2024

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 **bcbsmt.com** for more specific information.

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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BlueCross BlueShield of Montana

2024

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 **bcbsmt.com** for more specific information.

Bronze	Blue Preferred Bronze PPO℠				
	201	202	301	302[2]	705[2]
Individual Deductible[3]	$3,500	$4,000	$9,450	$5,200	$7,500
Coinsurance	50%	30%	0%	30%	50%
Out-of-Pocket Maximum (includes deductible)[3]	$9,450	$7,500	$9,450	$7,500	$9,400
Primary Care Office Visit	$35 copay	30%	0%	30%	$50 copay
Specialist Office Visit	50%	30%	0%	30%	$100 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	50%	30%	0%	30%	$50 copay
Emergency Room	$1,000 per occurrence deductible, then 50%	$1,000 per occurrence deductible, then 30%	0%	$1,000 per occurrence deductible, then 30%	50%
Urgent Care	$55 copay	30%	0%	30%	$75 copay
Inpatient Hospital Services	$850 per occurrence deductible, then 50%	$850 per occurrence deductible, then 30%	0%	$850 per occurrence deductible, then 30%	50%
Outpatient Surgery[4]	$600 per occurrence deductible, then 50%	$600 per occurrence deductible, then 30%	0%	$600 per occurrence deductible, then 30%	50%
Outpatient X-Rays and Diagnostic Imaging[4]	50%	30%	0%	30%	50%
Outpatient Imaging (CT/PET Scans/MRIs)[4]	50%	30%	0%	30%	50%
Network	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Preferred PPO℠
HSA Eligible[5]	No	Yes	No	Yes	No
Outpatient Prescription Drugs - Value Pharmacy[6]	0% / 10% / 20% / 35% / 45% / 50%[7]	20% / 25% / 30% / 35% / 45% / 50%[7]	0%[8]	20% / 25% / 30% / 35% / 45% / 50%[7]	$25 / $50 / $100 / $500[9]
Outpatient Prescription Drugs - Non-Value Pharmacy[6]	10% / 20% / 30% / 40% / 45% / 50%[7]	25% / 30% / 35% / 40% / 45% / 50%[7]	0%[8]	25% / 30% / 35% / 40% / 45% / 50%[7]	$25 / $50 / $100 / $500[9]
Prescription Drug Benefit Utilization Management Programs[10]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred 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 This plan is not available on the Health Insurance Marketplace® in Montana.
3 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.
4 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.
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6 Prescription drug coverage may not start until after the annual medical deductible has been met. Retail stores in the Value Pharmacy Network may offer members prescription drugs with a lower possible member cost share amount. Value pharmacy pricing is not available for 100% cost-sharing plans.
7 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.
8 Prescription benefit coverage starts after annual deductible has been met. Once annual deductible is met, outpatient prescription drugs are covered at 100%.
9 Four prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Specialty. Costs are for outpatient prescriptions through a preferred pharmacy. Deductible may apply to certain tiers. See your Summary of Benefits and Coverage for details.
10 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.

BlueCross BlueShield of Montana

2024

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 **bcbsmt.com** for more specific information.

Bronze	Blue Focus Bronze POS℠			
	205	302[2]	705	708
Individual Deductible[3]	$4,900	$5,200	$9,450	$7,500
Coinsurance	50%	30%	0%	50%
Out-of-Pocket Maximum (includes deductible)[3]	$9,450	$7,500	$9,450	$9,400
Primary Care Office Visit	$45 copay	30%	0%	$50 copay
Specialist Office Visit	50%	30%	0%	$100 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	50%	30%	0%	$50 copay
Emergency Room	$1,000 per occurrence deductible, then 50%	$1,000 per occurrence deductible, then 30%	0%	50%
Urgent Care	$60 copay	30%	0%	$75 copay
Inpatient Hospital Services	$850 per occurrence deductible, then 50%	$850 per occurrence deductible, then 30%	0%	50%
Outpatient Surgery[4]	$600 per occurrence deductible, then 50%	$600 per occurrence deductible, then 30%	0%	50%
Outpatient X-Rays and Diagnostic Imaging[4]	50%	30%	0%	50%
Outpatient Imaging (CT/PET Scans/MRIs)[4]	50%	30%	0%	50%
Network	Blue Focus POS℠	Blue Focus POS℠	Blue Focus POS℠	Blue Focus POS℠
HSA Eligible[5]	No	Yes	No	No
Outpatient Prescription Drugs - Value Pharmacy[6]	0% / 10% / 20% / 35% / 45% / 50%[7]	20% / 25% / 30% / 35% / 45% / 50%[7]	0%[8]	$25 / $50/ $100 / $500[9]
Outpatient Prescription Drugs - Non-Value Pharmacy[6]	10% / 20% / 30% / 40% / 45% / 50%[7]	25% / 30% / 35% / 40% / 45% / 50%[7]	0%[8]	$25 / $50/ $100 / $500[9]
Prescription Drug Benefit Utilization Management Programs[10]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred 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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4 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.

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7 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.

