Blue Preferred Silver PPO[SM] 308

BlueCross BlueShield of Montana

To learn more, call Blue Cross and Blue Shield of Montana at 1-800-447-7828 or your local agent. www.bcbsmt.com
Certain terms in the Outline of Coverage and Contract are listed in the Definitions section. Defined terms are capitalized.

Outline of Coverage	2023	This Plan does not have an Annual or Lifetime Plan Maximum	
Benefit Period	January 1 – December 31		
		In-Network	**Out-of-Network**
Deductible *Copayments and/or Coinsurance do not accumulate to The Plan Deductible.*	Individual: Family:	$7,500 $15,000	$30,000 $60,000
Out of Pocket Amount	Individual: Family:	$9,100 $18,200	$36,400 $72,800
Deductible Per Visit or Occurrence *These Deductibles are in addition to The Plan Deductible and/or Coinsurance. Once the Out of Pocket Amount is satisfied, Plan Deductible, per visit or occurrence Deductibles, Coinsurance and/or Copayments do not apply.*	Inpatient Admission: Outpatient Surgery – Facility:	No per occurrence Deductible; Plan Deductible and Coinsurance apply No per occurrence Deductible; Plan Deductible and Coinsurance apply	$2,000 $2,000
Coinsurance		None	None
Copayment *Deductible and/or Coinsurance do not apply to In-Network Services.*	Outpatient Infusion Therapy Services for Routine Maintenance Drugs: Professional: Facility:	 $100 $1,000	 No Copayment; Deductible and Coinsurance apply No Copayment; Deductible and Coinsurance apply
Deductible and/or Coinsurance Waived For:	**In and Out-of-Network:** Diabetic Education Benefit (the first $250) **In-Network:** Preventive Health Care; Routine and Diagnostic Mammograms; Well-Child Care; Outpatient Infusion Therapy Services for Routine Maintenance Drugs; Hospice **Out-of-Network:** The first $70 for Routine Mammograms; Well-Child Care; however, Coinsurance applies to Well-Child Care		

Blue Cross and Blue Shield of Montana (BCBSMT) Provider Networks

In-Network Providers – In-Network providers accept the BCBSMT Allowable Fee, in addition to the Deductible, Coinsurance and/or Copayment, as payment in full for covered services. In-Network providers submit claims for the Member and BCBSMT pays In-Network providers directly. The Member will not be billed amounts over the Deductible, Coinsurance and/or Copayment.

Subject to applicable laws and regulations, if an In-Network provider is not available to provide Medically Necessary covered services, the Member may obtain the covered services from an Out-of-Network provider at the In-Network Benefit level, however, the Out-of-Network provider may balance bill the Member the difference between the Allowable Fee and their charge, in addition to any Deductible, Coinsurance and/or Copayment.

Out-of-Network Providers – Nonparticipating Providers have not contracted with BCBSMT to provide services at negotiated rates, and out of pocket expenses can be significantly higher. These providers are under no obligation to submit claims for the Member and may bill the Member the difference between the Allowable Fee and their charge, in addition to any Deductible, Coinsurance and/or Copayment.

Emergency Services – Services provided in a Hospital emergency department (emergency room) for an Emergency Medical Condition which is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another Hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn fetus. These services pay as In-Network, even if provided Out-of-Network. An Out-of-Network provider may bill the difference between the Allowable Fee and their charge, in addition to any Deductible, Coinsurance and/or Copayment. Nonemergency Services for Mental Illness or Substance Use Disorder provided in an emergency setting will be paid the same as Emergency Services.

Finding Participating Providers – To locate In-Network providers in Montana check the on-line provider directory at www.bcbsmt.com or contact Customer Service at 1-800-447-7828.

Out of State Networks at Your Fingertips – The BlueCard program provides access to Participating Providers across the country. To find BlueCard Providers, visit the BlueCross and BlueShield Association website at https://provider.bcbs.com or call 1-800-810-BLUE (2583).

Deductible: The dollar amount each Member must pay for Covered Medical Expenses incurred during the Benefit Period before BCBSMT will make payment for any Covered Medical Expense to which the Deductible applies. This Plan has an In-Network Deductible and separate Out-of-Network Deductible.

Out of Pocket Amount: The total amount of Deductible and any applicable Coinsurance and/or Copayment that each Member would pay in a single Benefit Period. Once the Out of Pocket Amount is met, The Plan pays 100% of the Allowable Fee on covered services. However, any amount each Member pays for balances owed to nonparticipating providers and the Out-of-Network Pharmacy 50% Benefit reduction do not apply to the Out of Pocket Amount. This Plan has an In-Network Out of Pocket Amount and a separate Out-of-Network Out of Pocket Amount.

Coinsurance: The percentage of the Allowable Fee payable by the Member for Covered Medical Expenses. This Plan has an In-Network Coinsurance and a separate Out-of-Network Coinsurance.

Copayment: The specific dollar amount payable by the Member for Covered Medical Expenses.

Rating Factors and Trend: These rating factors are used: income and claims experience for the prior 12 Months for the product being rated, the Benefit difference for the Deductible, Coinsurance and/or Copayment relationship for the specific products in a category, the projected claims, income and enrollment for the next 12-Month rating period, projected expenses for the next rating period, and/or age of the applicant or subscriber, industry, and risk characteristics. The trend of premium increases during the preceding five years is: 2018 – 8.3%, 2019 – 0%, 2020 – (-14.1%), 2021 – 0%, 2022 – (-2%).

