MONTANA HEALTH INSURANCE ANSWERS

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

## 2021 GOLD LEVEL Cost Sharing: Small Group 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** | | | | | | | | | | | | | | |
| ***Mountain Health Co-op*** | | | | | | | | | | | | | | |
| **Connected Care Gold** | $1,000/$2,000 | $6,500/$13,000 | $30 copay per visit | $50 copay per visit | **$0 | 30% coinsurance after Deductible | | 40% coinsurance after Deductible | | $30 copay per visit | $5 copay | $20 copay | $50 copay | $100 copay |
| **Co-op Plus Gold** | $1,000/$2,000 | $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 | $5 copay | $20 copay | $50 copay | $100 copay |
| ***PacificSource Health Plans*** | | | | | | | | | | | | | | |
| **Voyager Gold HSA 3000** | $3,000/$6,000 | $3,000/$6,000 | After deductible 0% | | No deductible | After deductible 0% | | | | | After deductible 0% | | | |
| **Navigator Gold HSA 3000** | $3,000/$6,000 | $3,000/$6,000 | After deductible 0% | | No deductible | After deductible 0% | | | | | After deductible 0% | | | |
| **▪Voyager Gold 2000** | $2,000/$4,000 | $5,550/$11,000 | No deductible $30 | No deductible $60 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $30 | No deductible $10 | No deductible $35 | No deductible $60 | No deductible $250 |
| **▪Navigator Gold 2000** | $2,000/$4,000 | $5,550/$11,000 | No deductible $30 | No deductible $60 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $30 | No deductible $10 | No deductible $35 | No deductible $60 | No deductible $250 |
| **▪Voyager Gold 1000** | $1,000/$2,000 | $5,550/$11,000 | No deductible $30 | No deductible $60 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $30 | No deductible $10 | No deductible $35 | No deductible $60 | No deductible $250 |
| **▪Navigator Gold 1000** | $1,000/$2,000 | $5,550/$11,000 | No deductible $30 | No deductible $60 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $30 | No deductible $10 | No deductible $35 | No deductible $60 | 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.*

**Copay**: *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.

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# 2021 SILVER LEVEL Cost Sharing: Small Group 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 | PRIMARY CARE Office Visit | PREVENTIVE CARE* | | | | | | Generic Tier 1 | Preferred Brand Tier 2 | Non-Preferred Brand Tier 3 | Specialty Tier 4/SP |
| SILVER | | | | | | | | | | | | | | |
| ***Mountain Health Co-op*** | | | | | | | | | | | | | | |
| **Connected Care Silver Plus** | $4,400/$8,800 | $7,000/$14,000 | 0% after Deductible | 0% after Deductible | ** $0 | 0% after Deductible | | | | | 0% after Deductible | | | |
| **Connected Care Silver Option 2** | $5,700/$11,400 | $7,500/$15,000 | $40 copay per visit | $75 copay per visit after Deductible | **$0 | 40% coinsurance after Deductible | | 50% coinsurance after Deductible | | $40 copay per visit | $10 copay | $50 copay | $100 copay | $150 copay |
| **Connected Care Silver** | $4,000/$8,000 | $8,550/$17,100 | $35 copay per visit | $75 copay per visit | **$0 | 40% coinsurance after Deductible | | 50% coinsurance after Deductible | | $35 copay per visit | $10 copay | $50 copay | $100 copay | $150 copay |
| **Co-op Plus Silver** | $5,300/$10,600 | $8,550/$17,100 | Tier 1: $10 copay per visit Tier 2: 40% co-insurance After Deductible | $75 copay per visit | **$0 | 40% coinsurance after Deductible | | 50% coinsurance after Deductible | | Tier 1: $10 copay per visit Tier 2: 40% co- insurance After Deductible | $10 copay | $50 copay | $100 copay | $150 copay |
| ***PacificSource Health Plans*** | | | | | | | | | | | | | | |
| **Voyager Silver HSA 5500** | $5,5500/$11,000 | $5,500/$11,000 | After deductible 0% | | No deductible | After deductible 0% | | | | | After deductible 0% | | | |
| **Navigator Silver HSA 5500** | $5,5500/$11,000 | $5,500/$11,000 | After deductible 0% | | No deductible | After deductible 0% | | | | | After deductible 0% | | | |
| **Voyager Silver HSA 4500** | $4,500/$9,000 | $4,500/$9,000 | After deductible 0% | | No deductible | After deductible 0% | | | | | After deductible 0% | | | |
| **Navigator Silver HSA 4500** | $4,500/$9,000 | $4,500/$9,000 | After deductible 0% | | No deductible | After deductible 0% | | | | | After deductible 0% | | | |
| **Voyager Silver HSA 3000** | $3,000/$6,000 | $6,750/$13,500 | After deductible 20% | | No deductible | After deductible 20% | | | | | After deductible 20% | | | |
| **Navigator Silver HSA 3000** | $3,000/$6,000 | $6,750/$13,500 | After deductible 20% | | No deductible | After deductible 20% | | | | | After deductible 20% | | | |
| **▪Voyager Silver 6500** | $6,500/$13,000 | $7,500/$15,000 | No deductible $30 | No deductible $60 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $30 | No deductible $15 | No deductible $60 | No deductible $100 | No deductible $250 |
| **▪Navigator Silver 6500** | $6,500/$13,000 | $7,500/$15,000 | No deductible $30 | No deductible $60 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $30 | No deductible $15 | No deductible $60 | No deductible $100 | No deductible $250 |
| **▪Voyager Silver 5500** | $5,500/$11,000 | $7,500/$15,000 | No deductible $30 | No deductible $60 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $30 | No deductible $15 | No deductible $60 | No deductible $100 | No deductible $250 |
| **▪Navigator Silver 5500** | $5,500/$11,000 | $7,500/$15,000 | No deductible $30 | No deductible $60 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $30 | No deductible $15 | No deductible $60 | No deductible $100 | No deductible $250 |
| **▪Voyager Silver 4500** | $4,500/$9,000 | $7,500/$15,000 | No deductible $35 | No deductible $70 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $35 | No deductible $15 | No deductible $60 | No deductible $100 | No deductible $250 |
| **▪Navigator Silver 4500** | $4,500/$9,000 | $7,500/$15,000 | No deductible $35 | No deductible $70 | No deductible | After deductible 30% | | | After deductible $250 plus 30% | No deductible $35 | No deductible $15 | No deductible $60 | No deductible $100 | No deductible $250 |
| **▪Voyager Silver 3000** | $3,000/$6,000 | $8,150/$16,300 | No deductible $35 | After deductible 40% | No deductible | After deductible 40% | | | After deductible $250 plus 40% | No deductible $35 | No deductible $15 | No deductible $60 | No deductible $100 | No deductible $250 |
| **▪Navigator Silver 3000** | $3,000/$6,000 | $8,150/$16,300 | No deductible $35 | After deductible 40% | No deductible | After deductible 40% | | | After deductible $250 plus 40% | No deductible $35 | No deductible $15 | No deductible $60 | No deductible $100 | No deductible $250 |
| SILVER | | | | | | | | | | | | | | |

