

**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
<b>BRONZE</b>														
<b>BlueCross BlueShield</b>														
<b>Blue Preferred Bronze PPO 006</b>	\$6,500/\$13,000	\$6,500/\$13,000	No copay; 0% after deductible		\$0	No copay; 0% after deductible				No copay; \$0 after deductible				
<b>Blue Preferred Bronze PPO 102</b>	\$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	
<b>Blue Preferred Bronze PPO 103</b>	\$6,350/\$12,700	\$7,150/\$14,300	No copay; 30% coinsurance after deductible		\$0	30% coinsurance after deductible				\$0 copay	\$50 copay*	\$100 copay*	\$250 copay*	
<b>Blue Focus POS 104 (1 \$0 PCP visit*)</b>	\$6,000/\$12,000	\$7,150/\$14,300	No copay; 20% coinsurance after deductible		\$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	30% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
<b>BCBS Basic 103 Multi State Plan (1 \$0 PCP visit*)</b>	\$6,100/\$12,200	\$7,150/\$14,300	No copay; 30% coinsurance after deductible		\$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
<b>Montana Health Coop</b>														
<b>Access Care</b>	\$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	
<b>Access Care PLUS</b>	\$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	
<b>Connected Care</b>	\$5,550/\$11,100	\$7,150/\$14,300	\$40 for first 3 visits, before deductible; 50% coinsurance on visits after deductible	50% coinsurance after deductible	\$0	50% coinsurance after deductible				\$40 for first 3 visits, before deductible; 50% coinsurance on visits after deductible	35% coinsurance	40% coinsurance	45% coinsurance	50% coinsurance

(All above MHC drug plan cost-sharing is **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.

**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			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		
<b>SILVER</b>																
<b>BlueCross BlueShield</b>																
<b>Blue Preferred Silver PPO 101</b> (3 \$0 PCP visits*)	\$3,000/\$6,000	\$6,600/\$13,200	No copay; 20% coinsurance after deductible		\$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*	
<b>Blue Preferred Silver PPO 105</b>	\$3,000/\$6,000	\$4,500/\$9,000			\$0	20% coinsurance after deductible				\$0 after deductible	20% coinsurance after deductible	30% coinsurance after deductible	NA			
<b>Blue Focus Silver POS 102</b>	\$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*	\$10* non-preferred	\$50 copay*	\$100 copay*	\$250 copay*		
<b>Blue Focus Silver POS 103</b>	\$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*	\$10* non-preferred	\$50 copay*	\$100 copay*	\$250 copay*		
<b>BCBS Solution 102 Multi State Plan</b> (2 \$0 PCP visits*)	\$3,350/\$6,700	\$5,600/\$11,200	No copay; 20% coinsurance after deductible		\$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	\$10* non-preferred	\$50 copay*	\$100 copay*	\$250 copay*		
<b>Montana Health Coop</b>																
<b>Access Care</b>	\$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*		
<b>Connected Care</b>	\$2,150/\$4,300	\$7,150/\$14,300	\$35 for first 3 visits, before deductible; 40% coinsurance 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; 40% coinsurance on visits after deductible	25% coinsurance*	30% coinsurance*	35% coinsurance*	40% coinsurance*	
<b>PacificSource</b>																
<b>PSN Silver (HSA) 3000</b>	\$3,000/\$6,000	\$5,000/\$10,000	25% coinsurance after deductible		\$0	25% coinsurance after deductible				25% coinsurance after deductible						
<b>SmartHealth^ Silver (HSA) 3000</b>	\$3,000/\$6,000	\$5,000/\$10,000	25% coinsurance after deductible		\$0	25% 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.

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

**PROPOSED – NOT YET APPROVED**



**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
<b>GOLD</b>														
<b>BlueCross BlueShield</b>														
<b>Blue Focus Gold POS 101</b>	\$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*
<b>Blue Preferred Gold PPO 104</b> (3 \$0 PCP visits*)	\$1,400/\$2,800	\$3,350/\$6,700	No copay; 20% coinsurance after deductible		\$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*
<b>BCBS Premier 101 Multi-state Plan</b> (3 \$0 PCP visits*)	\$1,650/\$3,300	\$3,350/\$6,700	No copay; 20% coinsurance after deductible		\$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*
<b>Montana Health Coop</b>														
<b>Access Care</b>	\$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*	
<b>Connected Care</b>	\$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*	30% coinsurance*	35% coinsurance*	
<b>Connected Care PLUS</b>	\$2,500/\$5,000	\$2,500/\$5,000	0% after deductible		\$0	No copay; 0% after deductible				0% after deductible				
<b>PacificSource</b>														
<b>PSN Gold 1500</b>	\$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*	
<b>SmartHealth^ Balance Gold 1500</b>	\$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.

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



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 <i>30-day retail order</i> <i>(Costs differ for 90-day mail order)</i>				
			PRIMARY CARE	SPECIALIST	PREVENTIVE CARE*						Generic Tier 1	Preferred Tier 2	Non-Preferred Tier 3	Specialty Tier 4/SP	
<b>CATASTROPHIC</b>															
<b>BlueCross BlueShield</b>															
<b>Blue Preferred Security PPO 100</b>	\$7,150/\$14,300	\$7,150/\$14,300	\$50 copay	\$0 after deductible	\$0	No copay; \$0 after deductible				No copay; No charge after deductible					
<b>Montana Health Coop</b>															
<b>Access Care</b>	\$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](http://www.bcbsmt.com)
- [www.mhc.coop](http://www.mhc.coop)
- [www.PacificSource.com](http://www.PacificSource.com)