Your estimated premium will be _____.

Deductible, Copayment and/or Coinsurance apply to all services listed below, unless otherwise noted. This is only a summary of Benefits. Benefits and general provisions are subject to the terms of the Contract. Prior Authorization is not a guarantee of payment but is required for some services, supplies, treatments and prescription drugs to determine if services are Medically Necessary and a Benefit of the Contract.		
Professional Provider Services	Covered services include home and office calls, x-ray, lab and other services provided by a professional provider.	
Preventive Health Care, including Routine Mammograms and Well-Child Care	Services include: 1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's (USPSTF) current recommendations; and 2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention; and 3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women; and 4. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued prior to November 2009. Examples of Preventive Health Care services as defined under federal law include, but are not limited to, colonoscopies, immunizations, and vaccines. Examples of other Preventive Health Care services include, but are not limited to, physical examinations and annual In Home Health Assessment. Any services that are billed as a diagnostic service, will be covered under regular medical Benefits. Deductible, Copayment and/or Coinsurance do not apply to In-Network services which are paid at 100% of the Allowable Fee. Deductible and Coinsurance apply to Out-of-Network services, except for the first $70 for Out-of-Network Routine mammograms. Deductible does not apply to Out-of-Network Well-Child Care.	
Inpatient Hospital	Room and board, special care units, ancillary charges, and transplant coverage.	
Outpatient Hospital	Accidental Injury, x-ray/lab, surgery, chemotherapy, respiratory therapy, medical emergencies and other services.	
Maternity Services	Professional and facility services are processed under regular medical Benefits.	
Emergency Room Care	Services provided for accidental Injury and Emergency Services.	
Transplants	Processed under regular medical Benefits.	
Convalescent Home	Skilled nursing facility, transitional care units and extended care facilities. 60 days per Benefit Period.	
Chiropractic and Acupuncture Services	Chiropractic: 10-visit maximum per Benefit Period. Acupuncture: 12-visit maximum per Benefit Period.	
Home Health Care	180-visit maximum per Benefit Period.	
Hospice	Deductible and Coinsurance do not apply to In-Network services which are paid at 100% of the Allowable Fee. Deductible, Coinsurance and/or any applicable per occurrence Deductible apply to Out-of-Network services.	
Individual Therapies	Outpatient Physical, Occupational, Speech and cardiac Rehabilitation Therapies for professional and facility charges.	
Rehabilitation Therapy	Inpatient and Outpatient Rehabilitation Therapy services.	
Durable Medical Equipment and Prostheses	Initial purchase, replacement, and repair.	
Pediatric Vision (under 19 years of age)	Routine eye exam, Deductible and Coinsurance do not apply. Paid at 100% of the Allowable Fee. Lenses and frames processed under regular medical Benefits.	
Mental Illness	Processed under regular medical Benefits.	
Substance Use Disorder	Processed under regular medical Benefits.	
Autism Spectrum Disorder	Diagnosis and treatment of Autistic disorder, Asperger's disorder or pervasive developmental disorder.	
Mammograms (Medical/Diagnostic)	Deductible and Coinsurance do not apply to In-Network services which are paid at 100% of the Allowable Fee. Deductible and Coinsurance apply to Out-of-Network services.	
Diagnostic Services	Processed under regular medical Benefits.	
Diabetic Education Benefit	Deductible and Coinsurance do not apply to the first $250 per Benefit Period for Outpatient services. After the first $250 in payment, Deductible, Copayment and/or Coinsurance apply.	
Prescription Drugs	**Value Participating Pharmacy Copayment/Coinsurance**	**Participating/Nonparticipating Pharmacy Copayment/Coinsurance**
Retail: 30-day supply	Tier 1 – $10; Tier 2 – $15; Tier 3 – $50; Tier 4 – $100	Tier 1 – $20; Tier 2 – $30; Tier 3 – $100; Tier 4 – $150
Retail: 90-day supply Only available at Value Participating Pharmacies	Tier 1 – $30; Tier 2 – $45; Tier 3 – $150; Tier 4 – $300	
Mail-Order: 90-day supply Only available through the Preferred Mail-Order Pharmacy Network	Tier 1 – $30; Tier 2 – $45; Tier 3 – $150; Tier 4 – $300	
Specialty Medications: 30-day supply	Tier 5 – $250; Tier 6 – $500	
Deductible: *Does Not Apply* *(The Member must pay the difference between a Brand-Name Drug and the generic equivalent, in addition to any applicable Deductible, Copayment and/or Coinsurance, if the Member chooses a Brand-Name Drug when a Generic Drug is available.)*	Amounts paid at a Value or a Participating Pharmacy apply to any applicable In-Network Deductible and Out of Pocket Amount. Amounts paid at a nonparticipating Pharmacy apply to any applicable Out-of-Network Deductible and Out of Pocket Amount. Payment for prescription drugs purchased at a nonparticipating Pharmacy will be reduced by 50%, in addition to any applicable Participating Network Coinsurance and/or Copayment. This 50% Benefit reduction does not apply to any applicable Deductible and/or Out of Pocket Amount.	

Member's Rights – When requested by the Member or the Member's agent, BCBSMT is required to provide a summary of a Member's coverage for a specific health care service or course of treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or Hospital exceeds $500.

The Appeals section in the Contract contains information regarding utilization review procedures, including procedures for obtaining review of adverse determinations, and the Member's rights with respect to those procedures.

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		

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 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 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.