

2020 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 <i>(Costs differ for 90-day mail order)</i>			
			PRIMARY CARE Office Visit	SPECIALIST Office Visit	PREVENTIVE CARE*						Generic Tier 1	Preferred Brand Tier 2	Non-Preferred Brand Tier 3	Specialty Tier 4/SP
GOLD														
BlueCross BlueShield														
Blue Preferred Gold PPO 204	\$750/\$1,500	\$8,150/\$16,300	2 \$10 copay visits* then 30% co-insurance after deductible met	30% co-insurance* after deductible met	\$0	\$850 deductible/visit** + 30% co-insurance	30% co-insurance after deductible met	30% co-insurance after deductible met	\$15 copay/visit* for Urgent Care \$1,000 deductible/visit** + 30% co-insurance	30% co-insurance* after deductible met	\$5 copay*	\$50 copay*	\$100 copay*	\$250 copay*
Blue Focus Gold POS 207	\$300/\$600	\$8,150/\$16,300	20% co-insurance*	40% 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	20% co-insurance*	10% co-insurance	30% co-insurance	35% co-insurance	45% co-insurance
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-insurance After Deductible			\$35 copay per visit	10% co-insurance per prescription	25% co-insurance per prescription	35% co-insurance per prescription	45% co-insurance per 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 Deductible			Tier 1: \$5 copay per visit Tier 2: 30% co-insurance After Deductible	10% co-insurance per prescription	25% co-insurance per prescription	35% co-insurance per prescription	45% co-insurance per prescription	
PacificSource														
Navigator Gold 1500	\$1,500/\$3,000	\$5,000/\$10,000	After deductible 10%	No deductible, \$0		After deductible 10%				No deductible, \$15	No deductible, \$50	No deductible, \$75	No deductible, \$250	
Voyager Gold 1500	\$1,500/\$3,000	\$5,000/\$10,000	After deductible 10%	No deductible, \$0		After deductible 10%				No deductible, \$15	No deductible, \$50	No deductible, \$75	No deductible, \$250	
GOLD														

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 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 Office Visit	SPECIALIST Office Visit	PREVENTIVE CARE*						Generic Tier 1	Preferred Brand Tier 2	Non-Preferred Brand Tier 3	Specialty Tier 4/SP
SILVER														
BlueCross BlueShield														
Blue Preferred Silver PPO 203	\$650/\$1,300	\$8,150/\$16,300	40% co-insurance after deductible met	50% co-insurance after deductible met	\$0	\$850 deductible/visit* + 50% co-insurance after deductible met	\$600 deductible/visit** + 50% co-insurance after deductible met	50% co-insurance after deductible met	50% co-insurance/visit for Urgent Care* \$1,000 deductible/visit** + 50% co-insurance after deductible met	40% co-insurance after deductible met	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 308	\$8,150/\$16,300	\$8,150/\$16,300	\$0 after deductible met			\$0 after deductible met					\$10 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	\$40 copay/visit for Urgent Care* \$1,000 deductible/visit** + 50% co-insurance after deductible met	50% co-insurance after deductible met	\$5 copay*	\$50 copay*	\$100 copay*	\$250 copay*
Montana Health Co-op														
Connected Care Silver	\$4,000/\$8,000	\$8,150/\$16,300	First 10 visits \$40 copay per visit, Then \$40 copay per visit After Deductible	\$65 copay per visit After Deductible	\$0	40% co-insurance After Deductible				First 10 visits \$40 copay per visit, Then \$40 copay per visit After Deductible	20% co-insurance 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 visit, Then \$40 copay per visit After Deductible	\$65 copay per visit After Deductible	\$0	40% co-insurance After Deductible				First 10 visits \$40 copay per visit, 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	40% co-insurance After Deductible				Tier 1: \$10 copay per visit Tier 2: 40% co-insurance After Deductible	20% co-insurance per prescription	30% co-insurance per prescription	40% co-insurance per prescription	50% co-insurance per prescription
PacificSource														
Voyager Silver HSA 3500	\$3,500/\$7,000	\$6,750/\$13,500	After deductible 25%			\$0, No deductible	After deductible 25%				After deductible 25%			
Navigator Silver HSA 3500	\$3,500/\$7,000	\$6,750/\$13,500	After deductible 25%			\$0, No deductible	After deductible 25%				After deductible 25%			
Voyager Silver 5000	\$5,000/\$10,000	\$8,150/\$16,300	No deductible \$35	No deductible \$70	\$0, No deductible	After deductible 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 deductible 30%				No deductible \$35	After deductible 30%			
SILVER														

