2021

BlueCross BlueShield of Montana

Individual Plan Comparison Charts

All Blue Cross and Blue Shield of Montana plans provide coverage for preventive services and maternity care. Please see your Summary of Benefits and Coverage or visit **www.bcbsmt.com** for more specific information.

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BlueCross BlueShield of Montana

2021

Individual Plan Comparison Chart

Participating In-Network Provider Coverage Shown[1]

All Blue Cross and Blue Shield of Montana (BCBSMT) plans provide coverage for preventive services and maternity care. Please see your Outline of Coverage or visit **www.bcbsmt.com** for more specific information.

Bronze	Blue Preferred Bronze PPO℠					Blue Focus Bronze POS℠	
	201	202	301	302*	502*	205	302*
Individual Deductible[2]	$3,200	$4,000	$8,550	$5,200	$5,000	$4,700	$5,200
Coinsurance	50%	30%	0%	30%	50%	50%	30%
Out-of-Pocket Maximum (includes deductible)[2]	$8,550	$6,900	$8,550	$6,900	$6,900	$8,550	$6,900
Primary Care Office Visit	$25 copay	30%	0%	30%	50%	$40 copay	30%
Specialist Office Visit	50%	30%	0%	30%	50%	50%	30%
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	50%	30%	0%	30%	50%	50%	30%
Emergency Room	$1,000 per occurrence deductible, then 50%	$1,000 per occurrence deductible, then 30%	0%	$1,000 per occurrence deductible, then 30%	$1,000 per occurrence deductible, then 50%	$1,000 per occurrence deductible, then 50%	$1,000 per occurrence deductible, then 30%
Urgent Care	$40 copay	30%	0%	30%	50%	$40 copay	30%
Inpatient Hospital Services	$850 per occurrence deductible, then 50%	$850 per occurrence deductible, then 30%	0%	$850 per occurrence deductible, then 30%	$850 per occurrence deductible, then 50%	$850 per occurrence deductible, then 50%	$850 per occurrence deductible, then 30%
Outpatient Surgery[3]	$600 per occurrence deductible, then 50%	$600 per occurrence deductible, then 30%	0%	$600 per occurrence deductible, then 30%	$600 per occurrence deductible, then 50%	$600 per occurrence deductible, then 50%	$600 per occurrence deductible, then 30%
Outpatient X-Rays and Diagnostic Imaging[3]	50%	30%	0%	30%	50%	50%	30%
Outpatient Imaging (CT/PET Scans/MRIs)[3]	50%	30%	0%	30%	50%	50%	30%
Network	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Focus POS℠	Blue Focus POS℠
HSA Eligible[4]	No	Yes	No	Yes	Yes	No	Yes
Outpatient Prescription Drugs - Value Pharmacy[5,6]	0% / 10% / 20% / 35% / 45% / 50%	20% / 25% / 30% / 35% / 45% / 50%	0%[7]	20% / 25% / 30% / 35% / 45% / 50%	20% / 25% / 30% / 35% / 45% / 50%	0% / 10% / 20% / 35% / 45% / 50%	20% / 25% / 30% / 35% / 45% / 50%
Outpatient Prescription Drugs - Non-Value Pharmacy[5,6]	10% / 20% / 30% / 40% / 45% / 50%	25% / 30% / 35% / 40% / 45% / 50%	0%[7]	25% / 30% / 35% / 40% / 45% / 50%	25% / 30% / 35% / 40% / 45% / 50%	10% / 20% / 30% / 40% / 45% / 50%	25% / 30% / 35% / 40% / 45% / 50%
Prescription Drug Benefit Utilization Management Programs[8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through the Specialty Pharmacy provider. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to receive authorization from BCBSMT. You may also need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.						

1 Benefits are reduced when non-participating providers are used. This is a summary of benefit highlights only. All benefits shown represent what the member would pay.

2 The standard per person deductible and out-of-pocket maximum for this plan are shown. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Deductibles do not apply to services for which only copays are charged.

3 Members may have lower out-of-pocket costs for some services provided by non-emergency freestanding outpatient facilities than the out-of-pocket costs for services provided in a hospital setting. See your Outline of Coverage for additional details.

4 As a reminder, a Health Savings Account (HSA) has tax and legal ramifications. Blue Cross and Blue Shield of Montana does not provide legal or tax advice and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax adviser regarding tax consequences of specific health insurance plans or products.

5 Prescription benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Value Pharmacy Network may offer members prescription drugs with a lower possible member cost share amount.

6 Prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.

7 Prescription benefit coverage starts after annual deductible has been met. Once annual deductible is met, outpatient prescription drugs are covered at 100%.

8 Home delivery is not available for Specialty tier drugs. Drugs in these tiers are limited to a 30-day supply. Coverage limitations may apply to certain medications.

