MONTANA HEALTH INSURANCE ANSWERS

CSI

2021 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 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 per person/$1,500 per group	$8,500 per person/$17,100 per group	$10	30% Coinsurance after deductible	No Charge	$850 copay per stay with deductible, and 30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	$1,000 copay with deductible, and 30% coinsurance after deductible	30% Coinsurance after deductible	$5/$10	$10/$20	$50/$70	$100/$120
Blue Focus Gold POS 207	$300 per person/$600 per group	$8,500 per person/$17,100 per group	20% Coinsurance after deductible	40% Coinsurance after deductible	No Charge	$850 copay per stay with deductible, and 40% coinsurance after deductible	$600 copay with deductible, and 40% coinsurance after deductible	40% coinsurance after deductible	$1,000 copay with deductible, and 40% coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible/20% Coinsurance after deductible	20% Coinsurance after deductible/30% Coinsurance after deductible	30% Coinsurance after deductible/35% Coinsurance after deductible	35% Coinsurance after deductible/40% Coinsurance after deductible
Mountain Health Co-op														
Connected Care Gold	$1,000/$2,000	$6,000/$12,000	$35 copay per visit	$50 copay per visit	**$0	30% coinsurance after deductible		40% coinsurance after deductible		$35 copay per visit	10% Coinsurance	25% Coinsurance	35% Coinsurance	45% Coinsurance
Co-op Plus Gold	$750/$1,500	$7,000/$14,000	Tier 1: $5 copay per visit Tier 2: 30% co-insurance After Deductible	$50 copay per visit	**$0	30% coinsurance after deductible		40% coinsurance after deductible		Tier 1: $5 copay per visit Tier 2: 30% co- insurance after deductible	10% Coinsurance	25% Coinsurance	35% Coinsurance	45% Coinsurance
PacificSource Health Plans														
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.
^ SmartHealth network is available in Carbon, Missoula, Musselshell, Park, Stillwater, Sweet Grass and Yellowstone counties.

MONTANA HEALTH INSURANCE ANSWERS

CSI

2021 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	$800 per person/$1,600 per group	$8,500 per person/$17,100 per group	40% Coinsurance after deductible	50% Coinsurance after deductible	No Charge	$850 copay per stay with deductible, and 50% coinsurance after deductible	$600 copay with deductible, and 50% coinsurance after deductible	50% coinsurance after deductible	$1,000 copay with deductible, and 50% coinsurance after deductible	40% coinsurance after deductible	20% Coinsurance after deductible/25% Coinsurance after deductible	25% Coinsurance after deductible/30% Coinsurance after deductible	30% Coinsurance after deductible/35% Coinsurance after deductible	35% Coinsurance after deductible/40% Coinsurance after deductible
Blue Preferred Silver PPO 308	$8,550 per person/$17,100 per group	$8,500 per person/$17,100 per group	No Charge after deductible	No Charge after deductible	No Charge	No Charge after deductible					$10/$20	$15/$30	$50/$100	$100/$150
Blue Focus Silver POS 206	$4,200 per person/$8,400 per group	$8,500 per person/$17,100 per group	$25	50% Coinsurance after deductible	No Charge	$850 copay per stay with deductible, and 50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	$1,000 copay with deductible, and 50% coinsurance after deductible	50% coinsurance after deductible	$5/$10	$15/$25	$50/$70	$100/$120
Mountain Health Co-op														
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% coinsurance after deductible				First 10 visits $40 copay per visits, Then $40 copay per visit after deductible	20% coinsurance per prescription	30% coinsurance per prescription	40% coinsurance per prescription	50% coinsurance 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	$65 copay per visit After Deductible	$0	40% coinsurance after deductible				First 10 visits $40 copay per visits, Then $40 copay per visit after deductible	25% coinsurance per prescription	40% coinsurance per prescription	50% coinsurance per prescription	60% coinsurance 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% coinsurance after deductible				Tier 1: $10 copay per visit Tier 2: 40% coinsurance after deductible	20% coinsurance per prescription	30% coinsurance per prescription	40% coinsurance per prescription	50% coinsurance per prescription
PacificSource Health Plans														
Voyager Silver HSA 3500	$3,500/$7,000	$6,750/$13,500	After deductible 25%		No deductible,	After deductible 25%					After deductible 25%			
Navigator Silver HSA 3500	$3,500/$7,000	$6,750/$13,500	After deductible 25%		$0 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 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 deductible,	After deductible 30%				No deductible $35	After deductible 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.

