BlueCross BlueShield of Montana

Montana Association of Counties

2023 Rate is $278.90	Blue Cross Group Medicare Advantage (PPO)℠	
Effective 1/1/2023 - 12/31/2023	In-Network	Out-of-Network
Annual Deductible	$0	
Out-of-Pocket Maximum Includes the Annual Deductible	$0	$5,100
Inpatient Hospital Care	$0 copay	10% coinsurance
Emergency Care	$80 copay	
Ambulance Services	$0 copay	
Primary Care Office Visit	$0 copay	10% coinsurance
Specialist Office Visit	$0 copay	10% coinsurance
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	
Fitness Program	SilverSneakers℠	
Rewards Program	$25 worth of gift cards up to 4 times per year	

Turn over for prescription drug benefits →

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	Prescription Drug Benefits	
Annual Deductible	**$0**	
Initial Coverage Period Copays (30-day supply) Annual drug costs up to $4,660	**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 $4,660 (up to a total of $7,400 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 $7,400	Member pays whichever is greater: • 5% of the total cost, or • $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copay for all other drugs	
Preferred Pharmacy Networks	Albertson's, Kroger (Smith's), Walgreens, Walmart	

Contact your Benefit Administrator at **1-833-314-3004**
September 1 – January 31: Daily, 8:00 a.m. to 9:00 p.m. CT
February 1 – August 31: Monday through Friday, 8:00 a.m. to 8:00 p.m. local time.
Alternate technologies (for example, voicemail) will be used on weekends and holidays.

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.

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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.

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