*** This plan is not available on the Health Insurance Marketplace in Montana.**

BlueCross BlueShield of Montana

2021

Individual Plan Comparison Chart

Participating In-Network Provider Coverage Shown[1]

All Blue Cross and Blue Shield of Montana (BCBSMT) plans provide coverage for preventive services and maternity care. Please see your Outline of Coverage or visit **www.bcbsmt.com** for more specific information.

Silver	Blue Preferred Silver PPO℠			Blue Focus Silver POS℠	
	203	306*	308	206	306*
Individual Deductible[2]	$800	$4,500	$8,550	$4,200	$4,500
Coinsurance	50%	50%	0%	50%	50%
Out-of-Pocket Maximum (includes deductible)[2]	$8,550	$8,550	$8,550	$8,550	$8,550
Primary Care Office Visit	40%	$25 copay	0%	$25 copay	$25 copay
Specialist Office Visit	50%	50%	0%	50%	50%
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	40%	50%	0%	50%	50%
Emergency Room	$1,000 per occurrence deductible, then 50%	$1,000 per occurrence deductible, then 50%	0%	$1,000 per occurrence deductible, then 50%	$1,000 per occurrence deductible, then 50%
Urgent Care	50%	$40 copay	0%	$40 copay	$40 copay
Inpatient Hospital Services	$850 per occurrence deductible, then 50%	$850 per occurrence deductible, then 50%	0%	$850 per occurrence deductible, then 50%	$850 per occurrence deductible, then 50%
Outpatient Surgery[3]	$600 per occurrence deductible, then 50%	50%	0%	50%	50%
Outpatient X-Rays and Diagnostic Imaging[3]	50%	50%	0%	50%	50%
Outpatient Imaging (CT/PET Scans/MRIs)[3]	50%	50%	0%	50%	50%
Network	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Focus POS℠	Blue Focus POS℠
HSA Eligible[4]	No	No	No	No	No
Outpatient Prescription Drugs - Value Pharmacy[5,6]	20% / 25% / 30% / 35% / 45% / 50%	$5 / $15 / $50 / $100 / $250 / $350	$10 / $15 / $50 / $100 / $250 / $500	$5 / $15 / $50 / $100 / $250 / $350	$5 / $15 / $50 / $100 / $250 / $350
Outpatient Prescription Drugs - Non-Value Pharmacy[5,6]	25% / 30% / 35% / 40% / 45% / 50%	$10 / $25 / $70 / $120 / $250 / $350	$20 / $30 / $100 / $150 / $250 / $500	$10 / $25 / $70 / $120 / $250 / $350	$10 / $25 / $70 / $120 / $250 / $350
Prescription Drug Benefit Utilization Management Programs[7]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through the Specialty Pharmacy provider. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to receive authorization from BCBSMT. You may also need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.				

1 Benefits are reduced when non-participating providers are used. This is a summary of benefit highlights only. All benefits shown represent what the member would pay.

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5 Prescription benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Value Pharmacy Network may offer members prescription drugs with a lower possible member cost share amount.

6 Prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.

7 Home delivery is not available for Specialty tier drugs. Drugs in these tiers are limited to a 30-day supply. Coverage limitations may apply to certain medications.

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2021

Individual Plan Comparison Chart

Participating In-Network Provider Coverage Shown[1]

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Gold	Blue Preferred Gold PPO℠	Blue Focus Gold POS℠
	204	207
Individual Deductible[2]	$750	$300
Coinsurance	30%	40%
Out-of-Pocket Maximum (includes deductible)[2]	$8,550	$8,550
Primary Care Office Visit	$10 copay	20%
Specialist Office Visit	30%	40%
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	30%	20%
Emergency Room	$1,000 per occurrence deductible, then 30%	$1,000 per occurrence deductible, then 40%
Urgent Care	$15 copay	40%
Inpatient Hospital Services	$850 per occurrence deductible, then 30%	$850 per occurrence deductible, then 40%
Outpatient Surgery[3]	30%	$600 per occurrence deductible, then 40%
Outpatient X-Rays and Diagnostic Imaging[3]	30%	40%
Outpatient Imaging (CT/PET Scans/MRIs)[3]	30%	40%
Network	Blue Preferred PPO℠	Blue Focus POS℠
HSA Eligible[4]	No	No
Outpatient Prescription Drugs - Value Pharmacy[5,6]	$5 / $10 / $50 / $100 / $250 / $350	10% / 20% / 30% / 35% / 45% / 50%
Outpatient Prescription Drugs - Non-Value Pharmacy[5,6]	$10 / $20 / $70 / $120 / $250 / $350	20% / 30% / 35% / 40% / 45% / 50%
Prescription Drug Benefit Utilization Management Programs[7]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through the Specialty Pharmacy provider. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to receive authorization from BCBSMT. You may also need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.	

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BlueCross BlueShield of Montana

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Montana

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.