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MONTANA HEALTH INSURANCE ANSWERS

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

2021 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 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	$3,200 per person/$6,400 per group	$8,500 per person/$17,100 per group	$25	50% Coinsurance after deductible	No Charge	$850 copay per stay with deductible, and 50% coinsurance after deductible	$600 copay with deductible, and 50% coinsurance after deductible	50% coinsurance after deductible	$1,000 copay with deductible, and 50% coinsurance after deductible	50% Coinsurance after deductible	No Charge after deductible/10% Coinsurance after deductible	10% Coinsurance after deductible/20% Coinsurance after deductible	20% Coinsurance after deductible/30% Coinsurance after deductible	35% Coinsurance after deductible/40% Coinsurance after deductible
Blue Preferred Bronze PPO 202	$4,000 per person/$8,000 per group	$6,900 per person/$13,800 per group	30% Coinsurance after deductible	30% Coinsurance after deductible	No Charge	$850 copay per stay with deductible, and 30% coinsurance after deductible	$600 copay with deductible, and 30% coinsurance after deductible	30% Coinsurance after deductible	$1,000 copay with deductible, and 30% coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible/25% Coinsurance after deductible	25% Coinsurance after deductible/30% Coinsurance after deductible	30% Coinsurance after deductible/35% Coinsurance after deductible	35% Coinsurance after deductible/40% Coinsurance after deductible
Blue Preferred Bronze PPO 301	$8,500 per person/$17,100 per group	$8,500 per person/$17,100 per group	No Charge after deductible	No Charge after deductible	No Charge	No Charge after deductible	No Charge after deductible	No Charge after deductible	No Charge after deductible	No Charge after deductible	No Charge after deductible/No Charge after deductible	No Charge after deductible/No Charge after deductible	No Charge after deductible/No Charge after deductible	No Charge after deductible/No Charge after deductible
Blue Focus Bronze POS 205	$4,700 per person/$9,400 per group	$8,500 per person/$17,100 per group	$40	50% Coinsurance after deductible	No Charge	$850 copay per stay with deductible, and 50% coinsurance after deductible	$600 copay with deductible, and 50% coinsurance after deductible	50% coinsurance after deductible	$1,000 copay with deductible, and 50% coinsurance after deductible	50% Coinsurance after deductible	No Charge after deductible/10% Coinsurance after deductible	10% Coinsurance after deductible/20% Coinsurance after deductible	20% Coinsurance after deductible/30% Coinsurance after deductible	35% Coinsurance after deductible/40% Coinsurance after deductible
Mountain Health Co-op														
Connected Care Bronze	$7,500/$15,000	$8,150/$16,300	$65 copay per visit	70% coinsurance after Deductible	**$0	60% coinsurance after deductible		70% coinsurance after deductible		$65 copay per visit	10% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after Deductible	60% coinsurance after Deductible
Connected Care Bronze Expanded	$8,400/$16,800	$8,550/$17,100	$60 copay per visit	$80 Copay per visit	**$0	50% coinsurance after deductible		60% coinsurance after deductible		$60 copay per visit	$15 copay per prescription after deductible	$125 per prescription after deductible	$160 copay per prescription after Deductible	$185 copay per prescription after Deductible
Connected Care Bronze Plus	$7,000/$14,000	$7,000/$14,000	0% coinsurance after deductible	0% coinsurance after Deductible	**$0	0% coinsurance after deductible		0% coinsurance after Deductible		0% co-insurance after Deductible	0% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after deductible	0% coinsurance after Deductible
Co-op Plus Bronze	$8,500/$17,000	$8,550/$17,100	$10 Copay per visit	70% coinsurance after Deductible	**$0	60% coinsurance after deductible		70% coinsurance after deductible		$10 Copay per visit	10% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible	60% coinsurance after Deductible
PacificSource Health Plans														
Voyager Bronze HSA 6900	$6,900/$13,800	$6,900/$13,800	After deductible 0%		No deductible $0	After deductible 0%					After deductible 0%			
Navigator Bronze HSA 6900	$6,900/$13,800	$6,900/$13,800	After deductible 0%		No deductible $0	After deductible 0%					After deductible 0%			
Voyager Bronze 7000	$7,000/$14,000	$8,550/$17,100	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	$8,550/$17,100	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 noted.

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

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MONTANA HEALTH INSURANCE ANSWERS

CSI

2021 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 *(Costs differ for 90-day mail order)*			
			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	**First 3 Visits: $20 copay then $0 after deductible	$0 after deductible	$0	$0 after deductible					No Charge after deductible			
Mountain Health Co-op														
Connected Care Catastrophic	$8,550/$17,100	8550/17100	First 3 visits: $0 then 0% after deductible	0% co-insurance after deductible	**$0	0% co-insurance after deductible					0% coinsurance 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