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

MONTANA HEALTH INSURANCE ANSWERS

CSI

## 2021 BRONZE LEVEL Cost Sharing: SMALL GROUP 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** | | | | | | | | | | | | | | |
| ***Mountain Health Co-op*** | | | | | | | | | | | | | | |
| **Connected Care Bronze** | $7,250/$14,400 | $8,150/$16,300 | $60 coapy per visit | 70% co-insurance after Deductible | **$0 | 60% co-insurance after Deductible | | 70% co-insurance after Deductible | | $60 coapy per visit | $15 copay per perscription after Deductible | $125 per perscription after Deductible | $160 copay per perscription after Deductible | $185 copay per perscription after Deductible |
| **Connected Care Bronze Expanded** | $6,500/$17,000 | $8,550/$17,100 | $60 copay per visit | $75 Copay per visit | **$0 | 50% co-insurance after Deductible | | 60% co-insurance after Deductible | | $60 copay per visit | $15 copay per perscription after Deductible | $75 per perscription after Deductible | $125 copay per perscription after Deductible | $175 copay per perscription after Deductible |
| **Connected Care Bronze Plus** | $7,000/$14,000 | $7,000/$14,000 | 0% co-insurance after Deductible | 0% co-insurance after Deductible | **$0 | 0% co-insurance after Deductible | | 0% co-insurance after Deductible | | 0% co-insurance after Deductible | 0% co-insuarnce after | 0% co-insuarnce after | 0% co-insuarnce after Deductible | 0% co-insuarnce after |
| **Co-op Plus Bronze** | $7,800/$16,600 | $8,550/$17,100 | $10 Copay per visit | 70% co-insurance after Deductible | **$0 | 60% co-insurance after Deductilbe | | 70% co-insurance after Deductible | | $10 Copay per visit | $15 copay per perscription after Deductible | $125 per perscription after Deductible | $160 copay per perscription after Deductible | $185 copay per perscription after Deductible |
| ***PacificSource Health Plans*** | | | | | | | | | | | | | | |
| **Voyager Bronze 8150** | $8,150/$16,300 | $8,150/$16,300 | No deductible $40 | After deductible 0% | No deductible $0 | After deductible 0% | | | | No deductible $40 | After deductible 0% | | | |
| **Navigator Bronze 8150** | $8,150/$16,300 | $8,150/$16,300 | No deductible $40 | After deductible 0% | No deductible $0 | After deductible 0% | | | | No deductible $40 | After deductible 0% | | | |
| **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% | | | |
| **BRONZE** | | | | | | | | | | | | | | |

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