



Blue Cross Group Medicare Advantage (PPO)SM

	In-Network	Out-of-Network
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Annual Deductible	\$0	
Out-of-Pocket Maximum Includes the Annual Deductible	\$0	\$5,100
Primary Care Office Visit	\$0 copay	10% coinsurance
Specialist Office Visit	\$0 copay	10% coinsurance
Inpatient Hospital Care	\$0 copay	10% coinsurance
Outpatient Hospital Services	\$0 copay	10% coinsurance
Emergency Care	\$80 copay	
Emergency Ambulance	\$0 copay	
Dental Services – Preventive	\$5 copay Supplemental: 2 exams, 2 cleanings, 1 X-ray every year Out-of-network: Providers may balance bill above the network allowable charge.	
Dental Services – Comprehensive	\$1,000 combined in and out-of-network annual allowance on supplemental comprehensive dental services each year 100% plan pays: Basic restorative: e.g. cavities, non-surgical extractions, dental pain relief. Major restorative: e.g. surgical tooth extractions, root canals; includes crown and dentures. Basic and major restorative services covered the same as in-network except providers may balance bill above the in-network allowable charges.	
Vision Services – Routine Eye Exam	\$10 copay	\$40 allowance
Vision Services – Eyewear	\$150 allowance Combined in-network and out-of-network allowance on eyewear every 2 years (\$0 copay/standard eyeglass lenses)	
Hearing Services – Routine Hearing Exam	\$0 copay	10% coinsurance
Hearing Services – Hearing Aids	\$1,000 allowance Combined in-network and out-of-network allowance on hearing aids every 3 years	
Over-the-Counter Allowance	\$20 per month with rollover to next month	
Rewards Program	\$25 worth of gift cards up to 4 times per year	

Turn over for prescription drug benefits →



Prescription Drug Benefits	
Annual Deductible	\$0
Initial Coverage Period Copays (30-day supply) Annual drug costs up to \$4,430	Preferred Pharmacy / Standard Pharmacy
	Tier 1 – Preferred Generic \$0 / \$5
	Tier 2 – Generic \$6 / \$11
	Tier 3 – Preferred Brand \$39 / \$44
	Tier 4 – Non-Preferred Drug \$85 / \$95
	Tier 5 – Specialty 33% coinsurance
Gap Coverage Copays Annual drug costs exceeding \$4,430 (up to a total of \$7,050 out-of-pocket costs)	Tier 1 – Preferred Generic \$0 / \$5
	Tier 2 – Generic \$6 / \$11
	Tier 3 – Preferred Brand \$39 / \$44
	Tier 4 – Non-Preferred Drug \$85 / \$95
	Tier 5 – Specialty 15% coinsurance
After the Gap Copays After your total out-of-pocket costs exceed \$7,050	Member pays whichever is greater: <ul style="list-style-type: none"> 5% of the total cost, or \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copay for all other drugs
Preferred Pharmacy Networks	Albertson's, Arete, Health Mart Atlas, Kroger (Smith's), Walgreens, Walmart

Contact your Benefit Administrator at **1-406-443-8102**,
Monday – Friday, 8 a.m. – 5 p.m. MT for more information.

This information is not a complete description of benefits. Non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Montana members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.

The Healthy Activity Portal is a website owned and operated by HealthMine, Inc., an independent company that provides digital health and personal clinical engagement tools and services for Blue Cross and Blue Shield of Montana members. Registration is required to participate. Visit www.BlueRewardsMT.com to register and see what Healthy Actions earn rewards. Maximum annual rewards of \$100 in gift cards. One reward per Healthy Action per year. Healthy Action dates of service must be in the current plan year. Healthy Actions that earn rewards are subject to change.

HMO and PPO plans provided by Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HMO plans available for employer/union groups only. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.