S5,500/\$11,000 \$8,150/\$16,30	Jointected Care Diolize Flas	\$0,500,\$13,600	\$0,500/\$15,000	no charge / ii	ter beddetible	Şō			arge / inter Deduction				I	. Deddensie		
Solution and the performance of				Ć50							ć=0	\$15 Copay per	\$125 Copay per	\$160 Copay per	\$185 Copay	
Co-op Plus Bronze S7,200/\$14,400 S8,150/\$16,300 Tier 1: \$10 copay per visit Tier 2: 60% co-insurance After Deductible S0 S6,750/\$13,500 S6,750/\$13,500 S6,750/\$13,500 S6,750/\$13,500 After deductible 0% S0 S6,750/\$13,500 S6,750/\$13,500 S6,750/\$13,500 After deductible 0% S0 After deductible 0% S0 After deductible 0% S0 After deductible 0% S0 S7,000/\$14,000 S8,150/\$16,300 S0 After deductible 0% S0 S35 After deductible 0% S0	Connected Care Expanded Bronze	\$5,500/\$11,000	\$8,150/\$16,300		\$60 copay per visit	\$0		50% co-insurance A	After Deductible						prescription a	
Co-op Plus Bronze S7,200/\$14,400 \$8,150/\$16,300 \$8,150/\$16,												Deductible	Deductible	Deductible	Deduction	
So plus Bronze St. 150/514,400 S8,150/516,300 Tier 2: 60% co-insurance After Deductible S0 60% co-insurance After Deductib				Tier 1: \$10 copay							Tier 1: \$10					
After Deductible After Deduc	Co. on Dive Drawn	£7 200/£14 400	¢0 150/¢16 200		60% co-insurance	ćo		COOK on incurance	After Deductible						60% co-insur	
After deductible 0% After deductible 0% No deductible 0% No deductible 0% No deductible 0% After d	Co-op Plus Bronze	\$7,200/\$14,400	\$8,150/\$16,300		After Deductible	\$0		60% co-insurance A	Arter Deductible						After Deduct	
/oyager Bronze HSA 6750 \$6,750/\$13,500 \$6,750/\$13,500 \$6,750/\$13,500 After deductible 0% No deductible 0% After deductible 0% After deductible 0% After deductible 0% /oyager Bronze 7000 \$7,000/\$14,000 \$8,150/\$16,300 No deductible 0% No deductible 0% No deductible 0% No deductible 0% /oyager Bronze 7000 \$7,000/\$14,000 \$8,150/\$16,300 No deductible 0% No deductible 0% No deductible 0% /oyager Bronze 7000 \$7,000/\$14,000 \$8,150/\$16,300 No deductible 0% After deductible 40% No deductible 0%				Deductible							Deductible					
After deductible 0% Se,750/\$13,500 Se,750/\$13,500 After deductible 0% So After deductible 0% Aft	acificSource					No doductible										
After deductible No deductible No deductible No deductible No deductible After	Voyager Bronze HSA 6750	\$6,750/\$13,500	\$6,750/\$13,500	After ded	luctible 0%	\$0	After deductible 0%					After deductible 0%				
S7,000/\$14,000	Navigator Bronze HSA 6750	\$6,750/\$13,500	\$6,750/\$13,500	After ded	luctible 0%		After deductible 0%					After deductible 0%				
	Voyager Bronze 7000	\$7,000/\$14,000	\$8,150/\$16,300					After deduc	tible 40%			After deductible 40%				
	Navigator Bronze 7000	\$7,000/\$14,000	\$8,150/\$16,300					After deduc	tible 40%				After dedu	ctible 40%		

^{*} Deductible and other cost-sharing do not apply to these services, mandated preventive care services, or prescription drugs, as note

^{**} 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 countie

[^] Navigator product is available in Carbon, Flathead, Lake, Lewis & Clark, Missoula, Musselshell, Park, Stillwater, Sweet Grass and Yellowstone counties.





2020 CATASTROPHIC Cos	t Sharing f	or Individua	al Plans in the	e Montana	Federa	l Marketpla	асе							
	DEDUCTIBLE Ind/Family	MAX OOP Out-of-Pocket	PRO	VIDER VISITS		HOSPITAL	SURGERY Outpatient	LAB WORK/	ER SERVICES	MENTAL HEALTH	PRESCRIPTION DRUG COVERAGE 30-day retail order (Costs differ for 90-day mail order)			
HEALTH PLAN :: In Network		Ind/Family	PRIMARY CARE Office Visit	SPECIALIST Office Visit	PREVENTIVE CARE			IMAGING		SERVICES Office Visit	Generic Tier 1	Preferred Tier 2	Non-Preferred Tier 3	Specialty Tier 4/SP
CATASTROPHIC														
BlueCross BlueShield														
Blue Preferred Security PPO 200	\$8,150/\$16,300	\$8,150/\$16,300	3 \$20 copay visits* then \$0 after deductible is met	\$0 after deductible met	\$0	\$0 after deductible met \$0 after 0						deductible met		
Montana Health Co-op														
Connected Care Expanded Bronze	\$8,150/\$16,300	\$8,150/\$16,300	First 3 Visits \$0 Copay, Then No Charge After Deductible	No Charge After Deductible	\$0	No Charge After Deductible				First 3 Visits \$0 Copay, Then No Charge After Deductible	No Charge After Deductible			
CATASTROPHIC														

^{*} 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.

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

^{**} First 3 visits combined between Chemical Dependency, Mental Health, & Primary Care office visits.