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

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BlueCross BlueShield of Montana

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Individual Plan Comparison Chart

Participating In-Network Provider Coverage Shown[1]

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Silver	Blue Preferred Silver PPO℠			
	203	306[2]	308	703
Individual Deductible[3]	$1,200	$3,000	$8,150	$5,900
Coinsurance	50%	50%	0%	40%
Out-of-Pocket Maximum (includes deductible)[3]	$9,450	$9,450	$8,150	$9,100
Primary Care Office Visit	40%	$25 copay	0%	$40 copay
Specialist Office Visit	50%	50%	0%	$80 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	50%	50%	0%	$40 copay
Emergency Room	$1,000 per occurrence deductible, then 50%	$1,000 per occurrence deductible, then 50%	0%	40%
Urgent Care	50%	$40 copay	0%	$60 copay
Inpatient Hospital Services	$850 per occurrence deductible, then 50%	$850 per occurrence deductible, then 50%	0%	40%
Outpatient Surgery[4]	$600 per occurrence deductible, then 50%	50%	0%	40%
Outpatient X-Rays and Diagnostic Imaging[4]	50%	50%	0%	40%
Outpatient Imaging (CT/PET Scans/MRIs)[4]	50%	50%	0%	40%
Network	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Preferred PPO℠
HSA Eligible	No	No	No	No
Outpatient Prescription Drugs - Value Pharmacy[5]	20% / 25% / 30% / 35% / 45% / 50%[6]	$5 / $15 / $50 / $100 / $250 / $350[6]	$10 / $15 / $50 / $100 / $250 / $500[6]	$20 / $40 / $80 / $350[7]
Outpatient Prescription Drugs - Non-Value Pharmacy[5]	25% / 30% / 35% / 40% / 45% / 50%[6]	$10 / $25 / $70 / $120 / $250 / $350[6]	$20 / $30 / $100 / $150 / $250 / $500[6]	$20 / $40 / $80 / $350[7]
Prescription Drug Benefit Utilization Management Programs[8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred 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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5 Prescription drug coverage may not start until after the annual medical deductible has been met. Retail stores in the Value Pharmacy Network may offer members prescription drugs with a lower possible member cost share amount.
6 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.
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Silver	Blue Focus Silver POS℠		
	206	306[2]	706
Individual Deductible[3]	$4,000	$3,000	$5,900
Coinsurance	40%	50%	40%
Out-of-Pocket Maximum (includes deductible)[3]	$9,450	$9,450	$9,100
Primary Care Office Visit	$30 copay	$25 copay	$40 copay
Specialist Office Visit	$45 copay	50%	$80 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	$30 copay	50%	$40 copay
Emergency Room	40%	$1,000 per occurrence deductible, then 50%	40%
Urgent Care	$45 copay	$40 copay	$60 copay
Inpatient Hospital Services	40%	$850 per occurrence deductible, then 50%	40%
Outpatient Surgery[4]	40%	50%	40%
Outpatient X-Rays and Diagnostic Imaging[4]	40%	50%	40%
Outpatient Imaging (CT/PET Scans/MRIs)[4]	40%	50%	40%
Network	Blue Focus POS℠	Blue Focus POS℠	Blue Focus POS℠
HSA Eligible	No	No	No
Outpatient Prescription Drugs - Value Pharmacy[5]	0% / 10% / 20% / 30% / 40% / 50%[6]	$5 / $15 / $50 / $100 / $250 / $350[6]	$20 / $40 / $80 / $350[7]
Outpatient Prescription Drugs - Non-Value Pharmacy[5]	0% / 10% / 20% / 30% / 40% / 50%[6]	$10 / $25 / $70 / $120 / $250 / $350[6]	$20 / $40 / $80 / $350[7]
Prescription Drug Benefit Utilization Management Programs[8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred 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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Gold	Blue Preferred Gold PPO℠		Blue Focus Gold POS℠	
	204	704	207	707
Individual Deductible[2]	$750	$1,500	$250	$1,500
Coinsurance	30%	25%	40%	25%
Out-of-Pocket Maximum (includes deductible)[2]	$9,450	$8,700	$9,450	$8,700
Primary Care Office Visit	$10 copay	$30 copay	20%	$30 copay
Specialist Office Visit	30%	$60 copay	40%	$60 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	30%	$30 copay	40%	$30 copay
Emergency Room	$1,000 per occurrence deductible, then 30%	25%	$1,000 per occurrence deductible, then 40%	25%
Urgent Care	$15 copay	$45 copay	40%	$45 copay
Inpatient Hospital Services	$850 per occurrence deductible, then 30%	25%	$850 per occurrence deductible, then 40%	25%
Outpatient Surgery[3]	30%	25%	$600 per occurrence deductible, then 40%	25%
Outpatient X-Rays and Diagnostic Imaging[3]	30%	25%	40%	25%
Outpatient Imaging (CT/PET Scans/MRIs)[3]	30%	25%	40%	25%
Network	Blue Preferred PPO℠	Blue Preferred PPO℠	Blue Focus POS℠	Blue Focus POS℠
HSA Eligible[4]	No	No	No	No
Outpatient Prescription Drugs - Value Pharmacy[5]	$5 / $10 / $50 / $100 / $250 / $350[6]	$15 / $30 / $60 / $250[7]	10% / 20% / 30% / 35% / 45% / 50%[6]	$15 / $30 / $60 / $250[7]
Outpatient Prescription Drugs - Non-Value Pharmacy[5]	$10 / $20 / $70 / $120 / $250 / $350[6]	$15 / $30 / $60 / $250[7]	20% / 30% / 35% / 40% / 45% / 50%[6]	$15 / $30 / $60 / $250[7]
Prescription Drug Benefit Utilization Management Programs[8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred 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
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

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
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
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 એવા 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 में 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 ánánílwo'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.