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

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2020 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 <i>(Costs differ for 90-day mail order)</i>			
			PRIMARY CARE Office Visit	SPECIALIST Office Visit	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 201	\$2,850/\$5,700	\$8,150/\$16,300	2 \$25 visits* then 50% co-insurance after deductible met		\$0	\$850 deductible/visit* + 50% co-insurance after deductible met	\$600 deductible/visit* + 50% co-insurance after deductible met	50% co-insurance after deductible met	\$40 copay/visit for Urgent Care* \$1,000 deductible per visit** + 50% co-insurance after deductible met	50% coinsurance after deductible met	0% co-insurance after deductible met	20% co-insurance after deductible met	35% co-insurance after deductible met	45% co-insurance after deductible met
Blue Preferred Bronze PPO 202	\$3,100/\$6,200	\$6,750/\$13,500	30% co-insurance after deductible met		\$0	\$850 deductible/visit* + 30% co-insurance after deductible met	\$600 deductible/visit* + 30% co-insurance after deductible met	30% co-insurance after deductible met	30% co-insurance/visit for Urgent Care* \$1,000 deductible per visit** + 30% co-insurance after deductible met	30% coinsurance after deductible met	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 Bronze PPO 301	\$8,150/\$16,300	\$8,150/\$16,300	\$0 after deductible met		\$0	\$0 after deductible met				\$0 after deductible met				
Blue Focus Bronze POS 205	\$4,400/\$8,800	\$8,150/\$16,300	2 \$40 visits* then 50% co-insurance after deductible met		\$0	\$850 deductible/visit* + 50% co-insurance after deductible met	\$600 deductible/visit* + 50% co-insurance after deductible met	50% co-insurance after deductible met	\$40 copay/visit for Urgent Care* \$1,000 deductible per visit** + 50% co-insurance after deductible met	50% coinsurance after deductible met	0% co-insurance after deductible met	20% co-insurance after deductible met	35% co-insurance after deductible met	45% co-insurance after deductible met
Montana Health Co-op														
Connected Care Bronze	\$7,200/\$14,400	\$8,150/\$16,300	\$60 copay per visit After Deductible	60% co-insurance After Deductible	\$0	60% co-insurance After Deductible				\$60 copay per visit After Deductible	10% co-insurance per prescription After Deductible	40% co-insurance per prescription After Deductible	50% co-insurance per prescription After Deductible	60% co-insurance per prescription After Deductible
Connected Care Bronze Plus	\$6,900/\$13,800	\$6,900/\$13,800	No Charge After Deductible		\$0	No Charge After Deductible				No Charge After Deductible				
Connected Care Expanded Bronze	\$5,500/\$11,000	\$8,150/\$16,300	\$50 copay per visit	\$60 copay per visit	\$0	50% co-insurance After Deductible				\$50 copay per visit	\$15 Copay per prescription After Deductible	\$125 Copay per prescription After Deductible	\$160 Copay per prescription After Deductible	\$185 Copay per prescription After Deductible
Co-op Plus Bronze	\$7,200/\$14,400	\$8,150/\$16,300	Tier 1: \$10 copay per visit Tier 2: 60% co-insurance After Deductible	60% co-insurance After Deductible	\$0	60% co-insurance After Deductible				Tier 1: \$10 copay per visit Tier 2: 60% co-insurance After Deductible	10% co-insurance per prescription After Deductible	40% co-insurance per prescription After Deductible	50% co-insurance per prescription After Deductible	60% co-insurance per prescription After Deductible
PacificSource														
Voyager Bronze HSA 6750	\$6,750/\$13,500	\$6,750/\$13,500	After deductible 0%		No deductible \$0	After deductible 0%				After deductible 0%				
Navigator Bronze HSA 6750	\$6,750/\$13,500	\$6,750/\$13,500	After deductible 0%		No deductible \$0	After deductible 0%				After deductible 0%				
Voyager Bronze 7000	\$7,000/\$14,000	\$8,150/\$16,300	No deductible \$35	After deductible 40%	No deductible \$0	After deductible 40%				No deductible \$35	After deductible 40%			
Navigator Bronze 7000	\$7,000/\$14,000	\$8,150/\$16,300	No deductible \$35	After deductible 40%	No deductible \$0	After deductible 40%				No deductible \$35	After deductible 40%			
BRONZE														

* 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
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2020 CATASTROPHIC 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 <i>(Costs differ for 90-day mail order)</i>					
			PRIMARY CARE Office Visit	SPECIALIST Office Visit	PREVENTIVE CARE						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 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.

** First 3 visits combined between Chemical Dependency, Mental Health, & 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